This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0001 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/24/2023 9:39 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/24/2023 9: 39 am Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

CERTIFICATION BY 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 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 01/01/2022 and ending 12/31/2022 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Steve	Berkhouse	ı	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Steve Berkhouse			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	121, 761	50, 766	0	-135, 984	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	TOTAL	0	121, 761	50, 766	0	-135, 984	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

							From 01/01/ To 12/31/	2022	Part I Date/Ti		
	1.00	2. 00		3. 00				1. 00	5/24/20	123 9:3	9 am
	Hospital and Hospital Health Care Co										
1. 00 2. 00	Street: 1125 WEST JEFFERSON STREET City: FRANKLIN	PO Box: State: IN	Zip Cod	۵۰ 461	31_	County	y: JOHNSON				1.00 2.00
2.00	or cy. Trouveri	Component Name	CCN	CBS		rovi der	Date	Paymer	nt Syst	em (P,	2.00
			Number	Numb	oer	Type	Certi fi ed	_	0, or		
		1. 00	2. 00	3. (20	4. 00	5. 00	V 6. 00	7. 00		
	Hospital and Hospital-Based Componer	nt Identification:	2.00								
3. 00	Hospi tal	JOHNSON MEMORIAL HOSPITAL	150001	269	00	1	07/01/1966	N	Р	0	3. 00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Subprovi der - IPF Subprovi der - IRF Subprovi der - (Other) Swing Beds - SNF Swing Beds - NF Hospi tal -Based SNF Hospi tal -Based NF Hospi tal -Based OLTC Hospi tal -Based HHA	JOHNSON MEMORIAL HOME	157510	269	00		07/01/1997	N	P	N	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	Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other										13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
							From: 1.00		To 2. 0		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/20	022	12/31/		20.00
21. 00	Type of Control (see instructions)						9				21.00
					1	. 00	2. 00		3. 0	00	
	Inpatient PPS Information				·				0. 0		
22. 00	Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" for facility subject to 42 CFR Section \$60 hospital?) In column 2, enter "Y" for jid this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or	ustment, in accordance wear yes or "N" for no. Is 412.106(c)(2)(Pickle amor yes or "N" for no. Ps, including supplement column 1, "Y" for yes or generated yes or	ith 42 CF this endment tal UCPs, or "N" fo r to Octo	for r no ber		Y	Y				22. 00
	cost reporting period occurring on c	•									
22. 02	instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for the period prior to October 1. Enter in for the portion of the cost reportir	? (see instructions) En me portion of the cost r column 2, "Y" for yes o	ter in co eporting r "N" for			N	N				22. 02
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in of for the portion of the cost reportir 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	ic reclassification from the formula of the formula	m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (reas no er as		N	N		N		22. 03
22. 04	yes or "N" for no.						22. 04				
23. 00	yes or "N" for no. Which method is used to determine Mebelow? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	of admission, 2 if cens of identifying the days method used in the prio	us days, in this r cost	or 3			3 N				23. 00

Health Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0001 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/24/2023 9:39 am In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 105 1. 031 497 0 24.00 0 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν N Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N",

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0001 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/24/2023 9: 39 am XVIII XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	JOHNSON	MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 01/01/2022	Worksheet S-2 Part I	pared:
		, ,	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	Zum
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea	ar FTE Residents in N	onprovider Settings				
period that begins on or after and the second of the secon	s yes, or your facili aber of unweighted no otations occurring in a number of unweighted our hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64. 00
of (column 1 divided by (column	Program Name	Program Code	Unweighted	Unwei ahted	Ratio (col.	
	Program Name	Program code	FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00		65. 00
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col. 2))	
			Si te			
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	ysEffective f	or cost report	ing periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided)	unweighted non-primal occurring in all nonpo unweighted non-primal al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0.000000 Ratio (col.	66. 00
	i i ogi alli malle	11 ogi alii code	FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2.00	3.00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.000000	67.00

Health Financial Systems JOHNSON MEMORIAL HOSPITAL			Lieu	ı of Form		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provide	CCN: 15-0001	Period: From 01/01/ To 12/31/		Workshee Part I Date/Tim 5/24/202	e Prei	pared:
						7 (1111
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 4906				1. 00		
68.00 For a cost reporting period beginning prior to October 1, 2022, did you MAC to apply the new DGME formula in accordance with the FY 2023 IPPS (August 10, 2022)?				N		68. 00
			1. 00	2.00	3. 00	
Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it of	ontain an IPF s	subprovi der?	N			70. 00
Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME tearecent cost report filed on or before November 15, 2004? Enter "Y" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train reside program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for Column 3: If column 2 is Y, indicate which program year began during to (see instructions)	ching program i r yes or "N" fo nts in a new te r yes or "N" fo	n the most or no. (see eaching or no.	N	N	0	71.00
Inpatient Rehabilitation Facility PPS)F				75.00
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does i subprovider? Enter "Y" for yes and "N" for no.			N			75. 00
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME tearecent cost reporting period ending on or before November 15, 2004? En no. Column 2: Did this facility train residents in a new teaching prog CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period. (ter "Y" for yes ram in accordar If column 2 is	or "N" for ace with 42 ; Y,	N	N	0	76. 00
			-	1. 00		
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for 1.00 Is this a LTCH co-located within another hospital for part or all of to "Y" for yes and "N" for no.		ng period? E	Enter	N N		80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? E 86.00 Did this facility establish a new Other subprovider (excluded unit) ur			no.	N		85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classifi 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ed under sectio	n		N		87. 00
		Approved Permane Adjustme (Y/N) 1.00	ent ent	Number Approv Permane Adjustme 2.00	ed ent ents	
88.00 Column 1: Is this hospital approved for a permanent adjustment to the amount per discharge? Enter "Y" for yes or "N" for no. If yes, complet 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.				2.00		88. 00
corumn 2. Enter the number of approved permanent adjustments.	Wkst. A Lir		ve	Approv	ed	
	No.	Date		Permane Adjustm Amount Dischar	ent Per	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2. 00		3. 00		89. 00
on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amour per discharge. Column 3: Enter the amount of the approved permanent adjustment to the	t					
TEFRA target amount per discharge.		V		VIV		
		1.00		XI X 2. 00		
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services	? Enter "Y" for	· Y		Y		90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost re	port either in	N		Υ		91. 00
full or in part? Enter "Y" for yes or "N" for no in the applicable col 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certifi		N		92.00		
instructions) Enter "Y" for yes or "N" for no in the applicable column 93.00 Does this facility operate an ICF/IID facility for purposes of title N		- N		N		93. 00
"Y" for yes or "N" for no in the applicable column. 94. 00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for		N N		N		94. 00
applicable column. 95.00 fline 94 is "Y", enter the reduction percentage in the applicable co		0.00		0. 00		95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.	r no in the	N		N		96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable co	ı ulli.	0.00	I	0. 00	1	97. 00

Health Financial Systems JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0001	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I	2 epared:
	V 1. 00	XI X 2. 00	
Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	Y	Y	98.00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for		Y	98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	Y	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column		N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N d	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance or Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and i		Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH?	N		105.00
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of paymer for outpatient services? (see instructions)	- 1		106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?	N		107. 00
Enter "Y" for yes or "N" for no in column 2. (see instructions) 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	2 N		108. 00
Physical Occupationa		Respi ratory	
1.00 2.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	3. 00 N	4. 00 N	109.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§ Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through applicable.	If yes,	1. 00 N	110.00
	1.00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N N		111.00
1.00	2.00	3.00	+
112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			112.00
113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost			
113.00 Did this hospital participate in the Community Health Access and Rural			+
113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.			0115.00
113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or		(
113.00 Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			116. 00 117. 00

Health Financial Systems	JOHNSON MEMOR	II AL HOSPI TAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			Provi der CCN: 15-0001			Worksheet S- Part I Date/Time Pr 5/24/2023 9:	2 repared:
						1. 00	-
147.00 Was there a change in the statist	ical basis? Enter "Y" for	ves or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order o						N N	148. 00
149.00 Was there a change to the simplif				for no.		N	149.00
		Part A	Part E	3 T	itle V	Title XIX	
		1.00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155.00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovider - IPF		N	N		N	N	156. 00
157. 00 Subprovi der - I RF		N	N		N	N	157.00
158. 00 SUBPROVI DER		N	N.		N	N.	158. 00 159. 00
159.00 SNF 160.00 HOME HEALTH AGENCY		N N	N N		N N	N N	160.00
161. OO CMHC		IN IN	N N		N	N N	161.00
TOT. OO CWITE] IN		IN .		101.00
Multicampus						1. 00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	ne or more camp	ouses in di	fferent C	BSAs?	N	165. 00
Eliter i for yes or in for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						O. C	10 166. 00
	·					1. 00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery ar	nd Reinvest	ment Act			
167.00 Is this provider a meaningful use	r under §1886(n)? Enter	"Y" for yes or	"N" for no			Y	167. 00
168.00 If this provider is a CAH (line 1			ne 167 is "	Y"), ente	r the		168. 00
reasonable cost incurred for the 168.01 If this provider is a CAH and is	not a meaningful user, do	es this provide	er qualify	for a har	dshi p		168. 01
exception under §413.70(a)(6)(ii) 169.00 f this provider is a meaningful					enter the	9. 9	99169.00
transition factor. (see instruction	ons)						
					gi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending	date for the r	eporti ng				170.00
					1. 00	2. 00	
171.00 f line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt umn 1. If column 1 is yes	. I, line 2, co	ol. 6? Ente	r	N		0171.00

	Financial Systems JOHNSON MEMOR		011 45 51		u of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0001	Peri od: From 01/01/2022 To 12/31/2022		epared:
				Y/N	Date	37 (1111
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURS General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			ter all dates in	the	
1. 00	<u>Provider Organization and Operation</u> Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N S)		1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare	Drogram2 If	1.00 N	2. 00	3. 00	2.00
3. 00	yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary. Is the provider involved in business transactions, includicontracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	ng management offices, drug der or its of the board	N			3. 00
			Y/N	Туре	Date	
	Financial Data and Parasta		1.00	2. 00	3. 00	
4. 005. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff	for Compiled, vailable in Gerent from	Y	A		4.00
	those on the filed financial statements? If yes, submit re	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	•	s the provide			6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see i Were nursing programs and/or allied health programs approv cost reporting period? If yes, see instructions.	red and/or rene	· ·			7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.				9.00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	tne current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.		proved	N		11. 00
					Y/N	
	Bad Debts				1. 00	
	Is the provider seeking reimbursement for bad debts? If ye If line 12 is yes, did the provider's bad debt collection			cost reporting	Y N	12. 00 13. 00
14. 00	<pre>period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsur instructions.</pre>	ance amounts w	aived? If yes	s, see	N	14.00
15. 00	Bed Complement Did total beds available change from the prior cost report	ing period? If	yes, see ins	structions.	N	15.00
			t A		t B	
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2.00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	03/30/2023	Y	03/30/2023	16.00
17. 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	N		N		17. 00
18. 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 cost report? If yes, see instructions.	N		N		18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems JOHNSON MEMOR	LIAL HOSPITAL		In Lie	u of Form CN	IS-2552-10	
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0001	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part II	S-2 Prepared:	
			iption	Y/N	Y/N		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00	
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00	
		Y/N	Date	Y/N	Date		
04.00	lw	1.00	2. 00	3.00	4. 00	01.00	
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 (EXC	EPT CHILDRENS	HOSPI TALS)				
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, se	o instructions				22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense		23. 00				
20.00	reporting period? If yes, see instructions.	aus to app. a.	care made ad.	Tring the deat		20.00	
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	Š				24.00	
25. 00	Have there been new capitalized leases entered into during	the cost repo	orting period	? If yes, see		25. 00	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost report	ing period? I	If yes, see		26. 00	
27. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? It	f yes, submit		27. 00	
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	entered into du	ırina the cost	t reporting		28. 00	
	period? If yes, see instructions.		Ü				
29. 00	Did the provider have a funded depreciation account and/or		ebt Service F	Reserve Fund)		29. 00	
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat instructions.		debt? If yes	s, see		30. 00	
31. 00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes	s, see		31.00	
32. 00	Purchased Services Have changes or new agreements occurred in patient care se	ervices furnish	ed through co	ontractual		32.00	
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	itive bidding? If		33. 00	
	no, see instructions. Provider-Based Physicians					_	
34. 00	Were services furnished at the provider facility under an	arrangement wi	th provider-b	pased physicians?		34.00	
01.00	If yes, see instructions.	arrangement w	tii provider i	basea priysi erans.		01.00	
35. 00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		ents with the	provi der-based		35.00	
				Y/N	Date		
	Home Office Costs			1. 00	2. 00		
36 00	Home Office Costs Were home office costs claimed on the cost report?					36.00	
	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	home office	?		37. 00	
38. 00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			f		38.00	
39. 00				5,		39. 00	
40. 00	If line 36 is yes, did the provider render services to the instructions.	e home office?	If yes, see			40. 00	
	1.00 2.00						
	Cost Report Preparer Contact Information	<u> </u>					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TINA		SEVERS		41.00	
42. 00	Enter the employer/company name of the cost report preparer.	BLUE & CO				42.00	
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANI	DCO. COM	43. 00	

Heal th	n Financial Systems	JOHNSON MEMORI	I AL	HOSPI TAL			In Lieu	u of Form CMS-	2552-10
HOSPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der C	CCN: 1	Perio		Worksheet S-2	2
						To	01/01/2022 12/31/2022		epared: 39 am
				3.	. 00				
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the t	itle/position	MANA	AGER					41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the co	st report							42.00
	preparer.								
43.00	Enter the telephone number and email addr	ess of the cost							43.00
	report preparer in columns 1 and 2, respe	cti vel y.							

Heal th Fi nancial SystemsJOHNSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0001

				To	o 12/31/2022	Date/Time Pre 5/24/2023 9:3	
	·					1/P Days /	7 alli
						0/P Visits /	
						Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1. 00	2.00	0.00	1. 00	0.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	44	16, 060	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4. 00	HMO IRF Subprovider						4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	
7. 00	Total Adults and Peds. (exclude observation		44	16, 060	0. 00	0	7. 00
0.00	beds) (see instructions)	24 00	4.4	F 440	0.00		0.00
8. 00 9. 00	I NTENSI VE CARE UNI T	31. 00	14	5, 110	0. 00	0	8. 00 9. 00
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				0	13.00
14. 00	Total (see instructions)	43.00	58	21, 170	0. 00	0	14.00
15. 00	CAH visits		30	21, 170	0.00	0	15.00
16. 00	SUBPROVIDER - I PF					Ŭ	16.00
17. 00	SUBPROVIDER - IRF	41. 00	0	0		0	
18. 00	SUBPROVI DER		_				18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101. 00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	1
27. 00	Total (sum of lines 14-26)		58				27. 00
28. 00	Observation Bed Days					0	
29. 00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		0	0			31.00
32.00	Labor & delivery days (see instructions)		U	U			32. 00 32. 01
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33.00
33. 00	LTCH site neutral days and discharges						33.00
	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	34.00
	1 1 3 1.		-				

Heal th Fi nancial SystemsJOHNSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0001

				''	0 12/31/2022	5/24/2023 9: 3	
		I/P Days	/ O/P Visits	/ Trins	Full Time I	Equi val ents	<u> </u>
		171 bays	, , 0,1 113113	, 111 ps	Turr rime i	Equi vai cires	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	55p5.115111			Patients	& Residents	Payrol I	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	71.00	0.00	7. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 711	73	5, 155			1.00
	8 exclude Swing Bed, Observation Bed and	.,					
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 184	1, 358				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	ol	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	ol	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 711	73	_			7. 00
7.00	beds) (see instructions)	.,,		0, 100			/
8.00	INTENSIVE CARE UNIT	510	4	1, 544			8.00
9. 00	CORONARY CARE UNIT		•	.,			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		17	508			13.00
14. 00	Total (see instructions)	2, 221	94		0.00	613. 73	1
15. 00	CAH visits	2,221	0		0.00	0.0.70	15. 00
16. 00	SUBPROVIDER - I PF	Ĭ	Ü	J			16.00
17. 00	SUBPROVIDER - I RF	ol	0	0	0.00	0.00	
18. 00	SUBPROVI DER	Ĭ	ŭ		0.00	0.00	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	883	0	2, 900	0.00	7. 01	1
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		_	_,			23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			17			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	ol	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)	Ĭ	ŭ	Ĭ	0.00	620. 74	
28. 00	Observation Bed Days		106	2, 692	0.00	020.7.	28.00
29. 00	Ambulance Trips	٥		2,072			29. 00
30.00	Employee discount days (see instruction)	Ĭ		0			30.00
31. 00	Employee discount days - IRF			o o			31.00
32. 00	Labor & delivery days (see instructions)	٥	181	309			32.00
32. 01	Total ancillary labor & delivery room	Ĭ		0			32. 01
52.01	outpatient days (see instructions)						52.01
33. 00	LTCH non-covered days	ام					33.00
33. 01	LTCH site neutral days and discharges	l ol					33. 01
	Temporary Expansion COVID-19 PHE Acute Care	l ol	0	0			34.00
2 20	1 - 1 - 3	۰ - ۱	ŭ	'	1	ı	

Heal th Fi nancial SystemsJOHNSONHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Full Time Equivalents Nonpaid Workers Title V Title XVIII Title XIX Total All Patients Title V Workers Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Patients Title V Title XVIII Title XIX Total All Total All Title XIX Total All Total All Total All Title XIX Total All Total All Total All Total XIX Total All Total All Total XIX Total All Total XIX Total All Total					10	0 12/31/2022	5/24/2023 9:3	
Figurial and Its Figurial and Its Figurial and Workers Figuri			Full Time		Di sch	arges	072172020 710	
PART I - STATISTICAL DATA			Equi val ents			3		
PART I - STATISTICAL DATA		Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
PART I - STATISTICAL DATA			Workers					
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 412 2.00			11. 00	12. 00	13. 00	14. 00	15. 00	
8 exclude Swing Bed. Observation Bed and Hospice days/(see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IPF Subprovider 5.00 HM0 IPF Subprovider 6.00 Hospital Adults & Peds. Swing Bed SWF 7.00 Hospital Adults & Peds. Swing Bed SWF 8.00 INTENSIVE CARE UNIT 9.00 INTENSIVE CARE UNIT 9.00 ORNARY CARE UNIT 9.00 ORNARY CARE UNIT 9.00 OTHER SPECIAL CARE (SPECIFY) 11.00 SWIRGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 INTENSIVE CARE UNIT 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SWIBPROVIDER - IPF 18.00 ON WIRSING FACILITY 19.00 ON WIRSING FACILITY 19.00 ON WIRSING FACILITY 20.00 ON WIRSING FACILITY 21.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 ON WIRSING FACILITY 23.00 OTHER LONG TERM CARE 24.00 OTHER LONG TERM CARE 25.00 ON WIRSING FACILITY 26.00 OTHER LONG TERM CARE 27.00 OTHER LONG TERM CARE 28.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER LONG TERM CARE 29.00 ON WIRSING FACILITY 29.00 OTHER CARE WITTEN CARE WITT								
Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 238 412 2.00 3.300 4.00 MMO IFF Subprovider 0 3.500 4.00 MMO IFF Subprovider 0 4.000 4.000 6.00 HMO IFF Subprovider 0 5.00 6.001 HMO IFF Subprovider 0 5.00 6.001 HMO IFF Subprovider 0 6.000 1 6.000 1 6.000 1 6.000 1 6.000 1 6.000 1 6.000 6	1.00			0	519	28	1, 851	1.00
For the portion of LDP room available beds) 20								
2.00								
3. 00								
4. 00 HMD RF Subprovider 5. 00 6. 00					238	412		
5.00 Hospit tal Adult ts & Peds. Swing Bed NF 6.00 6.00 Hospit tal Adult ts & Peds. Swing Bed NF 7.00 Total Adult ts and Peds. (exclude observation beds) (see instructions) 8.00 INTERSIVE CARE UNIT 8.00 CORONARY CARE UNIT 9.00 11.00 USURGICAL INTERSIVE CARE UNIT 10.00 USURGICAL INTERSIVE CARE UNIT 11.00 11.00 USURGICAL INTERSIVE CARE UNIT 11.00 11.00 USURGICAL INTERSIVE CARE UNIT 11.00 1		•				0		
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 11.00 SURRICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 14.00 Total (see instructions) 16.00 (A visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 OTHER LONG TERM CARE 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 OTHER LONG TERM CARE 23.00 OTHER LONG TERM CARE 24.10 HOSPICE (non-distinct part) 25.00 CMRC - CMRC 26.00 CMRC - CMRC 26.00 Deservation Bed Days 29.00 Observation Bed Days 29.00 Days delivery days (see instruction) 31.00 Eapl ove discount days (see instructions) 32.01 Total and II ary I abor & delivery room outpatient days (see instructions) 33.00 LTCH site neutral days and discharges						0		
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Deds) (see instructions) Recommendation Recommendat								
8. 00 INTENSIVE CARE UNIT	7. 00	,						7. 00
9. 00 CORONARY CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 NURSERY 12. 00 14. 00 Total (see instructions) 0. 00 0 519 28 1,851 14. 00 15. 00 CAH visits 16. 00 15. 00 17. 00 SUBPROVIDER - IFF 0. 00 0 0 0 0 0 17. 00 SUBPROVIDER - IRF 0. 00 0 0 0 0 0 18. 00 SUBPROVIDER 18. 00 0 0 0 0 0 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 23. 00 24. 00 HOSPICE 0.00-distinct part) 25. 00 25. 00 CMHC - CMHC 25. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 26. 26 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 27. 00 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 0. 00 29. 00 Ambul ance Trips 30. 00 31. 00 Employee di scount days (see instructions) 31. 00 32. 01 Total ancillary Jabor & delivery room outpatient days (see instructions) 32. 01 33. 01 ITCH non-covered days 33. 01 33. 01 ITCH site neutral days and discharges 0 33. 01								
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13. 00 NURSERY								
14.00 Total (see instructions)								
15. 00 CAH visits		1		_				
16. 00 SUBPROVIDER - IPF 0. 00 0 0 0 0 17. 00 18. 00 17. 00 18. 00 19.		, ,	0.00	0	519	28	1, 851	
17. 00 SUBPROVI DER - IRF 0. 00 0 0 0 17. 00 18. 00 18. 00 19. 00 0 18. 00 18. 00 19. 00 0 0 18. 00 19. 00 0 0 18. 00 19. 00 0 0 0 18. 00 19. 00 0 0 0 18. 00 19. 00 0 0 0 18. 00 19. 00 0 0 0 0 0 0 0 18. 00 19. 00 0 0 0 0 0 0 0 0 0		y and the second						
18. 00 19. 00 19. 00 19. 00 19. 100 100 100 100 100 100 100 100 100 100		III	0.00	0				
19. 00		1	0.00	Ü		U	0	
20.00 NURSING FACILITY 20.00 21.00 21.00 21.00 22.00 22.00 4MBULATORY SURGICAL CENTER (D.P.) 23.00 4MSULATORY SURGICAL CENTER (D.P.) 24.00 40.		1						
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 77.00 Total (sum of lines 14-26) 27.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges								
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24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 32.00 Labor & delivery days (see instructions) 31.00 LTCH non-covered days 33.00 LTCH non-covered days and discharges		1	0.00					
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29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 31.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 29.00 30.00 31.00 31.00 32.00 32.01			0.00					
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31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 32.00 32.01								
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.00 32.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.01 Outpatient days (see instructions) 33.00 Outpatient days (see instructions)		1 1 3						
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01								
33.00 LTCH non-covered days 0 33.00 33.01 LTCH site neutral days and discharges 0 33.01	32.01							32.01
33.01 LTCH site neutral days and discharges 0 33.01	33 00				0			33 00
					1			

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0001

					Ţ	o 12/31/2022	Date/Time Pre 5/24/2023 9:3	
		Wkst. A Line	Amount	Reclassi fi cat	Adj usted	Paid Hours	Average	, u
		Number	Reported	i on of Sal ari es	Sal ari es (col. 2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col . 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200.00	48, 708, 818	-72, 351	48, 636, 467	1, 291, 148. 25	37. 67	1.00
	instructions)							
2. 00	Non-physician anesthetist Part A		0	0	0	0. 00	0. 00	2.00
3.00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A -		0	О	О	0. 00	0. 00	4.00
4 01	Administrative		0			0.00	0.00	4 01
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 1, 794, 251	0	_	0. 00 18, 631. 00	0. 00 96. 30	4. 01 5. 00
	Physician-Part B							
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0. 00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)		_	_	_			
8. 00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00	SNF	44.00	0	0		0. 00		
10. 00	Excluded area salaries (see instructions)		14, 917, 497	0	14, 917, 497	315, 594. 31	47. 27	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		5, 986, 765	0	5, 986, 765	46, 589. 00	128. 50	11. 00
12. 00	Contract Labor: Top Level		0	0	0	0. 00	0. 00	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part		17, 313	0	17, 313	96. 00	180. 34	13. 00
14. 00	A - Administrative Home office and/or related		0	0	0	0. 00	0.00	14. 00
	organization salaries and		J			0.00	0.00	00
14. 01	wage-related costs Home office salaries		0	0	0	0. 00	0.00	14. 01
14. 02	Related organization salaries		0	0	ő	0. 00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	0	О	0. 00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	o	0. 00	0.00	16. 01
10.01	- Teachi ng		O					10.01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		7, 465, 661	0	7, 465, 661			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		2, 997, 968	0	2, 997, 968			19. 00
20. 00	Non-physician anesthetist Part		2, 997, 908	0	2, 997, 908			20.00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		0	О	o			22. 00
	Admi ni strati ve		-	_				
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 210, 817		210, 817			22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related		0	0	0			25. 50
25. 51	(core) Rel ated organization		n	n	n			25. 51
	wage-related (core)		0					
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52
		l		1	1			·

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0001 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/24/2023 9:39 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 3, 600, 471 -5, 067 3, 595, 404 149, 308. 31 24. 08 26.00 27.00 Administrative & General 5.00 1, 496, 137 -8, 815 1, 487, 322 75, 665. 12 19. 66 27.00 28.00 3, 377, 095 3, 377, 095 34, 790. 00 97.07 28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 30.00 Operation of Plant 7.00 954, 575 0 954, 575 35, 679. 43 26. 75 30.00 6, 342. 53 Laundry & Linen Service 8.00 115, 332 115, 332 18. 18 31.00 31.00 0 32.00 Housekeepi ng 9.00 737, 716 C 737, 716 37, 099. 93 19. 88 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 619, 888 -361, 955 257, 933 8, 334. 00 30. 95 34.00 35.00 Dietary under contract (see C 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 0 353, 584 353, 584 22, 552. 00 15. 68 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 0 Nursing Administration 20, 088. 10 55. 79 38.00 38.00 13.00 1, 135, 702 -15,000 1, 120, 702 39.00 Central Services and Supply 14.00 87, 276 87, 276 4, 449. 20 19. 62 39.00 993, 803 993, 803 22, 849. 35 43.49 40.00 Pharmacy 15.00 40.00 Medical Records & Medical Records Library 41.00 16.00 652, 706 0 652, 706 29, 047. 80 22. 47 41.00

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0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

42.00

Social Service

43.00 Other General Service

HOSPI T	AL WAGE INDEX INFORMATION			Provi der C	[Period: From 01/01/2022 Fo 12/31/2022	Worksheet S-3 Part III Date/Time Prep 5/24/2023 9:39	pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d 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		50, 291, 662	-72, 351	50, 219, 31	1 1, 307, 307. 25	38. 41	1.00
	instructions)							
2.00	Excluded area salaries (see		14, 917, 497	0	14, 917, 49	7 315, 594. 31	47. 27	2.00
	instructions)							
3.00	Subtotal salaries (line 1		35, 374, 165	-72, 351	35, 301, 814	991, 712. 94	35. 60	3.00
	minus line 2)							
4.00	Subtotal other wages & related		6, 004, 078	0	6, 004, 078	46, 685. 00	128. 61	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		7, 465, 661	0	7, 465, 66	0.00	21. 15	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		48, 843, 904	-72, 351	48, 771, 553	1, 038, 397. 94	46. 97	6.00
7.00	Total overhead cost (see		13, 770, 701	-37, 253	13, 733, 448	446, 205. 77	30. 78	7.00
	I	l l		1	I	1		

instructions)

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0001	Peri od: From 01/01/2022	Worksheet S-3
			Date/Time Prepared

	To 12/31/2022	Date/Time Prep 5/24/2023 9:3	
		Amount	7 (111)
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	738, 846	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	6, 199, 890	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00		0	10.00
11. 00		60, 506	11.00
12.00		0	12.00
13.00		98, 829	13.00
14.00		0	14.00
15.00		302, 657	15.00
16. 00		0	16.00
	Noncumul ative portion)		
	TAXES		
17. 00		3, 261, 484	
18. 00		0	18.00
19. 00		3, 157	19. 00
20. 00		0	20.00
	OTHER	_	
21. 00		0	21. 00
	instructions))		
22. 00		0	22.00
23.00		9, 078	23.00
24. 00		10, 674, 447	24. 00
25 00	Part B - Other than Core Related Cost		25 00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part V Date/Time Prepared: 5/24/2023 9:39 am
Cost Center Description		Contract	Benefit Cost

			5/24/2023 9: 3	
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	5, 986, 765	10, 674, 447	1.00
2.00	Hospi tal	5, 986, 765	10, 674, 447	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF	0	0	4.00
5. 00	Subprovi der - (0ther)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DIALYSIS I			17. 00
18. 00	Other	0	0	18. 00

Heal th	Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	EALTH AGENCY STATISTICAL DATA		Provi der C		eriod: rom 01/01/2022	Worksheet S-4	
			Component	CCN: 15-7510 T		Date/Time Pre 5/24/2023 9:3	
					Home Health	PPS	<u> 7 ani</u>
					Agency I		
	la i					00	0.00
0.00	County	Title V	Title XVIII	Title XIX	JOHNSON Other	Total	0.00
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	O	2, 065	0	0	2, 065	1.00
2. 00	Unduplicated Census Count (see instructions)	0.00	122. 00				2.00
				Number of Empl	oyees (Full Ti	me Equivalent)	
		Enter the numbe	of bours in	Staff	Contract	Total	
		your normal		Starr	Contract	Total	
	LIGHT LIFALTH ACENOV AND DED OF THE OVERS	0		1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40. 00	0. 60	0. 00	0. 60	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0. 00	0. 00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			0. 65 2. 56	0. 00 0. 00		5. 00 6. 00
7. 00	Nursing Supervisor			0.00	0.00		7.00
8.00	Physi cal Therapy Servi ce			1. 04	0. 00		8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. 00 0. 64	0. 00 0. 00		9. 00 10. 00
11. 00	Occupational Therapy Supervisor			0.00	0.00		11.00
12.00	Speech Pathology Service			0.00	0. 00		12.00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. 00 0. 00	0. 00 0. 00		13. 00 14. 00
15. 00	Medical Social Service Supervisor			0.00	0. 00		
16.00	Home Heal th Ai de			0. 64	0.00		16.00
17. 00 18. 00	Home Health Aide Supervisor DIETICIAN			0. 00 0. 02	0. 00 0. 00		
						CBSA Data	
	HOME HEALTH AGENCY CBSA CODES					1. 00	
	Enter in column 1 the number of CBSAs where					1	19. 00
20. 00	List those CBSA code(s) in column 1 serviced first code).	during this co	st reporting	period (line 20) contains the	18020	20. 00
	,	Full Epi			555.0.1	-	
		Without \ Outliers	With Outliers	LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	286	0	5	0	291	21. 00
22. 00	Skilled Nursing Visit Charges	134, 680	0		0		
23.00	Physical Therapy Visits	339	0		0		23.00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	179, 940 232	0	4, 700 0	0		24. 00 25. 00
26. 00	Occupational Therapy Visit Charges	125, 120	0	0	0	125, 120	26. 00
27. 00	Speech Pathology Visit Charges	0	0		0		27. 00
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	0 0	0		0		28. 00 29. 00
30.00	Medical Social Service Visit Charges	О	0	-	0	0	30.00
31. 00 32. 00	Home Health Aide Visits Home Health Aide Visit Charges	11 3, 355	0		0	11 3, 355	31. 00 32. 00
33. 00	Total visits (sum of lines 21, 23, 25, 27,	868	0		0		33.00
24.00	29, and 31)	00			0	00	24.00
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	99 443, 194	0		0		34. 00 35. 00
	30, 32, and 34)		J				
36. 00	Total Number of Episodes (standard/non outlier)	115		7	0	122	36.00
37.00	Total Number of Outlier Episodes		0		0		37.00
38. UU	Total Non-Routine Medical Supply Charges	0	0	0	0	I 0	38. 00

	AL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovi der	CCN: 15-0001	Po	ri od:	u of Form CMS-2 Worksheet S-1	
03111	AL UNCOMPENSATED AND INDIGENT CARE DATA	ovidei	CON. 15-0001		om 01/01/2022	WOLKSHEET 3-1	U
				То		Date/Time Pre 5/24/2023 9:3	
						1. 00	
	Uncompensated and indigent care cost computation						
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by	line 202 co	lumn 8	3)	0. 220233	1.
00	Medicaid (see instructions for each line)					0.004.074	
00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?					3, 021, 261 Y	2. 3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	17	Ϋ́	4.			
00	If line 4 is no, then enter DSH and/or supplemental payments from			ar car c		. 0	1
00	Medi cai d charges					50, 803, 300	
00	Medicaid cost (line 1 times line 6)					11, 188, 563	7.
00	Difference between net revenue and costs for Medicaid program (li	ine 7 m	inus sum of	lines	s 2 and 5; if	8, 167, 302	8.
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for</pre>	each Li	ne)				
00	Net revenue from stand-alone CHIP					0	9.
0. 00	Stand-alone CHIP charges					0	10.
1.00	Stand-alone CHIP cost (line 1 times line 10)					0	11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (li	ine 11 i	minus line	9; if	< zero then	0	12.
	enter zero) Other state or local government indigent care program (see instru	uctions	for each L	i ne)			
3. 00	Net revenue from state or local indigent care program (Not included in the inc					0	13.
1. 00	Charges for patients covered under state or local indigent care p			,	n lines 6 or	0	1
	10)						
5. 00	State or local indigent care program cost (line 1 times line 14)					0	
6.00	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	gent ca	re program	(Tine	15 minus line	0	16.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and sta	ate/local i	ndi ger	nt care progra	ıms (see	l
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)			ndi ger	nt care progra		
	instructions for each line) Private grants, donations, or endowment income restricted to func	idi ng ch	arity care	ndi ger	nt care progra	0	
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos	ding ch	arity care operations			0	18.
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to func	ding ch	arity care operations			0	18.
8. 00	instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	ding ch	arity care operations t care prog	rams ((sum of lines	0 0 8, 167, 302 Total (col. 1	18.
3. 00	instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	ding ch	arity care operations t care prog Uninsure patient	rams ((sum of lines Insured patients	0 0 8, 167, 302 Total (col. 1 + col. 2)	18.
3. 00	instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i	ding ch	arity care operations t care prog	rams ((sum of lines	0 0 8, 167, 302 Total (col. 1	18.
3. 00 9. 00	instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil	ding ch spital indigen	arity care operations t care prog Uninsure patient	rams ((sum of lines Insured patients	0 0 8, 167, 302 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to func Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions)	ding cha espital indigen	uni ty care operations to care proguent to care proguent to care proguent to care proguent to care patient to care proguent t	rams (ed es	(sum of lines Insured patients 2.00	0 0 8, 167, 302 Total (col. 1 + col. 2) 3.00	18. 19.
8. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to function for transfers for support of hose to a contract the support of the suppor	ding cha espital indigen	uni ty care operations t care prog Uni nsurpatient 1.00	rams ((sum of lines Insured patients 2.00	0 0 8, 167, 302 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to function for each line, appropriations or transfers for support of hose to a notal unreimbursed cost for Medicaid, CHIP and state and local in the second line in the secon	ding chaspital of indigen	uni ty care operations t care prog Uni nsurpatient 1.00	rams (ed es	(sum of lines Insured patients 2.00	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242	18. 19. 20. 21.
3. 00 9. 00 0. 00	instructions for each line) Private grants, donations, or endowment income restricted to function for transfers for support of hose to a contract the support of the suppor	ding chaspital of indigen	uni ty care operations t care prog Uni nsurpatient 1.00	rams (ed s.s., 914, 914, 914, 914, 914, 914, 914, 914	(sum of lines Insured patients 2.00 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242	18. 19. 20. 21.
8. 00 9. 00 0. 00 1. 00 2. 00	Instructions for each line) Private grants, donations, or endowment income restricted to function for grants, appropriations or transfers for support of hose Total unreimbursed cost for Medicaid, CHIP and state and local in the second state and l	ding chaspital of indigen	uni ty care operations t care prog Uni nsurpatient 1.00	rams (ed s.s., 914, 914, 914, 914, 914, 914, 914, 914	(sum of lines Insured patients 2.00 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242	18. 19. 20. 21.
3. 00 9. 00 0. 00 1. 00 2. 00	instructions for each line) Private grants, donations, or endowment income restricted to function for grants, appropriations or transfers for support of hose Total unreimbursed cost for Medicaid, CHIP and state and local in the second state and	ding chaspital of indigen	uni ty care operations t care prog Uni nsurpatient 1.00	rams (ed cs	(sum of lines Insured patients 2.00 940,798 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242 0 1, 529, 242	18. 19. 20. 21.
3. 00 2. 00 3. 00 3. 00 3. 00	instructions for each line) Private grants, donations, or endowment income restricted to function for grants, appropriations or transfers for support of hose Total unreimbursed cost for Medicaid, CHIP and state and local in the second state and	ding chaspital indigen	Uni nsurpatient 1.00	rams (ed eds.)	(sum of lines Insured patients 2.00 940,798 940,798 0 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242	18. 19. 20. 21. 22. 23.
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	instructions for each line) Private grants, donations, or endowment income restricted to function for each grants, appropriations or transfers for support of hose total unreimbursed cost for Medicaid, CHIP and state and local is grant and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care presented the supposed of the supposed on the supposed of the supposed on the supposed on the supposed of the supposed on the suppos	ding chaspital indigen lity ts (see ff as	Uni nsurpatient 1.00 2,671 588	rams (ed ss, 914	(sum of lines Insured patients 2.00 940,798 940,798 0 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242 0 1, 529, 242	20. 21. 22. 23.
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	instructions for each line) Private grants, donations, or endowment income restricted to function of the structions of transfers for support of hose to a content of the structions of transfers for support of hose to a content of the structions of transfers for support of hose to a content of the structions of the struction of the structions of the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient	ding chaspital indigen lity ts (see ff as	Uni nsurpatient 1.00 2,671 588	rams (ed ss, 914	(sum of lines Insured patients 2.00 940,798 940,798 0 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242 0 1, 529, 242	20. 21. 22. 23.
33. 00 30. 00 31. 00 31. 00 44. 00	instructions for each line) Private grants, donations, or endowment income restricted to function dovernment grants, appropriations or transfers for support of hose Total unreimbursed cost for Medicaid, CHIP and state and local is and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care profile line 24 is yes, enter the charges for patient days beyond the	lity lity days burrogram?	Uni nsurpatient 1.00 2,671 588 eyond a Len	rams (ed ss, 914	(sum of lines Insured patients 2.00 940,798 940,798 0 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242 0 1, 529, 242	20. 21. 22. 23.
33. 00 99. 00 00 00 00 00 00 00 00 00 00 00 00 00	Instructions for each line) Private grants, donations, or endowment income restricted to function for the grants, appropriations or transfers for support of hose total unreimbursed cost for Medicaid, CHIP and state and local image image is a support of the grant for the entire facility care charges and uninsured discounts for the entire facility care charges and uninsured discounts for the entire facility care instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit.	lity lity days berogram? indiger	Uni nsurpatient 1.00 2,671 588 eyond a len	rams (ed :s	(sum of lines Insured patients 2.00 940,798 940,798 0 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3.00 3, 612, 712 1, 529, 242 0 1, 529, 242 1.00 N	20. 21. 22. 23. 24. 25. 26. 27.
88.00 99.00 11.00 22.00 44.00 45.00 66.00 77.00	Instructions for each line) Private grants, donations, or endowment income restricted to function for the grants, appropriations or transfers for support of hose to a numerial model of the grants and local into the grants approved for the entire facilicate instructions. Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilicate instructions. Cost of patients approved for charity care and uninsured discount instructions. Payments received from patients for amounts previously written of charity care. Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care proviously limit. Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see	lity Its (see of as a see of a see of as a see of a see of as a see of	Uni nsurpatient 1.00 2,671 588 eyond a len nt care pros	rams (ed :s	(sum of lines Insured patients 2.00 940,798 940,798 0 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3.00 3, 612, 712 1, 529, 242 0 1, 529, 242 1.00 N 0 12, 470, 234 92, 542 142, 373	20. 21. 22. 23. 24. 25. 26. 27. 27.
0. 00 11. 00 22. 00 44. 00 55. 00 77. 00 77. 01 88. 00	Instructions for each line) Private grants, donations, or endowment income restricted to function of the grants, appropriations or transfers for support of hose to a content of the grants and local interval of the grants appropriations or transfers for support of hose to a content of the grants appropriations for each line) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the grants of the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	ding chaspital indigen lity ats (see aff as days barogram? indigen ruction: (see instricted instric	Uninsurpatient 1.00 2,671 588 588 eyond a len nt care pro structions)	rams (ed :s , 914	(sum of lines Insured patients 2.00 940,798 940,798 0 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3. 00 3, 612, 712 1, 529, 242 0 1, 529, 242 1. 00 N 0 12, 470, 234 92, 542 142, 373 12, 327, 861	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Instructions for each line) Private grants, donations, or endowment income restricted to function for the grants, appropriations or transfers for support of hose to a numerial model of the grants and local into the grants approved for the entire facilicate instructions. Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilicate instructions. Cost of patients approved for charity care and uninsured discount instructions. Payments received from patients for amounts previously written of charity care. Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care proviously limit. Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see	ding chaspital indigen lity ats (see aff as days barogram? indigen ruction: (see instricted instric	Uninsurpatient 1.00 2,671 588 588 eyond a len nt care pro structions)	rams (ed :s , 914	(sum of lines Insured patients 2.00 940,798 940,798 0 940,798	0 0 8, 167, 302 Total (col. 1 + col. 2) 3.00 3, 612, 712 1, 529, 242 0 1, 529, 242 1.00 N 0 12, 470, 234 92, 542 142, 373	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

Hear tr	n Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	<u> 2552-10</u>
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der Co	CN: 15-0001	Period: From 01/01/2022	Worksheet A	
					To 12/31/2022	Date/Time Pre 5/24/2023 9:3	
	Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cat	Reclassi fied	7 aiii
	· ·			+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
		1. 00	2. 00	3.00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1 11 00	0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		3, 065, 371	3, 065, 37	1 0	3, 065, 371	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		4, 173, 319				1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	410, 288	10, 631, 807			11, 060, 720	
4. 01 4. 02	00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG	109, 593 773, 334	278, 211 3, 008, 665			387, 804 3, 781, 583	4. 01 4. 02
4. 02	00403 MATERI ALS MANAGEMENT	414, 053	44, 488			458, 381	4. 03
4. 04	00404 ADMI TTI NG	984, 769	23, 506	•			1
4. 05	00405 PATIENT ACCOUNTING	908, 434	709, 810	1, 618, 24	4 -214	1, 618, 030	
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 496, 137	7, 008, 462				1
7.00	00700 OPERATION OF PLANT	954, 575	3, 679, 286			4, 633, 458	1
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	115, 332 737, 716	90, 085 101, 307		·	202, 245 829, 656	
10.00		619, 888	434, 766				1
11. 00		0	0	1,001,00	0 601, 575		1
13.00		1, 135, 702	115, 359	1, 251, 06		1, 250, 790	1
14.00		87, 276	62, 807			89, 812	1
15.00		993, 803	7, 941, 015				
16. 00		652, 706	241, 053	893, 75	9 -61	893, 698	16.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	6, 458, 382	2, 197, 051	8, 655, 43	3 -533, 225	8, 122, 208	30.00
31. 00	1	1, 112, 759	1, 562, 442		·	2, 607, 437	1
41. 00		0	0		0 0	0	1
43.00		0	0		0 269, 193	269, 193	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00		2, 275, 794	957, 260				
53. 00 54. 00	1 t	986, 323 2, 316, 400	1, 244, 338 1, 039, 366				1
60.00		1, 974, 182	4, 164, 011			5, 925, 798	
65. 00		1, 620, 068	497, 884				
66.00	06600 PHYSI CAL THERAPY	901, 964	61, 932	963, 89	6 -15, 671	948, 225	66.00
67. 00		301, 511	160			301, 671	1
68.00		152, 602	1, 342			153, 944	1
69. 00 70. 00	1	407, 388 16, 381	203, 386 100, 318			600, 403 116, 381	1
71.00		10, 301	4, 163, 289				1
72. 00		Ö	0		0 3, 545, 012		
73.00		o	0		0 7, 929, 577	7, 929, 577	73.00
76. 00		551, 559	185, 152			627, 660	
76. 97		169, 014	135, 484			296, 334	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	77. 00
90.00	09000 CLINIC	838, 866	1, 578, 884	2, 417, 75	0 -171, 133	2, 246, 617	90.00
	09100 EMERGENCY	3, 314, 522	2, 714, 472				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
	0 10100 HOME HEALTH AGENCY 0 10200 OPIOID TREATMENT PROGRAM	591, 206 0	138, 590 0			724, 771	
102.00	SPECIAL PURPOSE COST CENTERS	l O	0		0 0	0	102.00
113.0	0 11300 INTEREST EXPENSE		0		0 0	0	113.00
118. 00		34, 382, 527	62, 554, 678				
	NONREI MBURSABLE COST CENTERS						
190.00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	184, 431	33, 376		·		
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	14, 061, 813	3, 561, 070				
	1 19201 SOUTH CLINIC 2 19202 WEST CLINIC	0	0		0 0		192. 01 192. 02
	3 19203 DI ABETES CENTER	80, 047	4, 983	85, 03	-		192. 02
	0 19300 NONPALD WORKERS	0	0	00,00	0 0	· ·	193.00
	1 19301 ADULT/CHILD CARE	o	0		0 0		193. 01
193. 03	2 19302 PHYSICIAN OFFICE BUILDING	0	875, 616	875, 61	6 -9	· ·	
	3 19303 OPTI FAST/FOUNDATI ON	0	0		0		193. 03
	0 07950 PARTNERSHI P HFC 1 07951 TRAFALGAR CLI NI C	0	483	1			194.00
	2 07951 TRAFALGAR CLINIC	ا	0		0 0 0		194. 01 194. 02
	3 07953 JAI L		0		o n		194. 02
	4 07954 ATHLETIC TRAINERS	ol ol	Ō		o o	0	194. 04
200.00	TOTAL (SUM OF LINES 118 through 199)	48, 708, 818	67, 030, 206	115, 739, 02	4 0	115, 739, 024	200.00

Provi der CCN: 15-0001

Period: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/24/2023 9:39 am

				5/24/2023 9:3	39 am
	Cost Center Description	Adjustments	Net Expenses	672 172020 71.0	, <u></u>
	'	(See A-8)	For		
			Allocation		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS	1			
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-88, 563	2, 976, 808	·	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	4, 173, 319	·	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-7, 716	11, 053, 004	·	4. 00
4. 01	00401 COMMUNI CATI ONS	-37, 205	350, 599		4. 01
4. 02	00402 DATA PROCESSING	0	3, 781, 583		4. 02
4. 03	00403 MATERIALS MANAGEMENT	0	458, 381		4. 03
4. 04	OO4O4 ADMI TTI NG	0	1, 004, 429		4. 04
4. 05	00405 PATIENT ACCOUNTING	0	1, 618, 030		4. 05
5.00	00500 ADMINISTRATIVE & GENERAL	-4, 738, 776	3, 746, 633		5. 00
7. 00	00700 OPERATION OF PLANT	-56, 528	4, 576, 930		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	202, 245		8. 00
9. 00	00900 HOUSEKEEPI NG	0	829, 656		9. 00
10.00	01000 DI ETARY	184	452, 515	l .	10.00
11. 00	01100 CAFETERI A	-158, 831	442, 744		11.00
13. 00	01300 NURSING ADMINISTRATION	6, 134	1, 256, 924		13.00
	01400 CENTRAL SERVI CES & SUPPLY	0	89, 812		14.00
	01500 PHARMACY	0	1, 693, 128		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-48, 750	844, 948		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.004.004	5 000 007	T	
	03000 ADULTS & PEDI ATRI CS	-2, 231, 821	5, 890, 387		30.00
31.00	03100 INTENSI VE CARE UNI T	0	2, 607, 437	<u> </u>	31.00
41.00	04100 SUBPROVI DER - I RF	0	0	l .	41.00
43. 00	04300 NURSERY	0	269, 193		43.00
FO 00	ANCILLARY SERVICE COST CENTERS		0.000.5//		
50.00	05000 OPERATING ROOM	0	2, 892, 566		50.00
53.00	05300 ANESTHESI OLOGY	-1, 125, 977	1, 131, 770		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 248, 467		54.00
60.00	06000 LABORATORY	-35, 254	5, 890, 544	·	60.00
65.00	06500 RESPI RATORY THERAPY	0	2, 062, 758		65.00
66.00	06600 PHYSI CAL THERAPY	-123	948, 102		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	301, 671		67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY	0	153, 944		68. 00 69. 00
	06900 ELECTROCARDI OLOGY	_	600, 403		70.00
	07000 ELECTROENCEPHALOGRAPHY	-100, 000	16, 381		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	-1, 292 0	2, 190, 649		71.00
	07300 DRUGS CHARGED TO PATIENTS	0	3, 545, 012 7, 929, 577		72. 00 73. 00
	03020 ONCOLOGY	-9, 368	618, 292		76.00
76. 00 76. 97	07697 CARDI AC REHABI LI TATI ON			l .	76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION	-95, 150 0	201, 184 0		77.00
77.00	OUTPATIENT SERVICE COST CENTERS		U		17.00
90.00	09000 CLINIC	-92, 400	2, 154, 217		90.00
	09100 EMERGENCY	-1, 902, 805	3, 929, 190	l .	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-1, 702, 603	3, 727, 170		92.00
	OTHER REIMBURSABLE COST CENTERS				92.00
	10100 HOME HEALTH AGENCY	0	724, 771		101.00
	10200 OPI OI D TREATMENT PROGRAM	0		·	102.00
102.00	SPECIAL PURPOSE COST CENTERS		U U		102.00
113 00	11300 I NTEREST EXPENSE	0	0		113.00
118. 00		-10, 724, 241	86, 858, 203		118.00
110.00	NONREI MBURSABLE COST CENTERS	10,721,211	00, 000, 200		1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	210, 492		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	16, 989, 378	·	192.00
	19201 SOUTH CLINIC	0	0		192. 01
	19202 WEST CLINIC	0	0		192.02
	19203 DI ABETES CENTER	0	80, 620		192. 03
	19300 NONPAI D WORKERS		00, 020 N		193.00
	19301 ADULT/CHILD CARE		n		193. 01
	19302 PHYSICIAN OFFICE BUILDING	l 0	875, 607		193. 02
	19303 OPTI FAST/FOUNDATI ON	0	0.0,007		193. 03
	07950 PARTNERSHI P HFC	0	483		194. 00
	07951 TRAFALGAR CLINIC	0	0		194. 01
	07952 EDI NBURGH	0	0		194. 02
	07953 JAI L	0	0		194. 03
	07954 ATHLETI C TRAINERS	0	o		194.04
200.00		-10, 724, 241	105, 014, 783		200.00
		•		•	•

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/24/2023 9:39 am Provider CCN: 15-0001

					 /24/2023 9:39 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2.00	3. 00	4. 00	5. 00	
1 00	A - NURSERY RECLASS	42.00	222 224	27 050	1 00
1. 00	NURSERY	4300	23 <u>2, 2</u> 34 232, 234	3 <u>6, 9</u> 59 36, 959	1.00
	B - IMPLANTABLE DEVICE RECLASS	<u> </u>	232, 234	30, 737	
1. 00	IMPL. DEV. CHARGED TO	72.00		3, 545, 012	1.00
1.00	PATI ENT	72.00		3, 343, 012	1.00
	TOTALS	+		3, 545, 012	
	C - CAFETERIA RECLASS		<u> </u>	0/010/012	
1.00	CAFETERI A	11. 00	353, 584	247, 991	1.00
	TOTALS		353, 584	247, 991	İ
	D - SHORT TERM DISABILITY RECL	_ASS			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 458	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	O	8, 424	2.00
3.00	DI ETARY	10. 00	0	8, 371	3.00
4.00	NURSING ADMINISTRATION	13. 00	0	15, 000	4.00
5.00	OPERATI NG ROOM	50. 00	0	3, 269	5. 00
6.00	ANESTHESI OLOGY	53. 00	0	6, 000	6. 00
7.00	CLINIC	<u> </u>	•_	2 <u>5, 8</u> 29	7. 00
	TOTALS		0	72, 351	
	E - EMPLOYEE WELLNESS RECLASS				
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	391	18, 273	1.00
	TOTALS		391	18, 273	
1 00	F - PART A RECLASS	20.00		4 000	1.00
1.00	ADULTS & PEDI ATRI CS	30.00	0	4, 200	1.00
2. 00	ANESTHESI OLOGY	5300		27, 527	2.00
	TOTALS		U	31, 727	
1 00	G - MEDICAL SUPPLIES RECLASS MEDICAL SUPPLIES CHARGED TO	71 00	0	1 572 ///	1 00
1. 00	PATIENTS	71. 00	۷	1, 573, 664	1.00
2. 00	FATTENTS	0. 00	0	0	2. 00
3. 00		0.00	o	0	3. 00
4. 00		0.00	o	0	4.00
5. 00		0.00	o	0	5. 00
6. 00		0.00	o	0	6.00
7.00		0.00	o	0	7.00
8.00		0.00	o	0	8.00
9.00		0.00	o	0	9. 00
10.00		0. 00	0	0	10.00
11.00		0. 00	0	0	11.00
12.00		0. 00	0	0	12.00
13.00		0. 00	0	0	13.00
14.00		0. 00	0	0	14.00
15.00		0. 00	0	0	15.00
16.00		0. 00	0	0	16.00
17. 00		0. 00	0	0	17. 00
18. 00		0. 00	0	0	18. 00
19. 00		0. 00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22. 00		0.00	0	0	22.00
23. 00 24. 00		0. 00 0. 00	0	0	23. 00 24. 00
24. 00 25. 00		0.00	0	0	25. 00
26. 00		0.00	0	0	26.00
27.00		0.00	0	0	27. 00
28. 00		0.00	0	0	28. 00
29. 00		0. 00	0	0	29.00
30.00		0. 00	0	0	30.00
31. 00		0. 00	o	0	31.00
32. 00		0. 00	o	0	32.00
33. 00		0. 00	ő	Ö	33.00
	TOTALS			1, 573, 664	
	H - DRUGS CHARGEABLE RECLASS		~		
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	7, 929, 577	1.00
2. 00		0.00	o	0	2.00
3.00		0.00	O	0	3.00
4.00		0.00	O	0	4.00
5.00		0.00	O	0	5.00
6.00		0.00	O	0	6.00
7.00		0. 00	o	0	7.00
8.00		0. 00	0	0	8. 00
9. 00		0. 00	0	0	9. 00
10.00		0. 00	0	0	10.00
11. 00		0. 00	0	0	 11.00
	<u> </u>				

						5/24/2023 9:3	39 am
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
12.00		0.00	0	0			12.00
13.00		0.00	0	0			13.00
14.00		0.00	0	0			14.00
	TOTALS		0	7, 929, 577			
500.00	Grand Total: Increases		586, 209	13, 455, 554			500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0001

Cost Centure Line Set arry Other Missi A.7 Ref						To	Date/Time Pr 5/24/2023 9:	
A. AURSERY RECLASS 30.00 29.00 10.00				Color	011	W	. "	
A								
			7.00	8.00	9.00	10.00		
B - IMPLANTAGE DEVICE RECLASS	1.00		30. 00	232, 234	36, 959	0		1.00
ADDITION				232, 234	36, 959			
PATEENTS								
TOTALS	1. 00		71.00		3, 545, 012	0		1.00
0			 	+	3 545 012			
1.00				<u> </u>	3, 343, 012			
0 - SHORT TERM DISABILITY RECURS 1.00 PHISTOPT EMPT INTER TRANSPORTMENT 1.00 3.40 0 0 0 1.00	1.00		10.00	353, 584	247, 991	0		1.00
1.00				353, 584	247, 991			
2.00 ADMINISTRATIVE & GENERAL 5.00 8.424 0 0 2.00 4.00 MIRCHING ADMINISTRATION 11.00 15.000 0 0 0 4.00 MIRCHING ADMINISTRATION 13.00 15.000 0 0 6.00 OFERATION OF BOOK 50.00 3.269 0 0 0 7.00 OFERATION OF BOOK 50.00 3.269 0 7.00 OFERATION OF BOOK 50.00 3.279 0 7.00					_			
1.00 DETAMY (10.00 B, 371) 0 0 3.00 0 5.00					-	I - I		1
A.00 MIRSTRATION 13, 00 15,000 0 0 4,000			l I		-	0		1
Department (Drophy)			l I		0	0		1
0.00 AMESTINES DILOGY			l I		0	o		1
TOTALS CADMINISTRATIVE & CENERAL 5.00 391 18,273 0 1.00			l I		0	o		6.00
E - BMPLOYER WELLNESS RECLASS 10.0 AMM ISTRATIVE & GENERAL 1.00 FARM ISTRATIVE & GENERAL 1.00 FA	7.00	CLINIC	90.00	2 <u>5,</u> 829	0	0		7.00
1.00				72, 351	0			
TOTALS F - PART A RECLASS 4 00			204	10.070			4	
F - PART A RECLASS 192.00 0 27,527 0 1.00	1.00							1.00
1.00 PHYSICIANS' PRIVATE OFFICES 192.03 0 4.200 0 2.76 527 0 2.00 1.100 2.00 1.100 2.00 31,727 31,727 31,7				341	18, 2/3			-
DIABETES CENTER	1 00		192 00	0	27 527	0		1 00
TOTALS G		•	l I	•		· · ·		
1.00 EMPLOYEE BENEFITS DEPARTMENT								
2.00 DATA PROCESSING 4.02 0 416 0 2.00 4.00 ADMITTING 4.03 0 1600 0 3.00 4.00 ADMITTING 4.04 0 3.846 0 4.00 5.00 PATENTALS MANAGEMENT 4.05 0 214 0 5.00 6.00 ADMINTING 4.05 0 214 0 5.00 6.00 ADMINISTRATIVE & GENERAL 5.00 0 387 0 6.00 7.00 OPERATION OF PLANT 7.00 0 387 0 7.00 8.00 LAUNDRY & LINEN SERVICE 8.00 0 3.172 0 8.00 9.00 HOUSEKEEPING 0 0 0 9.367 0 9.00 10.00 DIETARY 10.00 0 7.48 0 110.00 11.00 NURSING ADMINISTRATION 13.00 0 270 0 110.00 12.00 CENTRAL SERVICES & SUPPLY 14.00 0 60.271 0 12.00 14.00 MEDICAL RECORDS & LIBRARY 16.00 0 4.805 0 13.00 16.00 INTENSIVE CARE UNIT 31.00 0 265.183 0 15.00 16.00 INTENSIVE CARE UNIT 31.00 0 34.0357 0 17.00 18.00 AMESTHESIOLOGY 53.00 0 4.411 0 18.00 18.00 AMESTHESIOLOGY 53.00 0 4.411 0 18.00 19.00 AMESTHESIOLOGY 53.00 0 4.411 0 18.00 20.00 LABORATORY THERAPY 66.00 0 4.142 0 21.00 21.00 CERTROCKEPTHIC GRAPHY 70.00 77		G - MEDICAL SUPPLIES RECLASS						
3.00 MATERIALS MANAGEMENT						· ·		1
A. O. ADMITTING			1			-		1
5.00			1			0		1
6.00 ADMINISTRATIVE & GENERAL 5.00 0 387 0 0 0.00 7.00 OPERATION OF PLANT 7.00 0 0.399 0 7.00 8.00 LAUNDRY & LINEN SERVICE 8.00 0 3.172 0 8.00 9.00 HOUSEKEPI NG 9.00 0 748 0 10.00 11.00 DIETARY 10.00 0 748 0 10.00 12.00 CENTRAL SERVICES & SUPPLY 14.00 0 60.271 0 12.00 14.00 MESING ADMINISTRATION 13.00 0 60.271 0 12.00 14.00 MEDICAL RECORDS & LIBRARY 16.00 0 61 0 14.00 15.00 ADMINISTRATICS 30.00 0 265.183 0 15.00 16.00 INTENSIVE CARE UNIT 31.00 0 67.146 0 16.00 16.00 INTENSIVE CARE UNIT 31.00 0 67.146 0 16.00 18.00 ANESTHESIOLOGY 53.00 0 340.357 0 16.00 18.00 ANESTHESIOLOGY 53.00 0 441 0 18.00 19.00 RADIOLOGY-DIAGNOSTIC 54.00 0 90.808 0 19.00 20.00 LABORATORY HERAPY 65.00 0 47.146 0 22.00 21.00 RESPIRATORY HERAPY 66.00 0 10.371 0 22.00 22.00 PHYSICOLAL HERAPY 76.00 0 10.371 0 22.00 22.00 PHYSICOLAL HERAPY 76.00 0 12.388 0 22.00 24.00 CLINIC 90.00 0 96.494 0 22.00 25.00 HOME HEALTH AGENCY 91.00 0 96.494 0 27.00 26.00 CARDIA REREBERICY 91.00 0 96.494 0 27.00 27.00 DIABERIS CENTER 192.00 0 11.158 0 32.00 27.00 DIABERIS CENTER 192.00 0 15.73.664 1 0 0 0 27.00 OPERATION OF PLANT 7.00 0 4 0 0 0 27.00 OPERATION OF PLANT 7.00 0 4 0 0 0 27.00 OPERATION OF PLANT 7.00 0 4 0 0 0 27.00 OPERATION OF PLANT 7.00 0 18.00 0 0 27.00 OPERATION OF PLANT 7.00 0 14 0 0 0 27.00 OPERATION OF PLANT 7.00 0 14 0 0 0 27.00 OPERATION OF PLANT 7.00 0 16.491 0 0 27.00 OPERATION OF PLANT 7.00 0 10.00 10.00 10.00 10.00 10.00			1	- 1		0		1
7.00 OPERATION OF PLANT						0		1
B. OD LAUNDRY & LINEN SERVICE B. DO O 3, 172 O O P. OD			l I	9		o		4
10.00 DIETARY 10.00 0 748 0 10.00 11.00 12.00 12.00 11.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 12.00 13.00 13.00 14.00 15.00 14.00 15.00 15.00 15.00 16.00 17.00 17.0		•	l I	Ö		O		1
11.00	9. 00	HOUSEKEEPI NG	9. 00	O	9, 367	o		9.00
12. 00 CENTRAL SERVICES & SUPPLY						0		1
13. 00 PHARMACY		•	l I			0		1
14.00 MEDI CAL RECORDS & LI BRARY 16.00 0 61 0 14.00 15.00 ADULTS & PEDI ATRICS 30.00 0 265,183 0 15.00 16.00 10 16.00 10 16.00 10 16.00 10 16.00 10 16.00 10 16.00 17.00 0 0 0 340,357 0 17.00 0 17.00 0 17.00 0 17.00 0 18.00 0 18.00 0 17.00 0 18.00 0 18.00 0 19.00 0 19.00 0 19.00 0 19.00 0 19.00 0 19.00 0 19.0			l I			0		1
15. 00 ADULTS & PEDIATRICS 30. 00 0 265, 183 0 15. 00 16. 00 17. 00 0 0 0 0 0 0 0 0 0			l I			0		1
16. 00 INTENSIVE CARE UNIT 31. 00 0 67, 146 0 110. 00 17. 00 OPERATING ROOM 50. 00 0 340, 357 0 17. 00 18. 00 ANESTHESI OLOGY 53. 00 0 441 0 18. 00 19. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 90, 808 0 19. 00 20. 00 LABORATORY 66. 00 0 212, 395 0 22. 00 21. 00 RESPIRATORY THERAPY 65. 00 0 49, 142 0 22. 00 22. 00 PHYSI CAL THERAPY 66. 00 0 15, 666 0 22. 00 23. 00 ELECTROCARDI OLOGY 69. 00 0 10, 371 0 23. 00 24. 00 ELECTROCARDI OLOGY 76. 00 0 318 0 24. 00 25. 00 ONCOLOGY 76. 00 0 12, 388 0 25. 00 26. 00 CARDI AC REHABI LITATI ON 76. 97 0 8, 164 0 27. 00 29. 00 HOME HEALTH AGENCY 90. 00 0 96, 494 0 27. 00 29. 00 HOME HEALTH AGENCY 101. 00 0 5, 025 0 29. 00 OMME HEALTH AGENCY 101. 00 0 5, 025 0 30. 00 GIFT, FLOWER, COFFEE SHOP & 190. 00 0 11, 158 0 31. 00 32. 00 DI ABETES CENTER 192. 03 0 210 0 32. 00 33. 00 PHYSI CI AND SPFI CES 192. 00 0 1, 573, 664 1 0 32. 00 H - DRUGS CHARGEABLE RECLASS 190. 00 7, 236, 885 0 4. 00 4. 00 PHARMACY 15, 00 0 7, 236, 885 0 4. 00 5. 00 ADMIN IN STRATI ON 13. 00 0 16, 491 0 6. 00 6. 00 INTENSI VE CARE UNIT 31. 00 0 16, 491 0 6. 00 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 6. 00 7. 00 PERATI NOR NOR 50. 00 0 16, 491 0 8. 00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 6, 652 0 9. 00 10. 00 PHYSI CIA THERAPY 65. 00 0 6, 652 0 9. 00 10. 00 PHYSI CIA THERAPY 65. 00 0 6, 652 0 9. 00 10. 00 PHYSI CIA THERAPY 65. 00 0 6, 652 0 9. 00 10. 00 PHYSI CIA THERAPY 65. 00 0 6, 652 0 9. 00 10. 00 PHYSI CIA THERAPY 65. 00 0 6, 652 0 9. 00 10. 00 PHYSI CIA THERAPY 65. 00 0 6, 652 0 9. 00 10. 00 PHYSI CIA THERAPY 66. 00 0 6, 652 0						0		1
17. 00 OPERATING ROOM 50. 00 340, 357 0 17. 00 18. 00 ANESTHESIOLOGY 53. 00 0 441 0 18. 00 19. 00 RADIOLOGY-DI AGNOSTI C 54. 00 0 90, 808 0 19. 00 20. 00 LABORATORY 60. 00 0 212, 395 0 20. 00 21. 00 RESPIRATORY THERAPY 65. 00 0 49, 142 0 21. 00 22. 00 PHYSI CAL THERAPY 66. 00 0 15, 666 0 22. 00 23. 00 ELECTROCARDIOLOGY 69. 00 0 10, 371 0 23. 00 24. 00 ELECTROCARDIOLOGY 76. 00 0 318 0 24. 00 25. 00 ONCOLOGY 76. 00 0 318 0 24. 00 26. 00 CARDIA CREHABI LITATION 76. 97 0 8, 164 0 26. 00 28. 00 EMERGENCY 91. 00 0 96. 494 0 27. 00 28. 00 EMERGENCY 91. 00 0 196. 919 0 28. 00 29. 00 HOME HEALTH AGENCY 101. 00 0 5, 025 0 29. 00 ONCOLOGY 76. 00 0 7, 315 0 20. 00 ORATIEN T.LOWER, COFFEE SHOP & 190. 00 7, 315 0 20. 00 DABTERS CENTER 192. 03 0 210 0 33. 00 PHYSI CLANS PRI VATE OFFI CES 192. 03 0 210 0 33. 00 PHYSI CLANS PRI VATE OFFI CES 192. 03 0 210 0 33. 00 ONCOLOGY 10, 00 1, 573, 664 1			i i			o		1
19. 00 RADI OLLOGY-DI AGNOSTI C		•	i i	Ö		O		1
20.00 LABORATORY 60.00 0 212,395 0 20.00	18.00	ANESTHESI OLOGY	53.00	О	441	O		18. 00
21. 00 RESPIRATORY THERAPY 65. 00 0 49, 142 0 22. 00 22. 00 PHYSI CAL THERAPY 66. 00 0 15, 666 0 22. 00 23. 00 ELECTROCARDIOLOGY 69. 00 0 10, 371 0 23. 00 24. 00 ELECTROCARDHALOGRAPHY 70. 00 0 318 0 24. 00 25. 00 ONCOLLOGY 76. 00 0 12, 388 0 25. 00 26. 00 CARDI AC REHABI LITATI ON 76. 97 0 8, 164 0 26. 00 27. 00 CLI NI C 90. 00 0 96, 494 0 27. 00 28. 00 EMERGENCY 91. 00 0 196, 919 0 28. 00 29. 00 HOME HEALTH AGENCY 101. 00 0 5, 025 0 29. 00 30. 00 GI FT. FLOWER, COFFEE SHOP & 190. 00 0 7, 315 0 30. 00 21. 00 CANTEEN 194. 00 111, 158 0 31. 00 32. 00 DI ABETES CENTER 192. 00 0 111, 158 0 31. 00 33. 00 DI ABETES CENTER 192. 00 0 11, 573, 664 1						0		1
22.00 PHYSI CAL THERAPY				0		0		
23. 00 ELECTROCARDI OLOGY 69. 00 0 10, 371 0 23. 00 24. 00 24. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 318 0 24. 00 25. 00 00COLOGY 76. 00 0 12, 388 0 25. 00 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 0 96. 494 0 27. 00 28. 00 28. 00 29. 00 0 196. 919 0 28. 00 29.				0		0		
24. 00 LLECTROENCEPHALOGRAPHY 70. 00 0 318 0 24. 00 25. 00 0 0 0 0 12, 388 0 25. 00 0 0 0 0 0 12, 388 0 0 0 0 0 0 0 0 0				•		0		
25. 00 ONCOLOGY 76. 00 0 12, 388 0 25. 00 26. 00 CARDI AC REHABI LITATION 76. 97 0 8, 164 0 26. 00 27. 00 CLINIC 90. 00 0 96, 494 0 27. 00 28. 00 EMERGENCY 91. 00 0 196, 919 0 28. 00 29. 00 HOME HEALTH AGENCY 101. 00 0 5, 025 0 29. 00 30. 00 GIFT, FLOWER, COFFEE SHOP & 190. 00 0 7, 315 0 30. 00 31. 00 GIFT, FLOWER, COFFEE SHOP & 190. 00 0 7, 315 0 30. 00 32. 00 DI ABETES CENTER 192. 03 0 210 0 32. 00 33. 00 DI ABETES CENTER 193. 02 0 9 0 32. 00 33. 00 PHYSI CI AN OFFI CE BUI LDI NG 193. 02 0 7, 573, 664 1			1			0		1
26. 00 CARDI AC REHABI LITATION 76. 97 0 8, 164 0 26. 00 27. 00 CLINI C 90. 00 0 96, 494 0 27. 00 28. 00 EMERGENCY 91. 00 0 196, 919 0 28. 00 29. 00 HOME HEALTH AGENCY 101. 00 0 5, 025 0 29. 00 30. 00 GIFT, FLOWER, COFFEE SHOP & 190. 00 0 7, 315 0 30. 00 CANTEEN 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 111, 158 0 31. 00 32. 00 DI ABETES CENTER 192. 03 0 210 0 32. 00 33. 00 PHYSI CI AN OFFI CE BUI LDI NG 193. 02 0 9 0 33. 00 H - DRUGS CHARGEABLE RECLASS 1 100 0 1, 573, 664 1 100 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 1, 573, 664 1 100 2. 00 OPERATI ON OF PLANT 7. 00 0 4 0 2. 00 3. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 1 1 0 0 3. 00 4. 00 PHARMACY 15. 00 0 7, 236, 885 0 4. 00 5. 00 ADULTS & PEDI ATRI CS 30. 00 0 3. 049 0 5. 00 5. 00 ADULTS & PEDI ATRI CS 30. 00 0 618 0 6. 00 7. 00 OPERATI NG ROOM 50. 00 131 0 7. 00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPIRATORY THERAPY 65. 00 0 6. 00 9. 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00 9. 10. 00 PHYSI CAL THERAPY 66. 00 0 9. 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 75 0 0 10. 00 26. 00 PHYSI CAL THERAPY 66. 00 0 5 0 0 10. 00 27. 00 PHYSI CAL THERAPY 66. 00 0 5 0 0 10. 00 28. 00 CARDI AGENCY 29. 00 9. 00 20.				0		l I		1
27. 00 CLINIC 90. 00 0 96, 494 0 27. 00 28. 00 28. 00 EMERGENCY 91. 00 0 196, 919 0 28. 00 29. 00 30. 00 GIFT, FLOWER, COFFEE SHOP & 190. 00 0 7, 315 0 30. 00				o		o		1
29. 00 HOME HEALTH AGENCY 101. 00 0 5, 025 0 29. 00 30. 00 GIFT, FLOWER, COFFEE SHOP & 190. 00 0 7, 315 0 30. 00 31. 00 PHYSICI ANS' PRI VATE OFFI CES 192. 00 0 111, 158 0 31. 00 32. 00 DI ABETES CENTER 192. 03 0 210 0 32. 00 33. 00 PHYSICI AN OFFI CE BUILDING 193. 02 0 9 0 333. 00 TOTALS 0 1, 573, 664 1 0 1, 573, 664 1 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		CLINIC		О		o		27. 00
30. 00 GI FT, FLOWER, COFFEE SHOP & 190. 00 0 7, 315 0 30. 00 31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 111, 158 0 31. 00 32. 00 DI ABETES CENTER 192. 03 0 210 0 32. 00 33. 00 PHYSI CI AN OFFI CE BUI LDI NG 193. 02 0 9 0 33. 00 TOTALS 0 1, 573, 664 H - DRUGS CHARGEABLE RECLASS 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 139 0 1. 00 2. 00 OPERATI ON OF PLANT 7. 00 0 4 0 2. 00 3. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 1 0 0 2. 00 4. 00 PHARMACY 15. 00 0 7, 236, 885 0 3. 00 4. 00 PHARMACY 15. 00 0 7, 236, 885 0 4. 00 5. 00 ADULTS & PEDI ATRI CS 30. 00 0 7, 236, 885 0 5. 00 6. 00 INTENSI VE CARE UNI T 31. 00 0 618 0 6. 00 7. 00 OPERATI NG ROOM 50. 00 0 131 0 7. 00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 0 10. 00		EMERGENCY	91.00	0	196, 919	0		28. 00
CANTEEN				0		0		29. 00
31. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 1111, 158 0 32. 00 32. 00 33. 00 PHYSI CI AN OFFI CE BUI LDI NG 193. 02 0 9 0 33. 00 1 0 0 1, 573, 664 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00		190. 00	0	7, 315	0		30.00
32.00 DI ABETES CENTER 192.03 0 210 0 32.00 33.00 PHYSICIAN OFFICE BUILDING 193.02 0 9 0 TOTALS 0 1,573,664 H - DRUGS CHARGEABLE RECLASS	21 00		102.00		111 150			21 00
Note				- 1		l .		1
TOTALS			1	- 1		0		1
H - DRUGS CHARGEABLE RECLASS	55.00					<u> </u>		35.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 139 0 1. 00 2. 00 OPERATI ON OF PLANT 7. 00 0 4 0 2. 00 3. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 1 0 3. 00 4. 00 PHARMACY 15. 00 0 7, 236, 885 0 4. 00 5. 00 ADUITS & PEDI ATRI CS 30. 00 0 3, 049 0 5. 00 6. 00 INTENSI VE CARE UNIT 31. 00 0 618 0 6. 00 7. 00 OPERATI NG ROOM 50. 00 0 131 0 7. 00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00				31	,			
3. 00 NURSI NG ADMI NI STRATI ON 13. 00 1 1 0 3. 00 4. 00 PHARMACY 15. 00 0 7, 236, 885 0 4. 00 5. 00 ADULTS & PEDI ATRI CS 30. 00 0 3, 049 0 5. 00 6. 00 I NTENSI VE CARE UNI T 31. 00 0 618 0 6. 00 7. 00 OPERATI NG ROOM 50. 00 131 0 7. 00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5		•			139	l I		1.00
4. 00 PHARMACY 15. 00 0 7, 236, 885 0 4. 00 5. 00 ADULTS & PEDI ATRI CS 30. 00 0 3, 049 0 5. 00 6. 00 I NTENSI VE CARE UNI T 31. 00 0 618 0 6. 00 7. 00 OPERATI NG ROOM 50. 00 131 0 7. 00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00					4	0		2.00
5. 00 ADULTS & PEDI ATRI CS 30. 00 0 3, 049 0 5. 00 6. 00 I NTENSI VE CARE UNI T 31. 00 0 618 0 6. 00 7. 00 OPERATI NG ROOM 50. 00 0 131 0 7. 00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00		•			1	0		3.00
6. 00 INTENSIVE CARE UNIT 31.00 0 618 0 6.00 7. 00 OPERATING ROOM 50.00 0 131 0 0 7.00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00		•		o o		0		1
7. 00 OPERATI NG ROOM 50. 00 0 131 0 7. 00 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00		•	l I	0				1
8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 16, 491 0 8. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00				O O				
9. 00 RESPI RATORY THERAPY 65. 00 0 6, 052 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00			l I	0		0		1
10. 00 PHYSI CAL THERAPY 66. 00 0 5 0 10. 00				ől		o o		9. 00
11. 00 ONCOLOGY 76. 00 0 96, 663 0 11. 00		PHYSI CAL THERAPY	66. 00		5	O		10.00
	11. 00	ONCOLOGY	76. 00	0	96, 663	0		11.00

Heal th Financial Systems

| Provider CCN: 15-001 | Period: From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

						5/24/2023 9:3	39 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
12.00	CLI NI C	90.00	0	74, 639	C		12.00
13.00	EMERGENCY	91.00	0	80	C		13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	494, 820	C		14.00
	TOTALS		0	7, 929, 577			
500.00	Grand Total: Decreases		658, 560	13, 383, 203			500.00

				To	12/31/2022	Date/Time Pre 5/24/2023 9:3	pared:
				Acqui si ti ons		372472023 7.3	7 dili
		Beginning	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 ASSE	T BALANCES					
1.00	Land	4, 926, 609	0	0	0	0	1.00
2.00	Land Improvements	2, 727, 617	368, 602	0	368, 602	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	67, 759, 440	37, 781, 659	0	37, 781, 659		4.00
5.00	Fi xed Equi pment	13, 103, 672	1, 982, 854	0	1, 982, 854		5.00
6.00	Movable Equipment	54, 287, 477	0	0	0	12, 511, 388	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	142, 804, 815	40, 133, 115	0	40, 133, 115	12, 511, 388	
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	142, 804, 815	40, 133, 115	0	40, 133, 115	12, 511, 388	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
	DART I ANALYSIS OF SUMMORS IN SARITAL ASSE	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	4, 926, 609	0				1.00
2. 00	Land Improvements	3, 096, 219	0				2.00
3. 00	Buildings and Fixtures	0	0				3.00
4. 00	Building Improvements	105, 541, 099	0				4.00
5. 00	Fi xed Equipment	15, 086, 526	0				5.00
6. 00	Movabl e Equi pment	41, 776, 089	0				6. 00
7. 00	HIT designated Assets	0	0				7.00
8. 00	Subtotal (sum of lines 1-7)	170, 426, 542	0				8.00
9. 00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	170, 426, 542	0				10.00

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0001	Peri od:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022		pared:
						Date/Time Pre 5/24/2023 9:3	9 am
			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	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	3, 065, 371	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 173, 319	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	7, 238, 690	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(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 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3, 065, 371				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4, 173, 319				2.00
3.00	Total (sum of lines 1-2)	0	7, 238, 690				3.00
		•					•

Heal th	Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7		
					From 01/01/2022 To 12/31/2022		nared·	
						5/24/2023 9: 3		
		COM	PUTATION OF RA	TI 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		col . 2)	4 00	5.00		
	DART III DECONCILIATION OF CARLTAL COSTS C	1. 00	2. 00	3.00	4. 00	5. 00		
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C NEW CAP REL COSTS-BLDG & FIXT	170, 426, 542	0	170, 426, 54	2 1. 000000	0	1.00	
2. 00	CAP REL COSTS-BLDG & FIXT	170, 426, 342	0	170, 420, 34.	0.00000	Ŭ	2.00	
3. 00	Total (sum of lines 1-2)	170, 426, 542		170, 426, 54			3.00	
0.00	Total (Sam St Times 1 2)	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
				-				
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
			Capi tal -Rel at					
			ed Costs	through 7)	0.00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10. 00		
1. 00	NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0	0		0 3, 148, 757	0	1.00	
	CAP REL COSTS-BEDG & TTXT	0	0		0 4, 173, 319		2.00	
3. 00	Total (sum of lines 1-2)	0	0		7, 322, 076		3.00	
0.00	Total (Sam St 11165 1 2)		Sl	JMMARY OF CAPI		-	0.00	
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)		
			(see	instructions)				
			instructions)		ed Costs (see instructions)	9 through 14)		
		11. 00	12. 00	13. 00	14.00	15. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00		
1. 00	NEW CAP REL COSTS-BLDG & FLXT	-171, 949	0		0 0	2, 976, 808	1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	0	o		0	4, 173, 319	2.00	
3.00	Total (sum of lines 1-2)	-171, 949	0		0 0	7, 150, 127	3.00	

7155001	MENTO TO EXCENSES			Treviaer com 10 coor	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/24/2023 9:3	
			To	Expense Classification op/From Which the Amount is		3/24/2023 4.3	7 alli
					, to be haj acted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	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			EW CAP REL COSTS-BLDG & IXT	1. 00	0	1.00
2. 00	Investment income - CAP REL		O CA	AP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	Tel evi si on and radio servi ce		0		0. 00	0	8. 00
9. 00 10. 00	(chapter 21) Parking Lot (chapter 21) Provi der-based physician	A-8-2	0 -5, 558, 450		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.	N 0 2	0		0.00	0	
12. 00]	A-8-1	0			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	11.00
16. 00	and others Sale of medical and surgical supplies to other than		0		0. 00	0	16.00
17. 00	patients Sale of drugs to other than		0		0.00	0	17.00
18. 00			0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vendi ng machi nes		O		0. 00	0	20.00
	Income from imposition of interest, finance or penalty		0		0.00	0	21.00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	O RE	ESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	OPF	HYSI CAL THERAPY	66. 00		24.00
25. 00	Utilization review - physicians' compensation		0 * *	** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT			EW CAP REL COSTS-BLDG &	1. 00	0	26. 00
27. 00	Depreciation - CAP REL			AP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0 * *	** Cost Center Deleted ***		^	28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 00	CCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		OAL	DULTS & PEDIATRICS	30. 00		30. 99
	instructions)				1		l

From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

) 12/31/2022	5/24/2023 9: 3	
				Expense Classification on	Worksheet A	0,21,2020 ,10	, <u>u</u>
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	3031 301101 20301 Pt. 611	(2)	7 1110 0111	3551 5511151	21.110 #	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	3.00	31.00
31.00	pathology costs in excess of	7, 0, 3		SI ELGII I ATTIOLOGI	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32.00
32.00			U		0. 00	U	32.00
00.00	Depreciation and Interest		450.004	CAFETERI A	44.00		00.00
33. 00	CAFETERIA CANTEEN VENDING	В	- 158, 831	CAFETERI A	11. 00	0	33.00
	REVENUE			0.4557501.4	44.00		
33. 01	CAFETERIA CANTEEN VENDING	В	0	CAFETERI A	11. 00	0	33. 01
	REVENUE	_					
33. 02	MISC OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 03	MISC OTHER REVENUE	В		DI ETARY	10. 00	0	
33.04	MISC OTHER REVENUE	В	0	NURSING ADMINISTRATION	13. 00	0	33.04
33.05	MISC OTHER REVENUE	В	0	PHARMACY	15. 00	0	33.05
33.06	MISC OTHER REVENUE	В	-48, 750	MEDICAL RECORDS & LIBRARY	16. 00	0	33.06
33. 07	MISC OTHER REVENUE	В	-35, 254	LABORATORY	60.00	0	33. 07
33. 08	MI SC OTHER REVENUE	В		MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 08
00.00	I THE THE TEVENOL	5	., _ , _	PATI ENTS	,	Ŭ	00.00
33. 09	MISC OTHER REVENUE	В	929	ONCOLOGY	76. 00	0	33. 09
33. 10	MISC OTHER REVENUE	В		CLINIC	90.00	0	•
33. 11	MI SC OTHER REVENUE	В		MATERIALS MANAGEMENT	4. 03	0	33. 10
33. 12	MISC OTHER REVENUE	В		NURSING ADMINISTRATION		·	33. 11
					13.00	0	
33. 13	CABLE SERVICES	A		OPERATION OF PLANT	7. 00	0	
33. 14	TELEPHONE SERVICES	Α	-1, 1//	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 14
				FIXT		_	
33. 15	TELEPHONE SERVICES	Α		COMMUNI CATI ONS	4. 01	0	
33. 16	COMMUNI CATI ONS	Α		COMMUNI CATI ONS	4. 01	0	
33. 17	ADVERTISING EXP - A&G	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	ADVERTISING EXP - PHYSICAL	Α	-123	PHYSI CAL THERAPY	66. 00	0	33. 18
	THERAPY						
33. 19	ADVERTISING EXP - CLINIC	Α	0	CLINIC	90.00	0	33. 19
33. 20	ADVERTISING EXP - EMERGENCY	Α	0	EMERGENCY	91. 00	0	33. 20
	ROOM						
33. 21	LOBBYING EXPENSE - AHA	Α	-6, 880	ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	LOBBYING EXPENSE - IHA	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23	PROF - BUILDING-PLANT WORK	A		OPERATION OF PLANT	7. 00	0	•
00. 20	ORDERS	,,	20, 107	OF ENVIRONCE OF TEXAU	7.00	J	00.20
33. 24	PROF - BUILDING-PLANT WORK	Α	_7 716	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 24
55. ZŦ	ORDERS	A	7,710	LWI LOTEE BENEFIT TO BETAKTMENT	4.00	0	33.24
33. 25	1993 AHA LIFE	Α	01 562	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 25
JJ. ZJ	1773 AIM LITE	A	04, 303	FIXT	1.00	9	33.23
22 24	HAE EVDENCE	Λ	4 102 200	ADMINISTRATIVE & GENERAL	E 00	_	22 24
33. 26	HAF EXPENSE	A			5. 00	0	
33. 27	I NTEREST EXPENSE	А	-1/1,949	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 27
00.00	EL FOTDOFNOFDUAL CORARINA CETTE		_	FI XT	70	_	00.00
33. 28	ELECTROENCEPHALOGRAPHY OFFSET	Α		ELECTROENCEPHALOGRAPHY	70. 00	0	
50.00	TOTAL (sum of lines 1 thru 49)		-10, 724, 241				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) Do	scription all chapter referen		the same of the same of the same of	OHC D 1 45 4			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

Provider CCN: 15-0001

						10 12/31/2022	5/24/2023 9:3	epared: 39 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l 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	2, 231, 821	2, 231, 821	0	211, 500	0	1.00
2.00	53.00	ANESTHESI OLOGY	1, 125, 977	1, 125, 977	0	211, 500	0	2.00
3.00	70.00	ELECTROENCEPHALOGRAPHY	100, 000	100, 000	0	211, 500	0	3.00
4.00	76.00	ONCOLOGY	17, 313	C	17, 313	211, 500	69	4.00
5.00	76. 97	CARDIAC REHABILITATION	95, 150	95, 150	0	211, 500	0	5.00
6.00	90.00	CLINIC	92, 400	92, 400	0	211, 500	0	6.00
7. 00	91.00	EMERGENCY	1, 902, 805	1, 902, 805	0	211, 500	0	7.00
8.00	0.00		0	l c	0	0	0	8.00
9.00	0.00		0		0	0	0	9.00
10.00	0.00		0		0	0	0	10.00
200.00			5, 565, 466	5, 548, 153	17, 313		69	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of		Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Education	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1.00		ADULTS & PEDIATRICS	0	C	0	0	0	
2.00		ANESTHESI OLOGY	0	C	0	0	0	2.00
3.00	70.00	ELECTROENCEPHALOGRAPHY	0	C	0	0	0	3.00
4.00	76. 00 ONCOLOGY		7, 016	351	0	0	0	4.00
5.00	76. 97 CARDI AC REHABI LI TATI ON		0	C	0	0	0	5.00
6.00		CLINIC	0	C	0	0	0	6.00
7.00		EMERGENCY	0	C	0	0	0	7. 00
8.00	0.00		0	C	0	0	0	8.00
9.00	0.00		0	C	0	0	0	9.00
10.00	0.00		0	C	0	0	0	10.00
200.00			7, 016			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l 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	C	0			1.00
2.00		ANESTHESI OLOGY	0	C	0	1, 125, 977		2.00
3.00		ELECTROENCEPHALOGRAPHY	0	C	'	100, 000		3.00
4.00		ONCOLOGY	0	7, 016	10, 297			4.00
5.00		CARDIAC REHABILITATION	0	C	0	95, 150		5.00
6.00		CLINIC	0	C	0	92, 400		6.00
7.00	91. 00	EMERGENCY	0	C	0	1, 902, 805		7. 00
8.00	0.00		0	[C	0	0		8. 00
9.00	0.00		0	[C	0	0		9.00
10.00	0.00		0	[C	0	0		10.00
200.00			0	7, 016	10, 297	5, 558, 450		200.00

Heal th Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0001

Period:
From 01/01/2022
To 12/31/2022

Part I
Date/Time Prepared:
5/24/2023 9: 39 am

CAPITAL RELATED COSTS

Net Expenses
for Cost
Allocation
(from Wkst A)

NEW BLDG & MVBLE EQUIP
BENEFITS
DEPARTMENT

COMMUNICATION
S

		CAPITAL RELATED COSTS					
	Cost Center Description	Net Expenses	NEW BLDG &	MVBLE EQUIP	EMPLOYEE	COMMUNICATION	
	cost center bescription	for Cost	FLXT	WVDEL EQUIT	BENEFI TS	S	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1. 00	2.00	4. 00	4. 01	
	GENERAL SERVICE COST CENTERS						
	OO100 NEW CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP	2, 976, 808	2, 976, 808				1.00 2.00
2. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 173, 319 11, 053, 004	36, 161	4, 173, 319 1, 859	11, 091, 024		4.00
4. 01	00401 COMMUNI CATI ONS	350, 599	4, 763		25, 201		4. 01
4. 02	00402 DATA PROCESSING	3, 781, 583	75, 861		177, 832		4. 02
4. 03	00403 MATERI ALS MANAGEMENT	458, 381	46, 365		95, 214		4.03
4. 04 4. 05	OO4O4 ADMI TTI NG OO4O5 PATI ENT ACCOUNTI NG	1, 004, 429 1, 618, 030	27, 133 80, 587		226, 453 208, 899		4. 04 4. 05
5. 00	00500 ADMINI STRATI VE & GENERAL	3, 746, 633	115, 439		342, 017		5.00
7. 00	00700 OPERATION OF PLANT	4, 576, 930	408, 836		219, 509		7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	202, 245	29, 132		26, 521		1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	829, 656 452, 515	22, 625 47, 468		169, 641 59, 313		
11. 00	01100 CAFETERI A	442, 744	50, 546		81, 308		11.00
	01300 NURSING ADMINISTRATION	1, 256, 924	119, 572		257, 711		ı
	01400 CENTRAL SERVICES & SUPPLY	89, 812	20, 589		20, 070	0	14.00
	01500 PHARMACY	1, 693, 128	24, 794		228, 530		
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	844, 948	47, 007	11, 278	150, 093	10, 376	16.00
30. 00	03000 ADULTS & PEDIATRICS	5, 890, 387	334, 187	209, 777	1, 431, 734	34, 495	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 607, 437	95, 565		255, 884		
	04100 SUBPROVI DER - I RF	0	0	-	0		41.00
43. 00	04300 NURSERY	269, 193	7, 574	0	53, 403	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2, 892, 566	554, 546	623, 766	522, 578	24, 679	50.00
	05300 ANESTHESI OLOGY	1, 131, 770	4, 775		225, 430		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 248, 467	200, 340		532, 668		54.00
60.00	06000 LABORATORY	5, 890, 544	97, 540		453, 973		
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 062, 758 948, 102	4, 532 76, 806		372, 543 207, 411		1
	06700 OCCUPATI ONAL THERAPY	301, 671	76, 806 16, 178		69, 334		1
68. 00	06800 SPEECH PATHOLOGY	153, 944	1, 006		35, 092		ł
	06900 ELECTROCARDI OLOGY	600, 403	13, 088		93, 681		
	07000 ELECTROENCEPHALOGRAPHY	16, 381	2, 206		3, 767		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	2, 190, 649 3, 545, 012	0	,	0		71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	7, 929, 577	0		0	0	73.00
76.00	03020 ONCOLOGY	618, 292	84, 816		126, 834		
	07697 CARDI AC REHABI LI TATI ON	201, 184	30, 429		38, 866		76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
90.00	09000 CLINIC	2, 154, 217	139, 555	23, 115	186, 962	5, 889	90.00
	09100 EMERGENCY	3, 929, 190	120, 384		762, 191		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	704 771	15 014	01	125 051	/ 450	101.00
101.00	10100 HOME HEALTH AGENCY 10200 OPLOID TREATMENT PROGRAM	724, 771 0	15, 814 0		135, 951 0		101.00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		,			102.00
	11300 I NTEREST EXPENSE						113.00
118. 00		86, 858, 203	2, 956, 219	4, 016, 397	7, 796, 614	325, 874	118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	210, 492	15, 717	6, 245	42, 411	1 207	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	16, 989, 378	15, 717		3, 233, 592		190.00
	19201 SOUTH CLINIC	0	0		0, 200, 0,2		192.01
	19202 WEST CLINIC	0	0	0	0		192. 02
	19203 DI ABETES CENTER	80, 620	4, 872	1	18, 407		192.03
	19300 NONPALD WORKERS 19301 ADULT/CHILD CARE	0	0	0	0		193. 00 193. 01
193. 02	19302 PHYSICIAN OFFICE BUILDING	875, 607	0	0	0		193.01
193. 03	19303 OPTI FAST/FOUNDATI ON	0	0	o	0	0	193. 03
	07950 PARTNERSHI P HFC	483	0	0	0		194. 00
	07951 TRAFALGAR CLI NI C	0	0		0		194. 01
	07952 EDI NBURGH 07953 JAI L		0		0		194. 02 194. 03
	07954 ATHLETI C TRAINERS		0		0		194.03
200.00	Cross Foot Adjustments						200.00
201.00		105	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	105, 014, 783	2, 976, 808	4, 173, 319	11, 091, 024	380, 563	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0001

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/24/2023 9:39 am Cost Center Description DATA MATERI ALS ADMITTI NG PATI ENT Subtotal PROCESSI NG MANAGEMENT ACCOUNTI NG 4.04 4.05 4A. 05 4.02 4.03 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 100401 COMMUNICATIONS 4.01 4.01 4.02 00402 DATA PROCESSING 6, 029, 631 4.02 4.03 00403 MATERIALS MANAGEMENT 67,893 685, 255 4.03 1, 497, 796 00404 ADMITTING 229, 368 4 04 4 04 878 4.05 00405 PATIENT ACCOUNTING 403, 688 289 0 2, 352, 532 4.05 4, 719, 342 00500 ADMINISTRATIVE & GENERAL 449, 562 5.00 3,034 5.00 7.00 00700 OPERATION OF PLANT 78, 903 47 0 0 5, 360, 951 7.00 00800 LAUNDRY & LINEN SERVICE 58, 718 325, 072 0 0 8 00 119 8 00 9.00 00900 HOUSEKEEPI NG 392 0 0 1, 032, 480 9.00 10.00 01000 DI ETARY 51, 378 10, 938 0 0 657, 950 10.00 01100 CAFETERI A 0 574, 598 11.00 0 11.00 01300 NURSING ADMINISTRATION 0 13.00 141, 291 4.146 1, 838, 327 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 271 0 0 178, 921 14.00 01500 PHARMACY 15 00 170 650 274, 473 0 2, 405, 831 15.00 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 16.00 0 148, 631 1, 212, 499 16.00 166 03000 ADULTS & PEDIATRICS 350, 475 68, 948 108, 292 8, 440, 853 30.00 12, 558 30.00 31.00 03100 INTENSIVE CARE UNIT 172, 485 3, 921 17, 234 27, 068 3, 237, 259 31.00 04100 SUBPROVI DER - I RF 41.00 41.00 43.00 04300 NURSERY 2.707 4.251 337, 128 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 16, 148 209. 703 594, 522 329, 364 5, 767, 872 50.00 53.00 05300 ANESTHESI OLOGY 21 32, 052 50, 342 1, 464, 252 53 00 05400 RADI OLOGY-DI AGNOSTI C 205, 514 331, 812 521, 209 5, 542, 826 54.00 7,564 54.00 60.00 06000 LABORATORY 249, 553 92, 422 228, 732 359, 252 7, 588, 710 60.00 135, 786 34, 789 65.00 06500 RESPIRATORY THERAPY 7, 065 54, 641 2, 698, 830 65.00 66.00 06600 PHYSI CAL THERAPY 77,068 752 18, 987 29,822 1, 380, 092 66.00 67.00 06700 OCCUPATI ONAL THERAPY 20. 184 5, 512 8,658 426, 560 67.00 06800 SPEECH PATHOLOGY 14, 680 41 2, 387 3,749 213, 105 68.00 68.00 06900 FLECTROCARDI OLOGY 37. 454 69 00 62, 388 454 23, 847 890, 873 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 12 656 1,030 27, 201 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 513, 412 71.00 0 159, 572 55, 845 87, 711 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 68.351 3, 656, 882 72.00 43.519 8, 327, 083 07300 DRUGS CHARGED TO PATIENTS 73.00 154, 634 242, 872 73.00 76.00 03020 ONCOLOGY 198, 174 4,699 7,470 11,733 1,065,421 76.00 76.97 07697 CARDIAC REHABILITATION 460 3, 365 5, 285 294, 043 76.97 77 00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 289, 921 9, 450 61, 045 95, 879 2, 966, 033 90.00 91.00 09100 EMERGENCY 308, 271 14, 928 192, 704 302, 666 5, 690, 396 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 64, 223 309 1, 848 2, 903 952, 360 101. 00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102, 00 Ω 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 543, 326 627, 129 1, 497, 796 2, 352, 532 81, 787, 162 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 64, 223 541 0 343, 836 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 21, 850, 823 192. 00 1, 374, 373 57, 568 192. 01 19201 SOUTH CLINIC 0 o 0 192. 01 C 192. 02 19202 WEST CLINIC 0 192.02 0 C 0 0 192. 03 19203 DI ABETES CENTER 14,680 17 0 0 120, 197 192. 03 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193.00 0 193. 01 19301 ADULT/CHI LD CARE 1, 402 193. 01 0 0 0 193. 02 19302 PHYSICIAN OFFICE BUILDING 0 Ω 0 875, 607 193. 02 193. 03 19303 OPTI FAST/FOUNDATI ON 0 0 0 0 193.03 0 194. 00 07950 PARTNERSHIP HFC 33, 029 0 0 0 35, 756 194.00 0 194. 01 07951 TRAFALGAR CLINIC 0 0 194. 01 0 0 0 194. 02 07952 EDI NBURGH 0 C 0 194.02 194. 03 07953 JAI L 0 0 0 194.03 0 o 194. 04 07954 ATHLETIC TRAINERS 0 C 0 0 194.04 200.00 Cross Foot Adjustments 0 200, 00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 6, 029, 631 1, 497, 796 2, 352, 532 105, 014, 783 202. 00 202.00 685, 255

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0001

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/24/2023 9:39 am Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL PLANT LINEN SERVICE 9. 00 5.00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00401 COMMUNI CATI ONS 4.01 4.01 4.02 00402 DATA PROCESSING 4.02 4.03 00403 MATERIALS MANAGEMENT 4.03 4 04 00404 ADMITTING 4 04 00405 PATIENT ACCOUNTING 4.05 4.05 00500 ADMINISTRATIVE & GENERAL 4, 719, 342 5.00 5.00 7.00 00700 OPERATION OF PLANT 252, 254 5, 613, 205 7.00 00800 LAUNDRY & LINEN SERVICE 15, 296 415, 323 74, 955 8 00 8 00 9.00 00900 HOUSEKEEPI NG 48, 582 58, 212 69,088 1, 208, 362 9.00 26, 930 10.00 01000 DI ETARY 30, 959 122, 129 6,844 844, 812 10.00 01100 CAFETERI A 27, 037 11.00 130.049 28, 676 C 0 11.00 01300 NURSING ADMINISTRATION 0 86, 501 13.00 307, 646 67,837 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 8, 419 52, 974 0 11, 681 0 14.00 01500 PHARMACY 63, 793 15.00 15 00 113, 204 0 14,066 0 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 57, 053 <u>120,</u> 944 16.00 16.00 0 26, 669 0 03000 ADULTS & PEDIATRICS 397, 176 859, 831 124, 473 189, 595 760, 427 30.00 30.00 03100 INTENSIVE CARE UNIT 31.00 152, 326 245, 880 31, 962 54, 217 84, 385 31.00 04100 SUBPROVI DER - I RF 41.00 C 0 41.00 43.00 04300 NURSERY 15,863 19, 487 O 4, 297 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 314, 612 50.00 271.401 1, 426, 792 50.00 55, 615 0 53.00 05300 ANESTHESI OLOGY 68.899 12, 285 2, 709 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 260, 812 515, 456 113, 659 54.00 54.00 22, 363 0 60.00 06000 LABORATORY 357, 079 250, 962 55, 338 0 60.00 0 126, 991 06500 RESPIRATORY THERAPY 65.00 11, 661 0 2.571 0 65.00 66.00 06600 PHYSI CAL THERAPY 64.939 197, 614 5,504 43, 574 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 20,071 41,624 9, 178 67.00 06800 SPEECH PATHOLOGY 10, 027 2, 588 571 0 68.00 68.00 0 06900 ELECTROCARDI OLOGY 41, 919 33, 674 7, 425 69 00 69 00 2,077 0 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 280 5, 675 0 1, 251 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 118, 266 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 172.071 0 72.00 C 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 391, 823 0 0 0 73.00 76.00 03020 ONCOLOGY 50, 132 218, 224 0 48, 119 0 76.00 76.97 07697 CARDIAC REHABILITATION 13,836 78, 291 0 17, 263 0 76.97 77 00 07700 ALLOGENEIC STEM CELL ACQUISITION Ω 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 139, 564 359, 061 1, 391 79, 174 0 90.00 91.00 09100 EMERGENCY 267, 756 309, 735 91, 924 68, 297 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 44, 812 40, 689 0 8, 972 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 626, 348 5, 560, 231 411, 241 1, 196, 681 844, 812 118.00 NONREI MBURSABLE COST CENTERS 8, 917 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 16, 179 40, 440 0 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 4, 082 0 192.00 1,028,210 192. 01 19201 SOUTH CLINIC 0 192. 01 0 0 0 192.02 19202 WEST CLINIC 0 192.02 0 0 0 192. 03 19203 DI ABETES CENTER 12, 534 0 2,764 0 192.03 5,656 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 0 193. 01 19301 ADULT/CHI LD CARE 0 193. 01 0 0 66 C 193. 02 19302 PHYSICIAN OFFICE BUILDING 41, 201 C 0 0 0 193 02 193. 03 19303 OPTI FAST/FOUNDATI ON 0 0 0 0 193.03 194. 00 07950 PARTNERSHIP HFC 1, 682 0 0 0 0 194.00 0 194. 01 07951 TRAFALGAR CLINIC 0 0 194. 01 0 0 194. 02 07952 EDI NBURGH 0 0 0 194.02 0 C 194. 03 07953 JAI L 0 0 194.03 0 194. 04 07954 ATHLETIC TRAINERS 0 C 0 0 0 194.04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers C 0 201.00 TOTAL (sum lines 118 through 201) 4, 719, 342 1, 208, 362 844, 812 202. 00 202.00 5, 613, 205 415, 323

Provider CCN: 15-0001

Peri od: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/24/2023 9:39 am

						5/24/2023 9:3	9 am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMINISTRATIO	SERVICES & SUPPLY		RECORDS & LI BRARY	
		11. 00	13. 00	14.00	15. 00	16. 00	
GF	ENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
	0100 NEW CAP REL COSTS-BLDG & FIXT				I		1.00
1	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
1	0401 COMMUNI CATI ONS						4. 01
	0402 DATA PROCESSING						4. 02
	0403 MATERI ALS MANAGEMENT						4. 03
1	0404 ADMI TTI NG						4. 04
	0405 PATIENT ACCOUNTING						4. 05
	D500 ADMINISTRATIVE & GENERAL						5. 00
	0700 OPERATION OF PLANT						7. 00
	0800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPI NG						9. 00
	1000 DI ETARY						10.00
	1100 CAFETERI A	760, 360					11.00
1	1300 NURSING ADMINISTRATION	22, 788					13.00
1	1400 CENTRAL SERVICES & SUPPLY	5, 047		257, 042			14.00
	1500 PHARMACY	25, 919		0	2, 622, 813		15. 00
	1600 MEDICAL RECORDS & LIBRARY	32, 950		0	0	1, 450, 115	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	0=,			-1	.,,.,,,,,,,	
	3000 ADULTS & PEDIATRICS	121, 337	1, 011, 213	0	0	66, 758	30.00
	3100 INTENSIVE CARE UNIT	38, 698		0	o	16, 686	31.00
	4100 SUBPROVI DER - I RF	0	0	0	o	0	41.00
43.00 04	4300 NURSERY	21, 387	0	0	o	2, 621	43.00
AN	NCILLARY SERVICE COST CENTERS						
50.00 05	5000 OPERATING ROOM	73, 867	523, 361	0	0	203, 040	50.00
53.00 05	5300 ANESTHESI OLOGY	0	0	0	0	31, 034	53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	69, 922	0	0	0	321, 175	54.00
60.00 06	6000 LABORATORY	87, 572	0	0	0	221, 465	60.00
65. 00 06	5500 RESPIRATORY THERAPY	36, 533	0	0	0	33, 684	65.00
66.00 06	6600 PHYSI CAL THERAPY	26, 865	0	0	0	18, 384	66.00
67.00 06	5700 OCCUPATIONAL THERAPY	7, 631	0	0	0	5, 337	67.00
68. 00 06	SPEECH PATHOLOGY	4, 022	0	0	0	2, 311	68.00
69.00 06	5900 ELECTROCARDI OLOGY	14, 332	0	0	0	23, 089	69.00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	534	0	0	0	635	70.00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	257, 042	0	54, 070	71. 00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	42, 136	72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 622, 813	149, 721	73.00
76. 00 03	BO20 ONCOLOGY	17, 885	0	0	0	7, 233	76. 00
1	7697 CARDIAC REHABILITATION	4, 977	0	0	0	3, 258	76. 97
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	JTPATIENT SERVICE COST CENTERS				.1		
1	9000 CLINIC	44, 433		0	0	59, 106	90.00
	9100 EMERGENCY	72, 595	514, 343	0	0	186, 582	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	THER REIMBURSABLE COST CENTERS	1/ 540		0	ما	1 700	101 00
	0100 HOME HEALTH AGENCY	16, 542			0		101.00
	D200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	PECIAL PURPOSE COST CENTERS 1300 INTEREST EXPENSE				I		113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	745, 836	2, 323, 099	257, 042	2, 622, 813	1, 450, 115	
	ONREIMBURSABLE COST CENTERS	745, 630	2, 323, 077	257, 042	2,022,013	1, 450, 115	110.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 524	0	0	O	0	190. 00
	9200 PHYSICIANS' PRIVATE OFFICES	14, 324	0	0	Ö		192.00
	9201 SOUTH CLINIC	0		0	ol		192. 01
	9202 WEST CLINIC	0	0	0	ol O		192. 02
	9203 DI ABETES CENTER	0	0	0	ol		192. 03
	9300 NONPAI D WORKERS	0	0	0	ol		193. 00
	9301 ADULT/CHI LD CARE	0	0	0	ol		193. 01
	9302 PHYSICIAN OFFICE BUILDING	l	ا	n	ol Ol		193. 02
	9303 OPTI FAST/FOUNDATI ON	0	0	0	ol		193. 03
	7950 PARTNERSHI P HFC		l ő	n	n N		194. 00
	7951 TRAFALGAR CLINIC	0	0	o o	ol		194. 01
	7952 EDI NBURGH	Ö	l o	Ö	ol		194. 02
	7953 JAI L	o o	0	0	ol		194. 03
	7954 ATHLETIC TRAINERS	l o	l o	Ö	ol		194. 04
200.00	Cross Foot Adjustments]			٦		200.00
201.00	Negative Cost Centers	0	0	0	o		201. 00
202. 00	TOTAL (sum lines 118 through 201)	760, 360	2, 323, 099	257, 042	2, 622, 813	1, 450, 115	202. 00
				·	·		

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0001

					To 12/31/2022 Date/Time Pr 5/24/2023 9:	
	Cost Center Description	Subtotal	Intern &	Total	372472023 7.	37 4111
			Residents Cost & Post			
			Stepdown			
		0.4.00	Adjustments	0,4,00		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 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					4.00
4. 01 4. 02	00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG					4. 01 4. 02
4. 03	00403 MATERI ALS MANAGEMENT					4. 03
4.04	OO4O4 ADMI TTI NG					4.04
4. 05	00405 PATIENT ACCOUNTING					4. 05
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00 13. 00	01100 CAFETERI A 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					16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	11 071 //2	ol	11 071 //	2	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	11, 971, 663 4, 135, 595	0	11, 971, 66 4, 135, 59		30. 00 31. 00
41. 00	04100 SUBPROVI DER – I RF	0	Ö		o o	41.00
43.00		400, 783	0	400, 78	3	43.00
FO 00	ANCILLARY SERVICE COST CENTERS	0 (2/ 5/0	ما	0 /2/ 5/		
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	8, 636, 560 1, 579, 179	0	8, 636, 56 1, 579, 17		50.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 846, 213	o	6, 846, 21		54.00
60.00	06000 LABORATORY	8, 561, 126	O	8, 561, 12	6	60.00
65.00	06500 RESPI RATORY THERAPY	2, 910, 270	0	2, 910, 27		65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 736, 972 510, 401	0	1, 736, 97 510, 40		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	232, 624	0	232, 62		68.00
69.00	06900 ELECTROCARDI OLOGY	1, 013, 389	0	1, 013, 38		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	36, 576	0	36, 57		70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	2, 942, 790 3, 871, 089	0	2, 942, 79 3, 871, 08		71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 491, 440	0	11, 491, 44		73.00
76.00	03020 ONCOLOGY	1, 407, 014	0	1, 407, 01		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	411, 668	0	411, 66		76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0	77. 00
90. 00	09000 CLINIC	3, 648, 762	O	3, 648, 76	2	90.00
91.00	09100 EMERGENCY	7, 201, 628		7, 201, 62		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
101 0	OTHER REIMBURSABLE COST CENTERS D 10100 HOME HEALTH AGENCY	1 0/5 1/5	ما	1 O/F 1/	E	101 00
	10100 HOME HEALTH AGENCY 10200 OPI OI D TREATMENT PROGRAM	1, 065, 165 0		1, 065, 16	0	101. 00 102. 00
.02.0	SPECIAL PURPOSE COST CENTERS		<u> </u>		<u> </u>	1.02.00
	11300 INTEREST EXPENSE					113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	80, 610, 907	0	80, 610, 90	7	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	423, 896	O	423, 89	6	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	22, 883, 115		22, 883, 11		192.00
	1 19201 SOUTH CLINIC	0	O		0	192. 01
	2 19202 WEST CLINIC	0	0		0	192.02
	3 19203 DI ABETES CENTER D 19300 NONPAI D WORKERS	141, 151	0	141, 15	1	192. 03 193. 00
	1 19301 ADULT/CHI LD CARE	1, 468	o	1, 46	8	193. 00
193. 02	2 19302 PHYSICIAN OFFICE BUILDING	916, 808	o	916, 80		193. 02
	3 19303 OPTI FAST/FOUNDATI ON	0	0		0	193. 03
	DO7950 PARTNERSHI P HFC 107951 TRAFALGAR CLI NI C	37, 438	0	37, 43	ଠା ଧ	194. 00 194. 01
	207952 EDI NBURGH	0			ol	194.01
	3 07953 JAI L	0	ő		0	194. 03
	4 07954 ATHLETIC TRAINERS	0	o		0	194. 04
200.00	, ,	0	0	'	0	200.00
201. 00 202. 00		0 105, 014, 783	0	105, 014, 78	3	201. 00 202. 00
_02.00	1.1 (1 1.1.00 1.10 till odgir 201)		, YI		-1	,===.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0001

			Ť	0 12/31/2022	Date/Time Pre 5/24/2023 9:3	
		CAPI TAL REI	LATED COSTS		372472023 7.3	7 dili
Cost Center Description	Di rectly	NEW BLDG &	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New Capital	FIXT			BENEFITS DEPARTMENT	
	Related Costs					
CENEDAL SEDVICE COST CENTEDS	0	1. 00	2. 00	2A	4. 00	
1.00 GENERAL SERVICE COST CENTERS 1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	36, 161	1, 859		38, 020	4. 00
4.01 00401 COMMUNI CATI ONS 4.02 00402 DATA PROCESSI NG	0	4, 763 75, 861	0 1, 956, 495	4, 763 2, 032, 356	86 609	4. 01 4. 02
4. 03 00403 MATERI ALS MANAGEMENT	0	46, 365		55, 634	326	4. 02
4. 04 00404 ADMI TTI NG	0	27, 133		27, 133	776	4. 04
4. 05 OO405 PATIENT ACCOUNTING	0	80, 587		96, 947	716	4.05
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	0	115, 439 408, 836			1, 172 752	5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	29, 132			91	8.00
9. 00 00900 HOUSEKEEPI NG	O	22, 625			581	9. 00
10. 00 01000 DI ETARY	0	47, 468			203	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINI STRATI ON	0	50, 546 119, 572		50, 546 165, 355	279 883	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	20, 589		·	69	14. 00
15. 00 01500 PHARMACY	0	24, 794			783	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	47, 007	11, 278	58, 285	514	16. 00
30. 00 03000 ADULTS & PEDIATRICS	O	334, 187	209, 777	543, 964	4, 906	30.00
31. 00 03100 NTENSI VE CARE UNI T	O	95, 565		145, 378	877	31.00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00 04300 NURSERY	0	7, 574	0	7, 574	183	43.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	O	554, 546	623, 766	1, 178, 312	1, 791	50.00
53. 00 05300 ANESTHESI OLOGY	O	4, 775			772	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	200, 340			1, 825	54.00
60. 00 06000 LABORATORY	0	97, 540			1, 556	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	4, 532 76, 806			1, 277 711	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	l o	16, 178			238	67.00
68.00 06800 SPEECH PATHOLOGY	O	1, 006		1, 529	120	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	13, 088			321	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 206 0	2, 588 19, 635		13 0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	O	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 03020 0NC0L0GY 76. 97 07697 CARDI AC REHABI LI TATI ON	0	84, 816 30, 429			435 133	76. 00 76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	30, 429		44, 883	0	77. 00
OUTPATIENT SERVICE COST CENTERS			-	-		
90. 00 09000 CLINIC	0	139, 555	1		641	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	120, 384	43, 516	163, 900	2, 612	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS				O _I		72.00
101.00 10100 HOME HEALTH AGENCY	0	15, 814		15, 905		101. 00
102. 00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 956, 219	4, 016, 397	6, 972, 616	26, 717	
NONREI MBURSABLE COST CENTERS		45 747		24.040		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	15, 717	6, 245 149, 917		145 11, 095	190.00
192. 01 19201 SOUTH CLINIC		0	147, 717			192.00
192. 02 19202 WEST CLINIC	0	0	Ö	Ō		192. 02
192. 03 19203 DI ABETES CENTER	0	4, 872	760	5, 632		192. 03
193. 00 19300 NONPALD WORKERS 193. 01 19301 ADULT/CHILD CARE	0	0	0	0		193. 00 193. 01
193. 02 19302 PHYSICIAN OFFICE BUILDING	0	0		0		193. 01
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	Ö	Ō		193. 03
194. 00 07950 PARTNERSHI P HFC	0	0	0	0		194.00
194. 01 07951 TRAFALGAR CLI NI C 194. 02 07952 EDI NBURGH	0	0	0	0		194. 01 194. 02
194. 03 07953 JAI L		0	0	0		194. 02
194. 04 07954 ATHLETI C TRAINERS		0	0	o		194. 04
200.00 Cross Foot Adjustments		=	_	0	=	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0	0 2, 976, 808	0 4, 173, 319	0 7, 150, 127		201. 00 202. 00
	١	2, 7, 0, 000	., ., ., ., ., .	,, 100, 127	55, 526	

Provider CCN: 15-0001

						5/24/2023 9: 3	9 am
	Cost Center Description	COMMUNI CATI ON	DATA	MATERI ALS	ADMI TTI NG	PATI ENT	
		S 4. 01	PROCESSI NG	MANAGEMENT	4. 04	ACCOUNTI NG 4. 05	
CEN	NERAL SERVICE COST CENTERS	4.01	4. 02	4. 03	4. 04	4. 05	
	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	401 COMMUNI CATI ONS	4, 849					4. 01
	402 DATA PROCESSING	482	2, 033, 447				4. 02
	403 MATERIALS MANAGEMENT	104	22, 896				4. 03
	404 ADMI TTI NG	121	77, 353		105, 484		4. 04
	405 PATIENT ACCOUNTING	314	136, 141	33	0	234, 151	4. 05
	500 ADMI NI STRATI VE & GENERAL	275	151, 611	350	ol	0	5.00
	700 OPERATION OF PLANT	175	26, 609		ol	0	7. 00
	800 LAUNDRY & LINEN SERVICE	18	19, 802	- 1	ol	0	8.00
	900 HOUSEKEEPI NG	50	0	45	ol	0	9. 00
	000 DI ETARY	93	17, 327	1, 260	ol	0	10.00
	100 CAFETERI A	o	0	0	ol	0	11.00
	300 NURSING ADMINISTRATION	164	47, 649	478	ol	0	13.00
	400 CENTRAL SERVICES & SUPPLY	o	0	262	ol	0	14.00
	500 PHARMACY	82	57, 550		o	0	15.00
	600 MEDICAL RECORDS & LIBRARY	132	50, 125		ol	0	16.00
I NF	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS	440	118, 195	1, 447	4, 853	10, 784	30.00
31.00 03	100 INTENSIVE CARE UNIT	100	58, 169	452	1, 213	2, 695	31.00
41. 00 04	100 SUBPROVI DER - I RF	o	0	0	o	0	41.00
43.00 043	300 NURSERY	0	0	0	190	423	43.00
ANG	CILLARY SERVICE COST CENTERS						
50.00 050	OOO OPERATING ROOM	314	200, 498	1, 860	14, 759	32, 798	50.00
53.00 053	300 ANESTHESI OLOGY	0	0	2	2, 256	5, 013	53.00
	400 RADI OLOGY-DI AGNOSTI C	186	69, 308	871	23, 422	51, 790	54.00
	000 LABORATORY	243	84, 160	10, 648	16, 098	35, 774	60.00
65. 00 065	500 RESPI RATORY THERAPY	64	45, 793	814	2, 449	5, 441	65.00
	600 PHYSI CAL THERAPY	89	25, 990		1, 336	2, 970	66.00
	700 OCCUPATI ONAL THERAPY	21	6, 807	0	388	862	67.00
	800 SPEECH PATHOLOGY	21	4, 951	5	168	373	68. 00
	900 ELECTROCARDI OLOGY	154	21, 040	52	1, 678	3, 730	69. 00
	000 ELECTROENCEPHALOGRAPHY	7	0	1	46	103	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	18, 385	3, 930	8, 734	71.00
	200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	3, 063	6, 806	72.00
	300 DRUGS CHARGED TO PATIENTS	0	0	0	10, 883	24, 185	73.00
	020 ONCOLOGY	132	66, 833		526	1, 168	76. 00
	697 CARDI AC REHABI LI TATI ON	0	0	53	237	526	76. 97
	700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	TPATIENT SERVICE COST CENTERS			T			
	000 CLINIC	75	97, 774		4, 296	9, 548	90.00
	100 EMERGENCY	211	103, 962	1, 720	13, 563	30, 139	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	HER REIMBURSABLE COST CENTERS	1 00	04 (50	1 0/1	400		
	100 HOME HEALTH AGENCY	82	21, 659		130		101.00
	200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	ECIAL PURPOSE COST CENTERS						112 00
	300 I NTEREST EXPENSE	4 140	1 522 202	70.070	105 404	224 151	113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 149	1, 532, 202	72, 263	105, 484	234, 151	J118.00
	NREI MBURSABLE COST CENTERS		21 (50	(2)	ما	0	100 00
	OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	54	21, 659		0		190.00
	200 PHYSI CLANS' PRI VATE OFFI CES	588	463, 496		0		192.00
	201 SOUTH CLINIC	0	0	0	U		192.01
	202 WEST CLINIC	0	4 051	0	U		192. 02 192. 03
	203 DI ABETES CENTER	11	4, 951	2	U		
	300 NONPALD WORKERS	0	0	0	U O		193. 00 193. 01
	301 ADULT/CHILD CARE 302 PHYSICIAN OFFICE BUILDING	18	0	0	O O		193.01
	303 OPTI FAST/FOUNDATI ON		0	0	0		193. 02
	950 PARTNERSHIP HFC	29	11, 139	0	ol y		193.03
	950 PARTNERSHIP HFC 951 TRAFALGAR CLINIC	29	11, 139		ol y		194.00
	952 EDI NBURGH		0		٥		194.01
194. 03 079			0		٥		194. 02
	953 JATE 954 ATHLETIC TRAINERS		0		٥		194. 03
200.00	Cross Foot Adjustments		U		٩	U	200.00
201.00	Negative Cost Centers		Λ		n	n	201.00
201.00	TOTAL (sum lines 118 through 201)	4, 849	2, 033, 447	78, 960	105, 484	234, 151	
202.00	1.1 (3 1.1.33 110 till 34gil 201)	1, 547	2, 300, 141	, 5, ,00	100, 104	201, 101	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0001

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/24/2023 9:39 am Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL PLANT LINEN SERVICE 9. 00 5.00 10.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00401 COMMUNICATIONS 4.01 4.01 4.02 00402 DATA PROCESSING 4.02 4.03 00403 MATERIALS MANAGEMENT 4.03 4 04 00404 ADMITTING 4 04 00405 PATIENT ACCOUNTING 4.05 4.05 00500 ADMINISTRATIVE & GENERAL 309, 910 5.00 5.00 7.00 00700 OPERATION OF PLANT 16, 565 515, 926 7.00 00800 LAUNDRY & LINEN SERVICE 6, 889 1 004 63.885 8 00 8 00 9.00 00900 HOUSEKEEPI NG 3, 190 5, 350 10,627 48, 708 9.00 11, 225 1, 086 10.00 01000 DI ETARY 2,033 1,053 110, 794 10.00 01100 CAFETERI A 11.00 1.776 11, 953 1.156 C 0 11.00 01300 NURSING ADMINISTRATION 0 13.00 5.680 28.277 2, 734 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 553 4, 869 0 471 0 14.00 01500 PHARMACY 15 00 7,434 5,863 0 567 0 15.00 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 3, 747 <u>11,</u> 116 16.00 16.00 0 1,075 0 30.00 03000 ADULTS & PEDIATRICS 26, 082 79, 030 19, 146 99, 727 7,642 30.00 03100 INTENSIVE CARE UNIT 31.00 10,003 22,600 4, 916 2, 185 11, 067 31.00 04100 SUBPROVI DER - I RF 41.00 0 0 41.00 43.00 04300 NURSERY 1,042 1.791 0 173 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 17.823 50.00 131, 140 8,555 12,684 0 53.00 05300 ANESTHESI OLOGY 4, 525 1, 129 109 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 17, 127 47, 377 3, 440 4, 581 0 54.00 54.00 60.00 06000 LABORATORY 23, 449 23, 067 2, 231 0 60.00 0 06500 RESPIRATORY THERAPY 8, 339 1, 072 65.00 0 104 0 65.00 66.00 06600 PHYSI CAL THERAPY 4, 264 18, 163 847 1,756 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 1, 318 3,826 0 370 0 67.00 68.00 06800 SPEECH PATHOLOGY 238 23 0 68.00 658 0 06900 ELECTROCARDI OLOGY 3, 095 299 69 00 69 00 2, 753 319 0 70.00 07000 ELECTROENCEPHALOGRAPHY 84 522 0 50 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 7,766 C 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 11, 300 0 0 72.00 C 0 07300 DRUGS CHARGED TO PATIENTS 73.00 25, 731 0 0 0 73.00 76.00 03020 ONCOLOGY 3, 292 20,058 0 1,940 0 76.00 07697 CARDIAC REHABILITATION 7, 196 76.97 909 0 696 0 76.97 77 00 07700 ALLOGENEIC STEM CELL ACQUISITION O Ω 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 9, 165 33, 002 214 3, 191 0 90.00 91.00 09100 EMERGENCY 17, 583 14, 140 0 91.00 28, 469 2,753 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92 00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 2, 943 3, 740 0 362 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 238, 138 511,057 63, 257 48, 238 110, 794 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1,062 3, 717 0 359 0 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 628 0 192.00 67, 519 192. 01 19201 SOUTH CLINIC ol 0 192. 01 C 0 0 192.02 19202 WEST CLINIC 0 192.02 0 C 0 0 192. 03 19203 DI ABETES CENTER 371 0 111 0 192.03 1, 152 193. 00 19300 NONPALD WORKERS 0 193.00 0 C 0 0 193. 01 19301 ADULT/CHI LD CARE 0 193. 01 0 0 C 193. 02 19302 PHYSICIAN OFFICE BUILDING 2.706 C 0 0 0 193 02 193. 03 19303 OPTI FAST/FOUNDATI ON 0 0 0 193.03 0 0 0 194. 00 07950 PARTNERSHIP HFC 110 0 0 0 194.00 194. 01 07951 TRAFALGAR CLINIC 0 0 194. 01 0 0 194. 02 07952 EDI NBURGH 0 0 194.02 0 C 194. 03 07953 JAI L 0 0 0 0 194.03 194. 04 07954 ATHLETIC TRAINERS 0 C 0 0 0 194.04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 TOTAL (sum lines 118 through 201) 309, 910 110, 794 202. 00 202.00 515, 926 63, 885 48.708

Provider CCN: 15-0001

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/24/2023 9: 39 am

Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/24/2023 9: 3 MEDI CAL	9 am
		ADMI NI STRATI O N	SERVICES & SUPPLY		RECORDS & LI BRARY	
CENEDAL CEDALCE COCT CENTEDO	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FLXT						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 PROCESSING						4. 02
4. 03 00403 MATERI ALS MANAGEMENT						4. 03
4. 04 00404 ADMITTING						4. 04
4.05 00405 PATI ENT ACCOUNTI NG 5.00 00500 ADMI NI STRATI VE & GENERAL						4. 05 5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	65, 710					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 969	253, 189	70 400			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	436	0	73, 428 0	120 752		14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	2, 240 2, 848	0	0	138, 752 0	127, 861	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	2,040	<u> </u>	0	<u> </u>	127,001	10.00
30. 00 03000 ADULTS & PEDIATRICS	10, 484	110, 210	0	0	5, 880	30.00
31.00 03100 INTENSIVE CARE UNIT	3, 344	29, 882	0	0	1, 470	31.00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00 04300 NURSERY	1, 848	0	0	0	231	43.00
ANCILLARY SERVICE COST CENTERS	4 204	E7 040	0	٥	17 005	FO 00
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	6, 384 0	57, 040 0	0	0	17, 885 2, 734	50. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 043	Ö	0	0	28, 417	54. 00
60. 00 06000 LABORATORY	7, 568	O	0	o	19, 508	60.00
65. 00 06500 RESPIRATORY THERAPY	3, 157	0	0	0	2, 967	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 322	0	0	0	1, 619	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	659	0	0	0	470	67.00
68. 00 06800 SPEECH PATHOLOGY	348	0	0	0	204	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 239 46	0	0	0	2, 034 56	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	73, 428	0	4, 763	70.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	Ö	70, 120	0	3, 712	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	О	0	138, 752	13, 188	73.00
76. 00 03020 ONCOLOGY	1, 546	0	0	0	637	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	430	0	0	0	287	76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
90. 00 O9000 CLINIC	3, 840	ol	0	ol	5, 206	90. 00
91. 00 09100 EMERGENCY	6, 274	56, 057	0	ol	16, 435	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-,		-		,	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1, 430			0		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE				1		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	64, 455	253, 189	73, 428	138, 752	127, 861	
NONREI MBURSABLE COST CENTERS	01, 100	200, 107	70, 120	100, 702	127,001	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 255	0	0	0	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	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	0	0	O O		192. 03 193. 00
193. 01 19300 NONPATO WORKERS 193. 01 19301 ADULT/CHILD CARE	0	0	0	0		193. 00
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG	0	l o	Ö	Ö		193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON	0	o	0	0		193. 03
194. 00 07950 PARTNERSHI P HFC	0	0	0	0		194. 00
194. 01 07951 TRAFALGAR CLINIC	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 TRAINERS	0		0	0		194. 03 194. 04
200.00 Cross Foot Adjustments	U	ا	U	٩		200. 00
201.00 Negative Cost Centers	0	o	0	0		200.00
202.00 TOTAL (sum lines 118 through 201)	65, 710	253, 189	73, 428	138, 752	127, 861	
· · · · · · · · · · · · · · · · · · ·		·	,	,		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0001

			'	o 12/31/2022 Date/lime P 5/24/2023 9	
Cost Center Description	Subtotal	Intern &	Total		
		Residents			
		Cost & Post Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
GENERAL SERVICE COST CENTERS	1			T	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 2.00 O0200 CAP REL COSTS-MVBLE EQUIP					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01 00401 COMMUNI CATI ONS					4. 01
4. 02 00402 DATA PROCESSING					4. 02
4. 03 00403 MATERIALS MANAGEMENT					4. 03
4. 04 00404 ADMI TTI NG					4. 04
4. 05 OO405 PATIENT ACCOUNTING					4. 05
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 0PERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE					7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13.00 01300 NURSING ADMINISTRATION					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16. 00
30.00 O3000 ADULTS & PEDIATRICS	1, 042, 790	ol	1, 042, 790		30.00
31. 00 03100 NTENSI VE CARE UNI T	294, 351	ő	294, 351		31.00
41. 00 04100 SUBPROVI DER - RF	0	Ō	C C		41.00
43. 00 04300 NURSERY	13, 455	0	13, 455		43.00
ANCILLARY SERVICE COST CENTERS		_1		1	
50. 00 05000 OPERATING ROOM	1, 681, 843	0	1, 681, 843		50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	41, 177 935, 396	0	41, 177 935, 396		53. 00 54. 00
60. 00 06000 LABORATORY	519, 466	0	519, 466		60.00
65. 00 06500 RESPIRATORY THERAPY	97, 677	ő	97, 677		65. 00
66. 00 06600 PHYSI CAL THERAPY	151, 093	O	151, 093		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	34, 477	0	34, 477	'	67. 00
68.00 06800 SPEECH PATHOLOGY	8, 638	0	8, 638		68. 00
69. 00 06900 ELECTROCARDI OLOGY	97, 301	0	97, 301		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	5, 722	0	5, 722		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	136, 641 24, 881	0	136, 641 24, 881		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	212, 739	o	212, 739		73.00
76. 00 03020 0NC0L0GY	184, 951	o	184, 951		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	55, 350	0	55, 350		76. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C)	77. 00
OUTPATIENT SERVICE COST CENTERS	220 711	ما	220 711	I	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	330, 711 457, 818	0	330, 711 457, 818		90. 00 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	437,010	0	437,010	<u>'</u>	92.00
OTHER REIMBURSABLE COST CENTERS		-,			
101.00 10100 HOME HEALTH AGENCY	47, 200	0	47, 200		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	C)	102.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE				1	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 373, 677	o	6, 373, 677	,	118.00
NONREI MBURSABLE COST CENTERS	0,0,0,0,1	<u>~</u>	0,0.0,0	1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	50, 275	0	50, 275		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	699, 876	0	699, 876		192.00
192. 01 19201 SOUTH CLINIC	0	0	C		192.01
192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER	12 202	0	12, 293		192. 02 192. 03
193. 00 19300 NONPALD WORKERS	12, 293	0	12, 293		192.03
193. 01 19301 ADULT/CHI LD CARE	22	0	22		193.00
193. 02 19302 PHYSI CI AN OFFI CE BUILDING	2, 706	o	2, 706		193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON	O	0	C		193. 03
194. 00 07950 PARTNERSHI P HFC	11, 278	0	11, 278	3	194. 00
194. 01 07951 TRAFALGAR CLINIC	0	0	C	2	194. 01
194. 02 07952 EDI NBURGH	0	0	C		194.02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C TRAI NERS		0			194. 03 194. 04
200.00 Cross Foot Adjustments		ol Ol	,		200.00
201.00 Negative Cost Centers	l ő	ől	C		201.00
202.00 TOTAL (sum lines 118 through 201)	7, 150, 127	o	7, 150, 127	'	202.00

	Financial Systems NLLOCATION - STATISTICAL BASIS	JOHNSON MEMORIA	Provider CO		<u>In Lie</u> Period: From 01/01/2022	u of Form CMS-2 Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/24/2023 9:3	pared: 9 am
		CAPITAL RELA	TED COSTS			7 07 2 17 2020 71 0	
	Cost Center Description	NEW BLDG &	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ON	DATA	
		FIXT (SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT	S (# NON PT	PROCESSING (WORK	
		(040/2 121/)	,,,,,,,	(GROSS	PHONES)	ORDERS)	
		1. 00	2. 00	SALARI ES) 4. 00	4. 01	4. 02	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FLXT	245, 645					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	245, 045	2, 575, 451				2.00
4. 00 4. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATIONS	2, 984 393	1, 147 0	48, 231, 24 109, 59			4. 00 4. 01
4. 02	00402 DATA PROCESSING	6, 260	1, 207, 398	773, 33	4 135	3, 286	4. 02
4. 03 4. 04	00403 MATERI ALS MANAGEMENT 00404 ADMITTI NG	3, 826 2, 239	5, 720 0	414, 05 984, 76		37 125	4. 03 4. 04
4. 05	00405 PATIENT ACCOUNTING	6, 650	10, 096	908, 43	4 88	220	ł
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	9, 526 33, 737	25, 341 38, 869	1, 487, 32 954, 57		245 43	5. 00 7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	2, 404 1, 867	4, 280 3, 851	115, 33: 737, 71		32 0	1
10. 00	01000 DI ETARY	3, 917	17, 925	257, 93	3 26	28	ł
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	4, 171 9, 867	0 28, 254	353, 58 1, 120, 70		0 77	•
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 699	28, 498	87, 27	6 0	0	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 046 3, 879	4, 817 6, 960	993, 80 652, 70		93 81	15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	27, 577 7, 886	129, 458 30, 741	6, 226, 14 1, 112, 75		191 94	30. 00 31. 00
41. 00 43. 00	O4100 SUBPROVI DER - RF O4300 NURSERY	0 625	0	232, 23	0 0	0	
	ANCILLARY SERVICE COST CENTERS						
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	45, 761 394	384, 940 12, 257	2, 272, 52 980, 32		324 0	50.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 532	296, 632	2, 316, 40	52	112	54.00
60. 00 65. 00	06000 LABORATORY 06500 RESPIRATORY THERAPY	8, 049 374	121, 958 13, 372	1, 974, 18: 1, 620, 06		136 74	1
66. 00 67. 00	06600 PHYSI CAL THERAPY	6, 338	8, 722	901, 96		42	•
68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	1, 335 83	2, 061 323	301, 51 152, 60		11 8	67. 00 68. 00
69. 00 70. 00	O6900 ELECTROCARDI OLOGY O7000 ELECTROENCEPHALOGRAPHY	1, 080 182	29, 313 1, 597	407, 38 16, 38		34 0	69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 117		o o	0	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	72.00 73.00
76.00	03020 ONCOLOGY	6, 999	1, 868	551, 55	9 37	108	76.00
76. 97 77. 00	O7697 CARDIAC REHABILITATION O7700 ALLOGENEIC STEM CELL ACQUISITION	2, 511	8, 920 0	169, 01	4 O	0	•
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	11, 516	14, 265	813, 03	7 21	158	90.00
91. 00	09100 EMERGENCY	9, 934	26, 855	3, 314, 52			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	10100 HOME HEALTH AGENCY	1, 305	56	591, 20			101.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	102.00
	11300 INTEREST EXPENSE	242.044	2 470 411	22 004 05	1 1/2	2 474	113.00
118. 00	NONREIMBURSABLE COST CENTERS	243, 946	2, 478, 611	33, 904, 95	5 1, 162	2, 476	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 297 0	3, 854 92, 517	184, 43 14, 061, 81			190. 00 192. 00
192. 01	19201 SOUTH CLINIC	O	0	14, 001, 01	0 0	0	192. 01
	2 19202 WEST CLINIC 3 19203 DIABETES CENTER	0 402	0 469	80, 04	0 0 3		192. 02 192. 03
193.00	19300 NONPALD WORKERS	O	0		0 0	0	193. 00
	19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING	0	0		0 0 0		193. 01 193. 02
193. 03	19303 OPTI FAST/FOUNDATI ON	0	0	(0	193. 03
	07950 PARTNERSHI PHFC 07951 TRAFALGAR CLI NI C		0		0 0 0		194. 00 194. 01
194. 02	07952 EDI NBURGH 07953 JAI L	0	0				194. 02 194. 03
194. 04	07954 ATHLETIC TRAINERS		0			0	194. 04
200. 00 201. 00	1 1						200. 00 201. 00
201.00	1.10941.10 00011010	1	'		'		,_000

Health Fin	ancial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	CATION - STATISTICAL BASIS	Provi der CCN: 15-0001			Period: From 01/01/2022	Worksheet B-1	
					Γο 12/31/2022		
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG &	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ON	DATA	
		FIXT	(DOLLAR	BENEFITS	S (" NON DT	PROCESSI NG	
		(SQUARE FEET)	VALUE)	DEPARTMENT (GROSS	(# NON PT PHONES)	(WORK ORDERS)	
				SALARI ES)	T HONES)	ONDENS)	
		1. 00	2. 00	4. 00	4. 01	4. 02	
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 976, 808	4, 173, 319	11, 091, 02	380, 563	6, 029, 631	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	12. 118333	1. 620423	0. 22995!	280. 444363	1, 834. 945526	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			38, 020	4, 849	2, 033, 447	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 00078	3. 573324	618. 821363	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 MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/24/2023 9: 39 am Provider CCN: 15-0001

						5/24/2023 9: 3	
	Cost Center Description	MATERI ALS	ADMITTING	PATI ENT	Reconciliatio		
		MANAGEMENT	(GROSS	ACCOUNTI NG	n	E & GENERAL	
		(SUPPLY	CHARGES)	(GROSS		(ACCUM.	
		USAGE) 4. 03	4. 04	CHARGES) 4. 05	5A	COST) 5. 00	
	GENERAL SERVICE COST CENTERS	4.03	4. 04	4.05	JA	5.00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						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 PROCESSING						4. 02
4. 03	00403 MATERI ALS MANAGEMENT	18, 259, 077					4. 03
4. 04	00404 ADMI TTI NG	23, 396	366, 025, 037				4. 04
4. 05	00405 PATIENT ACCOUNTING	7, 693	0	366, 025, 037			4.05
5. 00	00500 ADMINISTRATIVE & GENERAL	80, 851	o	0		100, 295, 441	5.00
7.00	00700 OPERATION OF PLANT	1, 254	o	0	0	5, 360, 951	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 173	o	0	0	325, 072	8.00
9.00	00900 HOUSEKEEPI NG	10, 440	0	0	0	1, 032, 480	9.00
10.00	01000 DI ETARY	291, 447	0	0	0	657, 950	10.00
11.00	01100 CAFETERI A	0	0	0	0	574, 598	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	110, 473	0	0	0	1, 838, 327	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	60, 522	0	0	0	178, 921	14.00
15.00	01500 PHARMACY	7, 313, 665	0	0	0	2, 405, 831	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 421	0	0	0	1, 212, 499	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				I		
30. 00	03000 ADULTS & PEDI ATRI CS	334, 615	16, 849, 537	16, 849, 537	0	.,	30.00
31.00	03100 I NTENSI VE CARE UNI T	104, 475	4, 211, 590	4, 211, 590			31.00
41. 00	04100 SUBPROVI DER – I RF	0	0	0	_		41.00
43.00	04300 NURSERY	0	661, 446	661, 446	0	337, 128	43.00
FO 00	ANCILLARY SERVICE COST CENTERS	400.040	E4 04/ 0E4	E4 04/ 0E4		F 7/7 070	F0 00
50.00	05000 OPERATING ROOM	430, 262	51, 246, 954	51, 246, 954		-, ,	50.00
53.00	05300 ANESTHESI OLOGY	560	7, 832, 927	7, 832, 927		1, 464, 252	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	201, 533	81, 082, 739	81, 082, 739		5, 542, 826	54.00
60.00	06000 LABORATORY	2, 462, 605	55, 897, 253	55, 897, 253		7, 588, 710	
65.00	06500 RESPI RATORY THERAPY	188, 239	8, 501, 791	8, 501, 791	0	2, 698, 830	65.00
66.00	06600 PHYSI CAL THERAPY	20, 036	4, 640, 126	4, 640, 126 1, 247, 109		1, 380, 092	66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	1, 092	1, 347, 108 583, 289	1, 347, 108 583, 289		426, 560 213, 105	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1	5, 827, 662	5, 827, 662		890, 873	
70.00	07000 ELECTROCARDI OLOGY	12, 090 318	160, 289			27, 201	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 251, 855	13, 647, 246	160, 289 13, 647, 246		2, 513, 412	70.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	4, 231, 833	10, 635, 036	10, 635, 036		3, 656, 882	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	37, 789, 342	37, 789, 342		8, 327, 083	
76. 00	03020 ONCOLOGY	125, 199	1, 825, 622			1, 065, 421	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	12, 256	822, 245	822, 245		294, 043	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	022, 243	022, 243			77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	0	J. Company		77.00
90.00	09000 CLINIC	251, 805	14, 918, 205	14, 918, 205	0	2, 966, 033	90.00
91. 00	09100 EMERGENCY	397, 758	47, 092, 950	47, 092, 950			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,,	,,		, , , , , , , , ,	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	8, 237	451, 680	451, 680	0	952, 360	101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	o	0			102.00
	SPECIAL PURPOSE COST CENTERS						1
113.00	11300 NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	16, 710, 270	366, 025, 037	366, 025, 037	-4, 719, 342	77, 067, 820	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14, 418	0	0	0	343, 836	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	1, 533, 927	0	0	0	21, 850, 823	192. 00
	19201 SOUTH CLINIC	0	0	0	0		192. 01
	19202 WEST CLINIC	0	0	0	0		192. 02
	19203 DI ABETES CENTER	453	0	0	0	120, 197	
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	19301 ADULT/CHILD CARE	0	0	0	0		193. 01
	19302 PHYSICIAN OFFICE BUILDING	9	0	0	0	875, 607	
	19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193. 03
	07950 PARTNERSHI P HFC	0	0	0	_	35, 756	
	07951 TRAFALGAR CLINIC	0	0	0	_		194. 01
	07952 EDI NBURGH	0	0	0	0		194. 02
	07953 JAIL	0	O	0	0		194.03
	07954 ATHLETIC TRAINERS		o	0	0	0	194.04
200. 00 201. 00	1 1						200. 00 201. 00
201.00	1 1 0	685, 255	1, 497, 796	2, 352, 532		4, 719, 342	
∠U∠. UU	Part I)	000, 200	1, 477, 796	∠, აט∠, 53∠		4, / 19, 342	202.00
203.00	1 1 '	0. 037530	0. 004092	0. 006427		0. 047054	203.00
_55.50	, , , , , , , , , , , , , , , , , , ,	3. 557 550	3. 33 1072	3. 300 127	ı	3.317004	,

Health Fin	ancial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	MATERI ALS	ADMITTI NG	PATI ENT	Reconciliatio	-	
		MANAGEMENT	(GROSS	ACCOUNTI NG	n	E & GENERAL	
		(SUPPLY	CHARGES)	(GROSS		(ACCUM.	
		USAGE)		CHARGES)		COST)	
		4. 03	4. 04	4. 05	5A	5. 00	
204.00	Cost to be allocated (per Wkst. B,	78, 960	105, 484	234, 15	1	309, 910	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 004324	0. 000288	0.00064)	0. 003090	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
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	ATLON STATISTICAL BASIS	JUHNSUN MEMUR		CN 15 0001 5		U OF FORM CMS	
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet B-1 Date/Time Pre 5/24/2023 9:3	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS PAI D)	
		7. 00	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
	RAL SERVICE COST CENTERS						
2. 00 0020 4. 00 0040 4. 01 0040 4. 02 0040 4. 03 0040 4. 05 0040 5. 00 0050 7. 00 0070 8. 00 0090 10. 00 0110 11. 00 0110 13. 00 0130 14. 00 0140 15. 00 0160 16. 00 0160	NEW CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP DE EMPLOYEE BENEFITS DEPARTMENT COMMUNICATIONS DATA PROCESSING MATERIALS MANAGEMENT ADMITTING PATIENT ACCOUNTING OPERATION OF PLANT LAUNDRY & LINEN SERVICE OHOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY OPHARMACY OMEDICAL RECORDS & LIBRARY TIENT ROUTINE SERVICE COST CENTERS	180, 030 2, 404 1, 867 3, 917 4, 171 9, 867 1, 699 2, 046 3, 879	448, 409 74, 592 7, 389 0 0 0	175, 759 3, 917 4, 171 9, 867 1, 699 2, 046	21, 024 0 0 0 0	670, 309 20, 089 4, 449 22, 849 29, 048	13.00 14.00 15.00
	O ADULTS & PEDIATRICS	27, 577	134, 391	27, 577		106, 966	1
	00 INTENSIVE CARE UNIT 00 SUBPROVIDER - IRF	7, 886	34, 508 0	7, 886 C		34, 115 0	1
	NURSERY	625	0	625	0	18, 854	43.00
	LLARY SERVICE COST CENTERS OO OPERATING ROOM	45, 761	60, 045	45, 761	O	65, 119	50.00
	O ANESTHESI OLOGY	394		394		03, 117	1
	O RADI OLOGY-DI AGNOSTI C	16, 532			l .	61, 641	1
4	10 LABORATORY 10 RESPI RATORY THERAPY	8, 049 374		8, 049 374	0	77, 201 32, 206	1
	00 PHYSI CAL THERAPY	6, 338		6, 338		23, 683	1
1	OO OCCUPATI ONAL THERAPY	1, 335			l	6, 727	1
4	OO SPEECH PATHOLOGY	83		83		3, 546	
	00 ELECTROCARDI OLOGY 00 ELECTROENCEPHALOGRAPHY	1, 080 182	2, 242	1, 080 182	l .	12, 635 471	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		102		0	
72. 00 0720	OO IMPL. DEV. CHARGED TO PATIENT	0	0	C		0	72.00
	DO DRUGS CHARGED TO PATIENTS	0	0	C		0	
	20 ONCOLOGY 27 CARDI AC REHABI LI TATI ON	6, 999 2, 511	0	-,	l .	15, 767 4, 388	
	OO ALLOGENEIC STEM CELL ACQUISITION	2,311	1		l .	4, 300	1
OUTP	ATIENT SERVICE COST CENTERS		-				
90.00 0900		11, 516				39, 171	
	DO EMERGENCY DO OBSERVATION BEDS (NON-DISTINCT PART)	9, 934	99, 247	9, 934	0	63, 997	91.00
OTHE	R REIMBURSABLE COST CENTERS	I.		I.			72.00
	OO HOME HEALTH AGENCY	1, 305				14, 583	1
	OOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	0	0	C	0	0	102.00
	INTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	178, 331	444, 002	174, 060	21, 024	657, 505	
	PEIMBURSABLE COST CENTERS OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 207		1 207		12.004	100.00
	O PHYSICIANS' PRIVATE OFFICES	1, 297	4, 407	1, 297 C	0	12, 804 0	190.00
	SOUTH CLINIC	0	0	C			192. 01
	2 WEST CLINIC	0		C			192. 02
	03 DIABETES CENTER 00 NONPAID WORKERS	402		402	l .		192. 03 193. 00
	11 ADULT/CHILD CARE		1				193.00
	PHYSICIAN OFFICE BUILDING	0	0	C			193. 02
	03 OPTI FAST/FOUNDATI ON	0	0	C			193. 03
	O PARTNERSHIP HFC 1 TRAFALGAR CLINIC	0	0	C			194. 00 194. 01
	2 EDI NBURGH	0	Ö	1			194. 02
194. 03 0795		0	0	C			194. 03
	GENERAL AND LESS COST AND LESS	0	0	C	0	0	194. 04
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	5, 613, 205	415, 323	1, 208, 362	844, 812	760, 360	
202 25	Part I)	04 4700=:	0.00403=	, 6754	40 400045	4 4040:-	202 25
203. 00	Unit cost multiplier (Wkst. B, Part I)	31. 179276	0. 926215	6. 875107	40. 183219	1. 134343	J203. 00

Health Finar	ncial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co	CN: 15-0001	Period: From 01/01/2022	Worksheet B-1	
					To 12/31/2022	Date/Time Pre 5/24/2023 9:3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI N		CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET) (MEALS	(HOURS	
		(SQUARE FEET)	(POUNDS OF		SERVED)	PAI D)	
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
204.00	Cost to be allocated (per Wkst. B,	515, 926	63, 885	48, 70	08 110, 794	65, 710	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	2. 865778	0. 142470	0. 2771:	5. 269882	0. 098029	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						
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Cost Center Description		inancial Systems	JOHNSON MEMORI				u of Form CMS-2552-10
Cost Center Description	COST ALL	OCATION - STATISTICAL BASIS		Provider Co		rom 01/01/2022	Worksheet B-1
CONTROL NUMBER CONTROL NUMBER CONTROL NUMBER CONTROL					To	12/31/2022	Date/Time Prepared: 5/24/2023 9:39 am
PRINCE No. CONTROL		Cost Center Description					072172020 7: 07 dill
SERIOR SERVICE DOST CRITERS 13.00 14.00 15.00 16.00					REQUIS.)		
FORTING STRIVING COST CRITTERS			NRSI NG HRS)	REQUIS.)		CHARGES)	
1.00 1000G MEN CAP REL COSTS-BLIGG & FINT 2.00 2.0	GE	ENEDAL SEDVICE COST CENTEDS	13. 00	14. 00	15.00	16. 00	
4.00 GORDO DENTAL PRINCESSIN NE 4.00 4							1.00
4. 01 00 0010 COMMUNICATIONS 4. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.							
4. 0.2 0.0042 DATA PROCESSING 4. 0.2 3. 0.0042 DATA PROCESSING 4. 0.0 4. 1.0 0.0042 DATA PROCESSING 4. 0.0 4. 1.0 0.0042 DATA PROCESSING 4. 0.0 4. 1.0 0.0042 DATA PROCESSING 4. 0.0 5. 0.0 0.00500 DATA INSTRATION 5. 0.0 5. 0.0 0.00500 DATA INSTRATION 7. 0.0 7. 0.0 0.00500 DATA INSTRATIO							
4.03 00003 MATERIALS MANAGEMENT 4.04 000043 PATHEM ACQUARTING 4.05 00005 PATHEM ACQUARTING 4.06 000043 PATHEM ACQUARTING 4.06 00005 PATHEM ACQUARTING 4.07 0000000 PATHEM ACQUARTING 4.08 0000000 PATHEM ACQUARTING 4.09 000000 PATHEM ACQUARTING 4.00 00000 PATHEM ACQUARTING 4.00 000000 000000000000000000000000000							
4.05 0.0400 PATIENT ACCOUNTING	1						
0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.00000000							
7.00 00700 DOPATION OF PLANT							
9.00 00000 00000 0015 1748							
10.00 1000 DETARY							
11.00 0100 CAFETER							
13.00 1300 NURSIN X AMM INSTRATION 289,051 14.00 1400 1500 1600							
15.00 01500 PHARBACY 0 0 0 0 0 0 0 15.00			289, 051				
16. 00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 366, 025, 037 10. 00	1	1	1				
INPATI ENT BOUTINE SERVICE COST CENTERS 30.00 0.00 16, 849, 537 30.00 30.00 30.00 0.00 0.00 0.01 16, 849, 537 30.00 31.00 41.00 0.00 0.00 0.00 42.11, 590 31.00 41.00	1		1			366 025 037	
31.00 03100 INTENSIVE CARE UNIT 34, 115 0 0 4, 21, 590 31, 00 040 0300			<u> </u>	0		300, 023, 037	10.00
41.00 04100 SUBPROYI DER - I RF 0 0 0 0 0 0 0 0 0							
1.0 0.4300 NURSERY 0. 0. 0. 0. 6.01, 4.46 4.3, 0.0			1				
ANCILLARY SERVICE COST CENTERS 50. 00 500. 00 500. 00 500. 00 500. 00 500. 00 500. 00 500. 00 500. 00 500. 00 500. 00 500. 00 500. 00 600. 00	1	· ·	1			٦	
53.00 05300 ANESTHESI OLOGY 0 0 0 7, 832, 927 53.00			-	_	-		
54.00 05400 ABOILOGY-DI AGNOSTIC 0 0 0 81.082,739 54.00 05.00 06500 LEDGRADERY 0 0 0 0 0.58,97,253 60.00 065.00 06500 RESPIRATORY THERAPY 0 0 0 0 8,501,791 65.00 067.00 06700 DEVISICAL THERAPY 0 0 0 0 0.44,60,126 66.00 066.00 06600 DEVISICAL THERAPY 0 0 0 0 0.44,601,126 66.00 067.00 06700 DEVISICAL THERAPY 0 0 0 0 0.58,329 68.00 069.00 06900 DELECTROCARDIOLOGY 0 0 0 5,827,662 69.00 070.00 07000 LECTROCARDIOLOGY 0 0 0 0.58,27,662 69.00 071.00 07100 LECTROCARDIOLOGY 0 0 0 0.58,27,662 69.00 071.00 07100 LECTROCARDIOLOGY 0 0 0 0.582,246 77.00 071.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 10 0 13,447,246 77.00 072.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 10 0 13,447,246 77.00 073.00 07300 IMPL DEV. CHARGED TO PATIENTS 0 0 10 0 10,635,036 72.00 073.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 100 37,789,342 73.00 076.00 37300 ORGUGS CHARGED TO PATIENTS 0 0 0 0 1,825,622 76.00 076.90 37300 ORGUGS CHARGED TO PATIENTS 0 0 0 0 822,245 76.97 077.00 07700 ALLOCEMET CSTEM CELL ACQUISITION 0 0 0 0 822,245 76.97 077.00 07700 ALLOCEMET CSTEM CELL ACQUISITION 0 0 0 0 47,092,950 91.00 071.00 07900 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 47,092,950 91.00 071.00 079000 079000 07900 079000 07			1				
60.00 06000 LABORATORY 0 0 0 55,897,253 60.00	1	1	1		-		
66.00 06600 PHYSI CAL THERAPY			o				
67.00 06700 06CURATIONAL THERAPY 0 0 0 0 1.347.108 67.00 68.00 06800 05EPCEH PATHOLOGY 0 0 0 0 583.289 68.00 69.00 06900 05EPCETROCARDIOLOGY 0 0 0 0 583.289 68.00 69.00 06900 05EPCETROCARDIOLOGY 0 0 0 0 0 583.289 70.00 71.00 071			0	0	1		
68. 00 0o8000 SPEECH PATHOLOGY 0 0 0 0 583, 289 68. 00			0	0	1		
69. 00 0.0900 0			0	0	1		
17. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 100 0 13, 647, 246 77. 00 77. 00 77.00	69.00 06	6900 ELECTROCARDI OLOGY	0	0	0		69.00
12.00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 0 10, 635, 036 72.00			1	-			
13. 00 07300 DRIGS CHARGED TO PATLENTS 0 0 0 100 37, 789, 342 73. 00			0				
76. 97 07597 07697 07700			Ö	0			
77.00			0	0	1		
OUTPATI ENT SERVICE COST CENTERS O			1		1		
91.00 09100 BMERGENCY 03.997 0 0 47,092,950 91.00 92.00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 92.00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 92.00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 92.00 092000 092000 092000 09200 092000 092000 09200 092000 09200 09200 09200 09200 09200 09200			<u> </u>	0		0	77.00
92. 00 09200 09SERVATI ON BEDS (NON-DISTINCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 451, 680 101. 00 1020 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 102. 00 102. 00 102. 00 10200 001 0 1 TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 00 102. 00 113.00 INTEREST EXPENSE 113. 00 INTEREST EXPENSE 113. 00 INTEREST EXPENSE 113. 00 INTEREST EXPENSE 113. 00 INTEREST EXPENSE 100 0 0 0 0 0 0 0 100 0 0 0 100 0 100 0 0 100 0 0 100 0 0 100 0 0 100 0 100 0 0 100 0 0 100 0	1	1	0				
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 451,680 102.00 102.00 102.00 102.00 101.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 102.00 103.00 103.00 103.00 103.00 103.00 108.00 109.00 1			63, 997	0	0	47, 092, 950	
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 451, 680 101. 00 102. 00 1020 00 101 TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 00 102. 00 1300 INTEREST EXPENSE							92.00
113.00 11300 INTEREST EXPENSE	101.0010	D100 HOME HEALTH AGENCY	1				
113. 00			0	0	0	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 289,051 100 100 366,025,037 118.00							113.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192.00 192.00 192.00 194.00 192.01 192.01 192.01 192.01 192.01 192.01 192.01 SOUTH CLINIC 0 0 0 0 0 192.00 192.01 192.01 192.01 SOUTH CLINIC 0 0 0 0 0 0 192.01 192.01 192.02 192.02 WEST CLINIC 0 0 0 0 0 0 192.02 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 192.03 NONPAID WORKERS 0 0 0 0 0 0 192.03 193.00 NONPAID WORKERS 0 0 0 0 0 0 193.00 193.00 NONPAID WORKERS 0 0 0 0 0 0 193.00 193.00 193.00 193.02 193.02 193.02 193.02 193.02 193.02 193.02 193.03 193.	118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	289, 051	100	100	366, 025, 037	
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 192.01 19201 SOUTH CLINIC 0 0 0 0 192.01 192.01 192.02 19202 WEST CLINIC 0 0 0 0 0 192.01 192.02 192.03 19203 DI ABETES CENTER 0 0 0 0 0 192.03 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 193.00 NONPAI D WORKERS 0 0 0 0 0 193.00 193.01 19301 ADULT/CHILD CARE 0 0 0 0 0 193.01 193.01 19302 PHYSICIAN OFFICE BUILDING 0 0 0 0 193.02 19302 PHYSICIAN OFFICE BUILDING 0 0 0 0 193.03 19303 OPTIFAST/FOUNDATION 0 0 0 0 193.03 19303 OPTIFAST/FOUNDATION 0 0 0 0 193.03 194.00 07950 PARTNERSHIP HFC 0 0 0 0 0 194.00 194.00 19551 TRAFALGAR CLINIC 0 0 0 0 194.00 194.02 07952 EDI NBURGH 0 0 0 0 0 194.00 194.02 07953 JAIL 0 0 0 0 0 0 194.02 194.03 07953 JAIL 0 0 0 0 0 0 194.03 07954 ATHLETIC TRAINERS 0 0 0 0 0 0 194.03 194.04 07954 ATHLETIC TRAINERS 0 0 0 0 0 0 194.04 07954 OCOSE FOOT Adjustments 0 0 0 0 0 0 194.04 07954 OCOSE FOOT Adjustments 0 0 0 0 0 0 0 0 0 194.04 07954 OCOSE FOOT Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			I 0		I ol		100.00
192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC 0 0 0 0 0 192. 02 192. 03 19203 DI ABETES CENTER 0 0 0 0 0 0 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 ADULT/CHILD CARE 0 0 0 0 0 0 193. 01 193. 02 19302 PHYSICIAN OFFICE BUILDING 0 0 0 0 0 193. 02 193. 03 19303 OPTI FAST/FOUNDATION 0 0 0 0 0 193. 03 194. 00 07950 PARTNERSHIP HFC 0 0 0 0 0 0 194. 01 194. 01 07951 TRAFALGAR CLINIC 194. 02 07952 EDI NBURGH 0 0 0 0 0 0 194. 01 194. 03 07953 JAIL 0 0 0 0 0 0 194. 02 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 0 194. 04 200. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, 2, 323, 099 257, 042 2, 622, 813 1, 450, 115 202. 00	190.00 19	9000 GIFI, FLOWER, COFFEE SHOP & CANTEEN	1 1				
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS 193. 01 19301 ADULT/CHI LD CARE 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C 194. 02 07952 EDI NBURGH 194. 04 07954 ATHLETI C TRAI NERS 200. 00 Negati ve Cost Centers 202. 00 Cost to be all located (per Wkst. B, Part I) 192. 03 1920 0 0 0 0 0 0 0 193. 00 193. 00 194. 00 0 0 0 0 0 0 193. 00 193. 01 194. 02 0 0 0 0 0 0 0 194. 00 194. 03 0 0 0 0 0 0 0 0 0 194. 00 194. 04 0 0 0 0 0 0 0 0 0 0 0 194. 00 194. 05 0 0 0 0 0 0 0 0 194. 00 194. 06 0 0 0 0 0 0 0 0 194. 00 194. 07954 ATHLETI C TRAI NERS 200. 00 200. 00 257, 042 2, 622, 813 1, 450, 115 202. 00			1	_			
193. 00 19300 NONPAI D WORKERS 193. 01 19301 ADULT/CHILD CARE 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC 194. 02 07952 EDI NBURGH 194. 04 07954 ATHLETI C TRAI NERS 200. 00 Negati ve Cost Centers 202. 00 Cost to be all located (per Wkst. B, Part I) 202. 00 Cost to be all located (per Wkst. B, Part I) 202. 00 PARTNERSHI D WORKERS 0 0 0 0 0 0 0 0 193. 00 193. 00 0 0 0 0 0 0 0 0 193. 00 193. 00 0 0 0 0 0 0 0 0 193. 00 194. 00 0 0 0 0 0 0 194. 00 194. 01 07951 TRAFALGAR CLI NI C 0 0 0 0 0 0 0 194. 01 194. 02 07952 Cost to be all located (per Wkst. B, Part I) 195. 00 0 0 0 0 0 0 0 0 194. 01 194. 04 07954 257, 042 2, 622, 813 1, 450, 115 202. 00			0	0	-		
193. 01 19301 19301 ADULT/CHILD CARE 0 0 0 0 0 0 193. 01 193. 02 19302 19302 19302 19303 194. 00 07950 194. 00 07951 194. 01 07951 194. 02 07952 EDI NBURGH 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	-		
193. 02 19302 PHYSI CI AN OFFI CE BUILDING 0 0 0 193. 02 19303 OPTI FAST/FOUNDATI ON 0 0 0 193. 03 194. 00 07950 PARTNERSHI P HFC 0 0 0 0 0 0 194. 00 194. 01 07951 TRAFALGAR CLINIC 0 0 0 0 0 194. 01 194. 01 194. 02 07952 EDI NBURGH 0 0 0 0 0 194. 02 194. 03 07953 JAI L 0 0 0 0 0 194. 03 07953 JAI L 0 0 0 0 0 194. 03 07953 JAI L 0 0 0 0 0 194. 03 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0			
194. 00 07950 PARTNERSHIP HFC 0 0 0 0 0 194. 01 07951 TRAFALGAR CLINIC 0 0 0 0 194. 01 194. 02 07952 EDI NBURGH 0 0 0 0 0 0 194. 02 194. 03 07953 JAI L 0 0 0 0 0 0 194. 03 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 194. 04 07954 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 257, 042 2, 622, 813 1, 450, 115 202. 00			0	0			
194. 01 07951 TRAFALGAR CLINIC 0 0 0 0 194. 01 194. 02 194. 03 07952 EDI NBURGH 0 0 0 0 0 194. 02 194. 03 07953 JAI L 0 0 0 0 0 0 194. 03 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 257, 042 2, 622, 813 1, 450, 115 202. 00			0	0	-	- 1	
194. 02 07952 EDI NBURGH 0 0 0 0 194. 02 194. 03 07953 JAI L 0 0 0 0 0 194. 03 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 0 194. 04 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 257, 042 2, 622, 813 1, 450, 115 202. 00			0	0			
194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 194. 04 200. 00 201. 00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) 257, 042 2, 622, 813 1, 450, 115 202. 00	194. 02 07	7952 EDI NBURGH		0	Ö	- 1	
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 2,323,099 257,042 2,622,813 1,450,115 202.00	1	1	0	0	0	О	
201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 2,323,099 257,042 2,622,813 1,450,115 202.00	1	1	0	0	0	0	
202.00 Cost to be allocated (per Wkst. B, 2,323,099 257,042 2,622,813 1,450,115 202.00	1						
		Cost to be allocated (per Wkst. B,	2, 323, 099	257, 042	2, 622, 813	1, 450, 115	
203. 00	203 00		g 026007	2 570 420000	26 228 120000	0 002042	202.00
	203.00	Tour Cost multiplier (WKSt. D, Pall I)	0. 030967	2, 370. 420000	20, 220. 130000	0.003902	203.00

Heal th F	inancial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALI	LOCATION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
	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		
204.00	Cost to be allocated (per Wkst. B,	253, 189	73, 428	138, 75	2 127, 861		204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 875932	734. 280000	1, 387. 52000	0. 000349		205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						
'	,	. '	'				•

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0001	Period: From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/24/2023 9:3	
		Title	XVIII	Hospi tal	PPS	
				Costs		

						5/24/2023 9: 3	9 am
•			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst.	Áďj.		Di sal I owance		
		B, Part I,	,				
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
LNPA	ATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		•			
30.00 0300	00 ADULTS & PEDIATRICS	11, 971, 663		11, 971, 663	0	11, 971, 663	30.00
	00 INTENSIVE CARE UNIT	4, 135, 595		4, 135, 595		4, 135, 595	
	00 SUBPROVI DER - I RF	0		(0	41.00
43.00 0430		400, 783		400, 783	0	400, 783	
	ILLARY SERVICE COST CENTERS	,			-	1227.22	1
	OO OPERATI NG ROOM	8, 636, 560		8, 636, 560	0	8, 636, 560	50.00
	OO ANESTHESI OLOGY	1, 579, 179		1, 579, 179		1, 579, 179	
	OO RADI OLOGY-DI AGNOSTI C	6, 846, 213		6, 846, 213		6, 846, 213	
	OO LABORATORY	8, 561, 126		8, 561, 126		8, 561, 126	
	00 RESPI RATORY THERAPY	2, 910, 270	0	2, 910, 270		2, 910, 270	
	00 PHYSI CAL THERAPY	1, 736, 972	0	1, 736, 972		1, 736, 972	
	OO OCCUPATI ONAL THERAPY	510, 401	0	510, 401		510, 401	67.00
	OO SPEECH PATHOLOGY	232, 624	0	232, 624		232, 624	
	OO ELECTROCARDI OLOGY	1, 013, 389	Ü	1, 013, 389		1, 013, 389	
	OO ELECTROENCEPHALOGRAPHY	36, 576		36, 576		36, 576	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 942, 790		2, 942, 790		2, 942, 790	
	OO IMPL. DEV. CHARGED TO PATIENT	3, 871, 089		3, 871, 089		3, 871, 089	
	OO DRUGS CHARGED TO PATIENTS	11, 491, 440		11, 491, 440		11, 491, 440	
	20 ONCOLOGY	1, 407, 014		1, 407, 014		1, 417, 311	
	97 CARDI AC REHABI LI TATI ON	411, 668		411, 668	·	411, 668	
	00 ALLOGENEIC STEM CELL ACQUISITION	411,000		411,000		411,000	1
	PATIENT SERVICE COST CENTERS	<u> </u>			, 0	0	77.00
90.00 0900		3, 648, 762		3, 648, 762	2 0	3, 648, 762	90.00
	OO EMERGENCY	7, 201, 628		7, 201, 628		7, 201, 628	
	OO OBSERVATION BEDS (NON-DISTINCT PART)	4, 107, 023		4, 107, 023		4, 107, 023	
	ER REIMBURSABLE COST CENTERS	4, 107, 023		4, 107, 023)	4, 107, 023	72.00
	OO HOME HEALTH AGENCY	1, 065, 165		1, 065, 165		1, 065, 165	101 00
	OO OPIOID TREATMENT PROGRAM	1,005,105		1,005,105			102.00
	CLAL PURPOSE COST CENTERS	<u> </u>			,	0	1102.00
	00 INTEREST EXPENSE						113.00
200. 00	Subtotal (see instructions)	84, 717, 930	0	84, 717, 930	10, 297		
201.00	Less Observation Beds	4, 107, 023	0	4, 107, 023		4, 107, 023	
	Total (see instructions)		^				
202. 00	Tiotal (see Histructions)	80, 610, 907	0	J 80, 610, 907	10, 297	δU, 62 I, 2U4	12U2. UU

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0001	Period: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

					10 12/31/2022	5/24/2023 9: 3	
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. (Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	11, 894, 028		11, 894, 02			30.00
	03100 INTENSIVE CARE UNIT	4, 211, 590		4, 211, 59			31.00
	04100 SUBPROVI DER - I RF	0			0		41.00
	04300 NURSERY	661, 446		661, 44	6		43. 00
	ANCILLARY SERVICE COST CENTERS						
	O5000 OPERATING ROOM	7, 428, 696	43, 818, 258			0. 000000	
	05300 ANESTHESI OLOGY	1, 261, 367	6, 571, 560			0. 000000	
	D5400 RADI OLOGY-DI AGNOSTI C	10, 272, 974	70, 809, 765			0. 000000	
	06000 LABORATORY	12, 012, 761	43, 884, 492			0. 000000	
	06500 RESPI RATORY THERAPY	3, 255, 071	5, 246, 720			0. 000000	
	06600 PHYSI CAL THERAPY	468, 256	4, 171, 870			0. 000000	1
	06700 OCCUPATI ONAL THERAPY	449, 947	897, 161			0. 000000	
	06800 SPEECH PATHOLOGY	190, 917	392, 372			0. 000000	
	06900 ELECTROCARDI OLOGY	1, 367, 364	4, 460, 298			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	46, 125	114, 164			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 296, 038	10, 351, 208			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	2, 295, 800	8, 339, 236			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	7, 873, 346	29, 915, 996			0. 000000	
	03020 ONCOLOGY	4, 344	1, 821, 278			0. 000000	
	07697 CARDI AC REHABI LI TATI ON	0	822, 245	822, 24		0. 000000	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0. 000000	0. 000000	77. 00
	DUTPATIENT SERVICE COST CENTERS			,			
	09000 CLI NI C	30, 000	14, 888, 205			0. 000000	
	09100 EMERGENCY	5, 166, 752	41, 926, 198			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	450, 000	4, 505, 509	4, 955, 50	9 0. 828779	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	451, 680				101.00
	10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
	SPECIAL PURPOSE COST CENTERS	T T		T	<u> </u>		
	11300 INTEREST EXPENSE	70 (0) 000	000 000 015	0// 005 00			113.00
200.00	Subtotal (see instructions)	72, 636, 822	293, 388, 215	366, 025, 03	/		200.00
201.00	Less Observation Beds	70 (0) 000	000 000 015	0// 005 00	_		201.00
202. 00	Total (see instructions)	72, 636, 822	293, 388, 215	366, 025, 03	/		202. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0001	Period: Worksheet C From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/24/2023 9:39 am

				5/24/2023 9:39 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - RF				41.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 168528			50.00
53. 00 05300 ANESTHESI OLOGY	0. 201608			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 084435			54.00
60. 00 06000 LABORATORY	0. 153158			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 342313			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 374337			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 378886			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 398814			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 173893			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 228188			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 215633			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 363994			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 304092			73.00
76. 00 03020 0NC0L0GY	0. 776344			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 500663			76. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS	0.00000			77.00
90. 00 09000 CLINIC	0. 244585			90.00
91. 00 09100 EMERGENCY	0. 152924			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 828779			92.00
OTHER REIMBURSABLE COST CENTERS	0.020777			72.00
101. 00 10100 HOME HEALTH AGENCY				101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				102.00
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201. 00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
202.00 10101 (366 111311 0611 0113)	1 1			_{[2} 02.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-00	Peri od: From 01/01/2022 Part I To 12/31/2022 Pate/Ti me Prepared: 5/24/2023 9:39 am

				-	To 12/31/2022	Date/Time Pre 5/24/2023 9:3	pared: 9 am
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	•	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	•				
		col. 26)					
		1. 00	2.00	3. 00	4.00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	D3000 ADULTS & PEDIATRICS	11, 971, 663		11, 971, 663	3 0	11, 971, 663	30.00
	D3100 INTENSIVE CARE UNIT	4, 135, 595		4, 135, 59	5 0	4, 135, 595	31.00
41.00	04100 SUBPROVI DER - I RF	0		(0	0	41.00
43.00	04300 NURSERY	400, 783		400, 783	3 0	400, 783	43.00
4	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 636, 560		8, 636, 560	0	8, 636, 560	50.00
53.00	D5300 ANESTHESI OLOGY	1, 579, 179		1, 579, 179	9 0	1, 579, 179	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	6, 846, 213		6, 846, 213	3 0	6, 846, 213	54.00
60.00	D6000 LABORATORY	8, 561, 126		8, 561, 126	5 0	8, 561, 126	60.00
65.00	06500 RESPI RATORY THERAPY	2, 910, 270	0	2, 910, 270	0	2, 910, 270	65.00
66.00	06600 PHYSI CAL THERAPY	1, 736, 972	0	1, 736, 972	2 0	1, 736, 972	66.00
67.00	06700 OCCUPATI ONAL THERAPY	510, 401	0	510, 40°	0	510, 401	67.00
68.00	06800 SPEECH PATHOLOGY	232, 624	0	232, 624	1 0	232, 624	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 013, 389		1, 013, 389	9 0	1, 013, 389	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	36, 576		36, 576	5 0	36, 576	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 942, 790		2, 942, 790	0	2, 942, 790	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3, 871, 089		3, 871, 089	9 0	3, 871, 089	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	11, 491, 440		11, 491, 440	0	11, 491, 440	73.00
76.00	D3020 ONCOLOGY	1, 407, 014		1, 407, 014	10, 297	1, 417, 311	76. 00
76. 97	07697 CARDIAC REHABILITATION	411, 668		411, 668	0	411, 668	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		(0	0	77. 00
	DUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	3, 648, 762		3, 648, 762			
91.00	D9100 EMERGENCY	7, 201, 628		7, 201, 628	3 0	7, 201, 628	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 107, 023		4, 107, 023	3	4, 107, 023	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	1, 065, 165		1, 065, 16	5	1, 065, 165	
	10200 OPIOID TREATMENT PROGRAM	0		(0	102. 00
	SPECIAL PURPOSE COST CENTERS						
1	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	84, 717, 930	0				
201. 00	Less Observation Beds	4, 107, 023		4, 107, 023		4, 107, 023	
202. 00	Total (see instructions)	80, 610, 907	0	80, 610, 90	7 10, 297	80, 621, 204	202.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-00	01

				l l	o 12/31/2022	Date/lime Pre 5/24/2023 9:3	
			Ti tl	e XIX	Hospi tal	Cost	, am
			Charges	.=			
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	'	+ col. 7)	Rati o	I npati ent	
				, i		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
•	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	11, 894, 028		11, 894, 028			30.00
31.00	03100 INTENSIVE CARE UNIT	4, 211, 590		4, 211, 590			31.00
	04100 SUBPROVI DER - I RF	0		C			41.00
43.00	04300 NURSERY	661, 446		661, 446			43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	7, 428, 696	43, 818, 258			0.000000	
	05300 ANESTHESI OLOGY	1, 261, 367	6, 571, 560		l I	0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	10, 272, 974	70, 809, 765		l I	0.000000	
60.00	06000 LABORATORY	12, 012, 761	43, 884, 492		l l	0.000000	
65. 00	06500 RESPI RATORY THERAPY	3, 255, 071	5, 246, 720			0.000000	
	06600 PHYSI CAL THERAPY	468, 256	4, 171, 870	4, 640, 126	l I	0.000000	
	06700 OCCUPATI ONAL THERAPY	449, 947	897, 161			0.000000	
68.00	06800 SPEECH PATHOLOGY	190, 917	392, 372	583, 289	0. 398814	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 367, 364	4, 460, 298	5, 827, 662	0. 173893	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	46, 125	114, 164	160, 289	0. 228188	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 296, 038	10, 351, 208	13, 647, 246	0. 215633	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 295, 800	8, 339, 236	10, 635, 036	0. 363994	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 873, 346	29, 915, 996	37, 789, 342	0. 304092	0.000000	73.00
76.00	03020 ONCOLOGY	4, 344	1, 821, 278	1, 825, 622	0. 770704	0.000000	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	822, 245	822, 245	0. 500663	0.000000	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	0. 000000	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	30, 000	14, 888, 205		I I	0.000000	
	09100 EMERGENCY	5, 166, 752	41, 926, 198		· •	0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	450, 000	4, 505, 509	4, 955, 509	0. 828779	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	451, 680		I I		101.00
102. 00	10200 OPIOID TREATMENT PROGRAM	0	0	0			102.00
	SPECIAL PURPOSE COST CENTERS	1		T			
	11300 INTEREST EXPENSE	70 (0)					113.00
200.00		72, 636, 822	293, 388, 215	366, 025, 037			200.00
201.00		70 (0)					201.00
202.00	Total (see instructions)	72, 636, 822	293, 388, 215	366, 025, 037			202. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1!	From 01/01/2022	Worksheet C Part I Date/Time Prepared: 5/24/2023 9:39 am

				5/24/2023 9:39 am
		Title XIX	Hospi tal	Cost
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
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING 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 RESPIRATORY 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 0NC0L0GY	0. 000000			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	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
102.00 10200 OPIOLD TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202. 00
•	·			•

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2022 Fo 12/31/2022	Part I Date/Time Pre	nared·
				10 12/01/2022	5/24/2023 9: 3	
			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			T	. 1		
30. 00 ADULTS & PEDIATRICS	1, 042, 790	0	1 ., 0 , , ,			
31.00 INTENSIVE CARE UNIT	294, 351		294, 35		190. 64	
41. 00 SUBPROVI DER - I RF	0	0	1	0	0. 00	
43. 00 NURSERY	13, 455		13, 45		26. 49	
200.00 Total (lines 30 through 199)	1, 350, 596		1, 350, 590	9, 899		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col . 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		007.075				
30. 00 ADULTS & PEDIATRICS	1, 711					30.00
31. 00 INTENSIVE CARE UNIT	510	97, 226	1			31.00
41. 00 SUBPROVI DER - I RF	0	0				41.00
43. 00 NURSERY	0	0	1			43.00
200.00 Total (lines 30 through 199)	2, 221	324, 601	1			200. 00

Health Financial Systems	JOHNSON MEMOR	I AL F	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	ſ	Provi der C		From 01/01/2022	Worksheet D Part II Date/Time Pre 5/24/2023 9:3	
			Titl∈	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal			Ratio of Cos		Capital Costs	
	Related Cost	(fr	om Wkst.	to Charges	Program	(column 3 x	

			10) 12/31/2022	5/24/2023 9:3	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 681, 843			· · ·		
53. 00 05300 ANESTHESI OLOGY	41, 177	,		243, 425		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	935, 396			3, 323, 440		
60. 00 06000 LABORATORY	519, 466	55, 897, 253		3, 565, 406	33, 133	
65. 00 06500 RESPIRATORY THERAPY	97, 677			678, 164		65.00
66. 00 06600 PHYSI CAL THERAPY	151, 093	4, 640, 126		190, 473		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	34, 477			188, 634		67.00
68. 00 06800 SPEECH PATHOLOGY	8, 638			90, 912		68.00
69. 00 06900 ELECTROCARDI OLOGY	97, 301	5, 827, 662		975, 858	16, 293	
70. 00 07000 ELECTROENCEPHALOGRAPHY	5, 722	160, 289		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				704, 378		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	24, 881	10, 635, 036	0. 002340	788, 077		
73.00 07300 DRUGS CHARGED TO PATIENTS	212, 739	37, 789, 342	0. 005630	2, 399, 260	13, 508	73.00
76. 00 03020 0NC0L0GY	184, 951	1, 825, 622	0. 101308	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	55, 350	822, 245	0. 067316	0	0	76. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	330, 711					
91. 00 09100 EMERGENCY	457, 818	47, 092, 950		1, 639, 081		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 072191	436, 683		
200.00 Total (lines 50 through 199)	5, 333, 623	348, 806, 293		16, 713, 585	227, 667	200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider 0		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/24/2023 9:3	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments 1A	Nursing Program	Allied Health Post-Stepdowr Adjustments	Allied Health	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA IA	1.00	ZA	2.00	3.00	
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0	(0 0 0 0 0 0 0 0		31. 00 41. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)		(col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	(7, 84 1, 54 0 50 50 9, 89	0.00 0.00 0.00 0.00	510 0 0	31. 00 41. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY Total (lines 30 through 199)	0 0 0 0 0 0					30. 00 31. 00 41. 00 43. 00 200. 00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0001	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2022	Part IV Nate/Time Prepared:

					To 12/31/2022	Date/Time Pre 5/24/2023 9:3	
			Title	e XVIII	Hospi tal	PPS	, alli
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	0	0	1	0	0	50.00
	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0		0	0	60.00
	06500 RESPIRATORY THERAPY	0	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0	0	1	0	0	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT				0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS				0	0	73.00
	03020 ONCOLOGY				0 0	0	76.00
	07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	o o	77.00
77.00	OUTPATIENT SERVICE COST CENTERS			1	<u> </u>		77.00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
	09100 EMERGENCY	0	l		0 0	Ō	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0		0	0	200.00

Health Financial Systems		JOHNSON MEMO	ORI AL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SI	ERVICE OTHER P	ASS	Provi der	CCN: 15-0001	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/24/2023 9:3	
				Ti t	le XVIII	Hospi tal	PPS	
Cost Contan Decement on		ALL Others		atal Coat	Total	Total Charges	Dotin of Cont	

				'	12/31/2022	5/24/2023 9: 3	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0	0	(51, 246, 954		
	ANESTHESI OLOGY	0	0	(7, 832, 927		
	RADI OLOGY-DI AGNOSTI C	0	0	(81, 082, 739		
60. 00 06000		0	0	(55, 897, 253		
	RESPI RATORY THERAPY	0	0	(8, 501, 791		
	PHYSI CAL THERAPY	0	0	(4, 640, 126		
	OCCUPATI ONAL THERAPY	0	0	(1, 347, 108		
	SPEECH PATHOLOGY	0	0	(583, 289		
	ELECTROCARDI OLOGY	0	0	(5, 827, 662		
	ELECTROENCEPHALOGRAPHY	0	0	(160, 289		
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(13, 647, 246		
	IMPL. DEV. CHARGED TO PATIENT	0	0	(10, 635, 036		
	DRUGS CHARGED TO PATIENTS	0	0	(37, 789, 342		
76. 00 03020		0	0	(1, 825, 622		
	CARDI AC REHABI LI TATI ON	0	0	(822, 245		
	ALLOGENEIC STEM CELL ACQUISITION	0	0	(0	0. 000000	77. 00
	TIENT SERVICE COST CENTERS						
90.00 09000		0	0	(14, 918, 205		
91. 00 09100		0	0	(47, 092, 950		
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(4, 955, 509		
200. 00	Total (lines 50 through 199)	0	0	(348, 806, 293		200.00

Health Financial Systems	JOHNSON MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	LLARY SERVICE OTHER PASS	Provi der C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/24/2023 9:3	pared: 9 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10) 11.00		Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
ANCILLARY SERVICE COST CENTERS						

Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	1, 461, 578	0	6, 585, 378	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	243, 425		664, 248	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 323, 440	0	12, 276, 454	0	54.00
60. 00 06000 LABORATORY	0. 000000	3, 565, 406	0	3, 088, 817	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	678, 164	0	278, 635	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	190, 473	0	47, 386	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	188, 634	0	7, 810	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	90, 912	0	15, 242	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	975, 858	0	1, 645, 889	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	704, 378	0	1, 342, 313	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	788, 077	0	967, 335	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	2, 399, 260	0	7, 805, 914	0	73.00
76. 00 03020 0NC0L0GY	0. 000000	0	0	225, 913	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	0	186, 728	0	76. 97
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	28, 216	0	3, 113, 472	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 639, 081	0	4, 427, 822	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	436, 683	0	925, 351	0	92.00
200.00 Total (lines 50 through 199)		16, 713, 585	0	43, 604, 707	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0001 Peri od: Worksheet D From 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/24/2023 9:39 am Title XVIII Hospi tal Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 4.00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 168528 6, 585, 378 1, 109, 821 50.00 05300 ANESTHESI OLOGY 0. 201608 0 0 0 53.00 664, 248 133, 918 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0. 084435 12, 276, 454 1, 036, 562 54.00 60.00 06000 LABORATORY 0.153158 3, 088, 817 0 0 0 0 473,077 60.00 65.00 06500 RESPIRATORY THERAPY 0.342313 278, 635 0 95, 380 65.00 0 06600 PHYSI CAL THERAPY 47, 386 17, 738 66.00 0.374337 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 378886 7, 810 2, 959 67.00 68.00 06800 SPEECH PATHOLOGY 0. 398814 15, 242 0 0 0 0 6,079 68.00 1, 645, 889 0 06900 ELECTROCARDI OLOGY 0.173893 286, 209 69.00 69.00 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0. 228188 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.215633 1, 342, 313 289, 447 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 0.363994 967, 335 0 0 352, 104 72.00 07300 DRUGS CHARGED TO PATIENTS 0 7, 805, 914 2, 373, 716 73 00 0.304092 73 00 0 03020 ONCOLOGY 76.00 0.770704 225, 913 174, 112 76.00 76. 97 07697 CARDIAC REHABILITATION 0.500663 186, 728 0 0 93, 488 76.97 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0. 244585 3, 113, 472 0 0 761, 509 90.00 91.00 09100 EMERGENCY 0. 152924 4, 427, 822 0 0 677, 120 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.828779 925, 351 0 0 766, 911 92.00 0 200.00 Subtotal (see instructions) 43, 604, 707 8, 650, 150 200. 00 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

43, 604, 707

0

o

8, 650, 150 202. 00

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	JOHNSON MEMORIAL HOSI	SPI TAL	In Lieu	of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Pro		From 01/01/2022	
			To 12/31/2022	Date/Time Prepared

	23 9:39 am
Title XVIII Hospital	PPS
Costs	
Cost Center Description Cost Cost	
Rei mbursed Rei mbursed	
Services Services Not	
Subj ect To Subj ect To	
Ded. & Coi ns. Ded. & Coi ns.	
(see inst.) (see inst.)	
6.00 7.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 0 0	50.00
53. 00 05300 ANESTHESI OLOGY 0 0	53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0	54.00
60. 00 06000 LABORATORY 0 0	60.00
65. 00 06500 RESPI RATORY THERAPY 0 0	65.00
66. 00 06600 PHYSI CAL THERAPY 0 0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0	67.00
68. 00 06800 SPEECH_PATHOLOGY 0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0	73. 00
76. 00 03020 0NC0L0GY 0 0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0	76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0	77. 00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C	90.00
91. 00 09100 EMERGENCY	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0	92.00
200.00 Subtotal (see instructions) 0 0	200.00
201.00 Less PBP Clinic Lab. Services-Program 0	201.00
Only Charges 202.00 Net Charges (line 200 - line 201) 0 0	202.00
202.00	J202.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-000	Peri od: From 01/01/2022	Worksheet D-1	
			Date/Time Pre 5/24/2023 9:3	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

		Title XVIII	Hospi tal	5/24/2023 9: 3 PPS	9 am	
	Cost Center Description	THE AVIII	1103pi tui	113		
	DADT I ALL DROWNED COMPONENTO			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1. 00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		7, 847	1.00	
2.00	Inpatient days (including private room days, excluding swing-			7, 847	2.00	
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3. 00	
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	and days)		5, 155	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5.00	
0.00	reporting period	adje, in edg. Beesing		· ·	0.00	
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00	
7 00	reporting period (if calendar year, enter 0 on this line)	da	. 21 -6	0	7.00	
7. 00	Total swing-bed NF type inpatient days (including private rool reporting period	m days) through becember	31 of the cost	U	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)					
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 711	9. 00	
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	coom days)	0	10.00	
10.00	through December 31 of the cost reporting period (see instruc		oom days)	O	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11. 00	
40.00	December 31 of the cost reporting period (if calendar year, e			0	40.00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	re room days)	0	12. 00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room davs)	0	13. 00	
	after December 31 of the cost reporting period (if calendar y	ear, enter O on this lir	ne)			
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00	
15.00				0	15. 00 16. 00	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			U	16.00	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0. 00	17. 00	
	reporting period	· ·				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00	
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00	
17.00	reporting period	3 through becomber 31 of	the cost	0.00	17.00	
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0. 00	20. 00	
21 00	reporting period	->		11 071 //0	21 00	
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	11, 971, 663	21. 00 22. 00	
22.00	5 x line 17)	ici 31 of the cost report	ing period (ind		22.00	
23.00		31 of the cost reportin	ng period (line é	0	23. 00	
24.00	x line 18)	. 21 -6			24.00	
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	er 31 of the cost reporti	ng period (iine	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)					
26. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		11 071 ((2	26.00	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus Tine 26)		11, 971, 663	27. 00	
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0		
30.00	Semi -pri vate room charges (excluding swing-bed charges)	11		0		
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	ctions)	0. 00		
35.00	Average per diem private room cost differential (line 34 x li			0. 00	35. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and naturate "	fforonti - L (I'	0	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrementiai (line	11, 971, 663	37. 00	
	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, 525. 64		
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		2, 610, 370 0	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39			2, 610, 370		
	, J.		'	, = , = , = , 0		

COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	2552-10
				From 01/01/2022 To 12/31/2022		
		Title	xVIII	Hospi tal	PPS	17 alli
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient	Inpati ent	Diem (col. 1		(col. 3 x	
	Cost	Days	÷ col . 2) 3.00	4.00	col . 4) 5.00	
42.00 NURSERY (title V & XIX only)	1.00	2.00		4.00		42.00
Intensive Care Type Inpatient Hospital			0.0	<u> </u>		72.00
43. 00 INTENSIVE CARE UNIT	4, 135, 595	1, 544	2, 678. 4	9 510	1, 366, 030	43.00
44. OO CORONARY CARE UNIT						44.00
45. 00 BURN INTENSIVE CARE UNIT						45.00
46. 00 SURGI CAL INTENSI VE CARE UNIT						46.00
47. 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
oost conten bescription					1.00	
48.00 Program inpatient ancillary service co	st (Wkst. D-3, col. 3	3, line 200)			3, 490, 754	48. 00
48.01 Program inpatient cellular therapy acq				column 1)	0	48. 01
49.00 Total Program inpatient costs (sum of	ines 41 through 48.0	01)(see instru	ctions)		7, 467, 154	49.00
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Progra	m innationt routing	convices (free	m Wks+ D sur	of Dorte L and	324, 601] 50. 00
	all impatrent routine	services (110	III WKSt. D, Sui	OF PALLS F ALL	324, 001	30.00
51.00 Pass through costs applicable to Progra	am inpatient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	227, 667	51.00
and IV)		-	•			
52.00 Total Program excludable cost (sum of					552, 268	1
53.00 Total Program inpatient operating cost medical education costs (line 49 minus		erated, non-ph	ysıcıan anestl	netist, and	6, 914, 886	53.00
TARGET AMOUNT AND LIMIT COMPUTATION	111le 52)					1
54. 00 Program di scharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
55.01 Permanent adjustment amount per discha	S				0.00	
55. 02 Adjustment amount per discharge (contr	3 -				0.00	
56.00 Target amount (line 54 x sum of lines	· · · · · · · · · · · · · · · · · · ·		lina E/ minua	line F2)	0	
57.00 Difference between adjusted inpatient 58.00 Bonus payment (see instructions)	operating cost and ta	arget alliount (i i ne so mi nus	11 ne 53)		58.00
59.00 Trended costs (lesser of line 53 ÷ line	e 54. or line 55 from	n the cost rep	ortina period	endi na 1996.	0.00	•
updated and compounded by the market b			3 1	3		
60.00 Expected costs (lesser of line 53 ÷ li	ne 54, or line 55 fro	om prior year	cost report, ι	updated by the	0.00	60.00
market basket)	flino E2 . lino E4	ic loss than	the lawest of	Lines EE plus	0	/1 00
61.00 Continuous improvement bonus payment (55.01, or line 59, or line 60, enter t					l	61.00
53) are less than expected costs (line						
enter zero. (see instructions)		-				
62.00 Relief payment (see instructions)					0	
63.00 Allowable Inpatient cost plus incentive PROGRAM INPATIENT ROUTINE SWING BED COS		uctions)			0	63.00
64.00 Medicare swing-bed SNF inpatient routi		ember 31 of the	e cost reporti	na period (See	0	64.00
instructions)(title XVIII only)	io cooto tin ough book	J	o 0001 . opo. 1.	g po oa (ooo		01100
65.00 Medicare swing-bed SNF inpatient routi	ne costs after Decemb	per 31 of the	cost reportino	g period (See	0	65.00
instructions)(title XVIII only)			(E) (11 11	1 1		.,
66.00 Total Medicare swing-bed SNF inpatient CAH, see instructions	routine costs (line	64 plus line	65)(TITIE XVII	i only); for	0	66.00
67.00 Title V or XIX swing-bed NF inpatient	routine costs through	n December 31	of the cost re	eporting period	0	67.00
(line 12 x line 19)						
68.00 Title V or XIX swing-bed NF inpatient	routine costs after [December 31 of	the cost repo	orting period	0	68.00
(line 13 x line 20)	tiont routing costs /	(lino (7 : lin	. (0)			40.00
69.00 Total title V or XIX swing-bed NF inpa PART III - SKILLED NURSING FACILITY, O					0	69.00
70.00 Skilled nursing facility/other nursing						70.00
71.00 Adjusted general inpatient routine ser						71.00
72.00 Program routine service cost (line 9 x	line 71)					72.00
73.00 Medically necessary private room cost	11	•	,			73.00
74.00 Total Program general inpatient routing 75.00 Capital-related cost allocated to inpa	,			Part II column		74.00
75.00 Capital-related cost allocated to inpa 26, line 45)	trent routine Service	= COSIS (IIOII)	worksneet B, I	art II, COLUMN		75.00
76.00 Per diem capital-related costs (line 7	5 ÷ line 2)					76.00
77.00 Program capital -related costs (line 9:	k line 76)					77.00
78.00 Inpatient routine service cost (line 7			1.3			78.00
79.00 Aggregate charges to beneficiaries for				nus lina 70)		79.00
80.00 Total Program routine service costs fo 81.00 Inpatient routine service cost per die	•	Just Tilli tätlö	n (iine 78 Mil	ius IIIIe /9)		80.00
82.00 Inpatient routine service cost per die		1)				82.00
83.00 Reasonable inpatient routine service co					1	83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compens						85.00
86.00 Total Program inpatient operating cost:		nrough 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BE						
87.00 Total observation bed days (see instru	ctions)				2, 692	87.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 9 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			4, 107, 023	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	1, 042, 790	11, 971, 663	0. 08710	95 4, 107, 023	357, 742	90.00
91.00 Nursing Program cost	0	11, 971, 663	0. 00000	0 4, 107, 023	0	91.00
92.00 Allied health cost	0	11, 971, 663	0. 00000	0 4, 107, 023	0	92.00
93.00 All other Medical Education	0	11, 971, 663	0. 00000	0 4, 107, 023	0	93.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-000	Peri od: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/24/2023 9:3	
	Title XIX	Hospi tal	Cost	
Cost Center Description		-		
			1 00	

Dept 1 - ALL PROFIT DESCRIPTION Dept 1 - ALL PROFIT DESCRIPTION IMPAILENT DAYS IMPAILENT DA			Title XIX	Hospi tal	5/24/2023 9: 3 Cost	9 alli
NAME		Cost Center Description			1 00	
Inpatient days (including private room days and saing-bed days, excluding newborn) 7,847 2.00		PART I - ALL PROVIDER COMPONENTS			11.00	
Inipatient days (including private room days, excluding swing-bed and newborn days) 1, 847 2,00	4 00				7.047	4.00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do do not complete this line. 4.00 do not complete this line. 4.00 Seni-private room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line). 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days). 8.00 Experiment days) (see Instructions) and Including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) af					· ·	
do not complete this line. 4. 05 Semi-private room days (excluding swing-bed and observation bed days) 7. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost period (if calendary year, enter 0 on this line) 7. 00 Total swing-bed SM type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 7. 00 Total swing-bed SM type inpatient days (including private room days) through December 31 of the cost period (if calendary year, enter 0 on this line) 8. 00 Total swing-bed SM type inpatient days (including private room days) shows a period on this line) 9. 00 Total inpatient days including private room days after December 31 of the cost period (if calendary year, enter 0 on this line) 10. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) 10. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) after the cost period (if calendary year, enter 0 on this line) 10. 00 Swing-bed SM type inpatient days applicable to title XVIII only (including private room days) after though year of the cost reporting period (if calendary year, enter 0 on this line) 10. 00 Swing-bed SM type inpatient days applicable to title SV or XIX only (including private room days) after though year of the cost reporting period (if calendary year, enter 0 on this line) 10. 00 Swing-bed SM type inpatient days applicable to title SV or XIX only (including private room days) 10. 00 Swing-bed SM type inpatient days applicable to services through December 31 of the cost reporting period (if calendary year, enter 0 on this line) 10. 00 Swing-bed SW type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 10. 00 Swing-bed Not year period the cost period (including private room days) 10. 00 Swing-bed own type bed SW services applicable to services through December 31 o				ivate room days	· ·	
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of coporting period in the cost period period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line) 7.00 Total inpatient days including private room days) after December 31 of the cost period (if callendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and period (if callendar year, enter 0 on this line) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applica	0.00		ye, yeu nave emy p.	. vato . com dayo,	· ·	0.00
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 11, 971, 663 27. 00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28. 00 9. 00 Pri vate room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-pri vate room charges (excluding swing-bed charges) 0 30. 00 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0. 0000000 31. 00 32. 00 Average pri vate room per diem charge (line 29 + line 3) 0. 00 32. 00 33. 00 Average semi-pri vate room per diem charge (line 30 ÷ line 4) 0. 00 33. 00 34. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions) 0. 00 34. 00 35. 00 Average per diem pri vate room cost differential (line 34 x line 31) 0. 00 35. 00 36. 00 Pri vate room cost differential adjustment (line 3 x line 35) 0. 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 27 minus line 36) 27 minus line 36) 27 minus line 36) 28. 00 PRATTII - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 11, 372 39. 00 38. 00 Algusted general inpatient routine service cost per diem (see instructions) 1, 525. 64 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 111, 372 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	26. 00				0	26, 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 4.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 11, 971, 663) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 31.00 Account of the charges (excluding swing-bed charges) 32.00 Average per vivate room charge differential (line 32 minus line 33) (see instructions) 32.00 Average per diem private room cost differential (line 31, 971, 663) 33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 36.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 37.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 38.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 37.00 Average per diem private		,	(line 21 minus line 26)		11, 971, 663	
29.00 30.00 Private room charges (excluding swing-bed charges) 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.000000 31.00 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32.00 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 0.00 32.00 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 11, 971, 663) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 1,525.64 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 111,372 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 11, 971, 663) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.0000000000000000000000000000000000						
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 33.00 37.00 35.00 37.00 111, 971, 663 37.00 27 minus line 36) Program general inpatient routine service cost per diem (see instructions) 1, 525.64 38.00 40.00		,	. 11116 20)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 Average per diem private room cost differential (line 33 x line 31) 38.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost differential (line 34 x line 31) 39.00 Average per diem private room cost d						
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 11,971,663 37.00 27 minus line 36) 11,971,663 37.00 28 minus line 36) 11,971,663 37.00 29 minus line 36) 11,971,663 37.00 20 minus line 36) 40.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00			ne 31)		0.00	
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,525.64 38.00 Program general inpatient routine service cost (line 9 x line 38) 111,372 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,525.64 38.00 Program general inpatient routine service cost (line 9 x line 38) 111,372 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00	,	and private room cost di	fferential (line	11, 971, 663	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,525.64 38.00 Program general inpatient routine service cost (line 9 x line 38) 111,372 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,525.64 38.00 Program general inpatient routine service cost (line 9 x line 38) 111,372 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			USTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00				1, 525. 64	38. 00
		,	•			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 111,372 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41.00	liotal Program general inpatient routine service cost (line 39	+ IINE 4U)	l	111, 372	41.00

OMPUT.	Financial Systems ATION OF INPATIENT OPERATING COST		Provi der CO		eriod: rom 01/01/2022	u of Form CMS-2 Worksheet D-1	
					o 12/31/2022	Date/Time Pre 5/24/2023 9:3	
	Cost Center Description	Total I npati ent	Ti tl Total I npati ent	e XIX Average Per Diem (col. 1	Hospi tal Program Days	Program Cost (col. 3 x	
		Cost 1.00	Days 2.00	÷ col . 2) 3.00	4. 00	col . 4) 5.00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	400, 783	508	788. 94	17	13, 412	42.
. 00	INTENSIVE CARE UNIT	4, 135, 595	1, 544	2, 678. 49	4	10, 714	43.
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
. 00	SURGICAL INTENSIVE CARE UNIT						45
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk			111 11 10	1)	81, 840	
. 01	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column I)	0 217, 338	
	PASS THROUGH COST ADJUSTMENTS						1
00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50
. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51
00	and IV)	EO and E1)				0	-
. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated, non-phy	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line			, 			
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
. 00	Target amount per discharge					0. 00	55
	Permanent adjustment amount per discharge					0.00	
02	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	1
00	Difference between adjusted inpatient operat			ine 56 minus	ine 53)	0	57
. 00	Bonus payment (see instructions)	I' EE C			!!	0	
. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost repo	orting period (ending 1996,	0. 00	59
. 00	Expected costs (lesser of line 53 ÷ line 54,		m prior year o	cost report, u	odated by the	0. 00	60
. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	which operating	g costs (line	0	61
	enter zero. (see instructions)		g	(,,	_	
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	62
	PROGRAM INPATIENT ROUTINE SWING BED COST	·	,				
. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the d	cost reporting	period (See	0	65
00	instructions)(title XVIII only)	(1:	/	/EX /±! ±1 = 30/11		0	 , ,
. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (iine	64 prus rine 6	os)(title xvii	only); For	0	66
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost rep	porting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	rting period	0	68
	(line 13 x line 20)			·	g p		
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69
. 00	Skilled nursing facility/other nursing facil						70
	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72
. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73))			74
00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	Vorksheet B, Pa	art II, column		75
00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
	Program capital-related costs (line 9 x line	76)					77
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi den irecord	ds)			78
00	Total Program routine service costs for comp				us line 79)		80
	Inpatient routine service cost per diem limi		`				81
. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82
. 00	Program inpatient ancillary services (see in		/				84
	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum		i ougri 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PAS						

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		pared: 9 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			4, 107, 023	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	1, 042, 790	11, 971, 663	0. 08710	95 4, 107, 023	357, 742	90.00
91.00 Nursing Program cost	0	11, 971, 663	0. 00000	0 4, 107, 023	ol	91.00
92.00 Allied health cost	0	11, 971, 663	0. 00000	0 4, 107, 023	0	92.00
93.00 All other Medical Education	0	11, 971, 663	0. 00000	0 4, 107, 023	0	93.00

INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0001	Peri od:	Worksheet D-3	3
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/24/2023 9:3	epared:
		Titl∈	: XVIII	Hospi tal	PPS	
	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	
	FIENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS			3, 677, 019		30.00
	INTENSIVE CARE UNIT			658, 230		31.00
	SUBPROVI DER - I RF			0		41.00
	NURSERY					43.00
	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 1685		246, 317	
	ANESTHESI OLOGY		0. 2016		49, 076	
	RADI OLOGY-DI AGNOSTI C		0. 0844		280, 615	
	LABORATORY		0. 1531		546, 070	
	RESPI RATORY THERAPY		0. 3423		232, 144	
	PHYSI CAL THERAPY		0. 3743		71, 301	
	OCCUPATI ONAL THERAPY		0. 3788		71, 471	
	SPEECH PATHOLOGY		0. 3988		36, 257	
	ELECTROCARDI OLOGY		0. 1738		169, 695	
	ELECTROENCEPHALOGRAPHY		0. 2281		0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2156		151, 887	
	IMPL. DEV. CHARGED TO PATIENT		0. 3639		286, 855	
	DRUGS CHARGED TO PATIENTS		0. 3040		729, 596	
	ONCOLOGY		0. 7763		0	
	7 CARDIAC REHABILITATION		0. 5006		0	
	DALLOGENEIC STEM CELL ACQUISITION		0.0000	00 0	0	77.00
	ATLENT SERVICE COST CENTERS					
	CLINIC		0. 2445		6, 901	
	EMERGENCY		0. 1529		250, 655	
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 8287		361, 914	
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			16, 713, 585	3, 490, 754	
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			16, 713, 585		202.00

				6.5. 0110.4	
Health Financial Systems JOHNSON MEMORIAL INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15 0001	Period:	u of Form CMS-2 Worksheet D-3	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN. 15-0001	From 01/01/2022	WOLKSHEEL D-3	
			To 12/31/2022		
				5/24/2023 9: 3	9 am
	Ti tI	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col . 2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		I	321, 179		30.00
31. 00 03100 NTENSI VE CARE UNI T			6, 135		31.00
41. 00 04100 SUBPROVI DER - I RF			0, 133		41.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		l			10.00
50. 00 05000 OPERATI NG ROOM		0. 16852	165, 635	27, 914	50.00
53. 00 05300 ANESTHESI OLOGY		0. 20160	•	4, 525	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 08443			
60. 00 06000 LABORATORY		0. 1531		12, 640	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3423	3 15, 745	5, 390	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 37433	1, 375	515	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37888	1, 142	433	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 3988	4 287	114	
69. 00 06900 ELECTROCARDI OLOGY		0. 17389		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 22818		23	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 21563		4, 387	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 36399		0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 3040		17, 167	73.00
76. 00 03020 0NCOLOGY		0. 77070		0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 50066		0	76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS		1			
90. 00 09000 CLINIC		0. 24458		0	
91. 00 09100 EMERGENCY		0. 15292		5, 601	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 8287		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	. (11		439, 763	81, 840	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (IIne 61)		120 7/2		201.00
202.00 Net charges (line 200 minus line 201)		I	439, 763		202. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	From 01/01/2022	Worksheet E Part A Date/Time Prepared: 5/24/2023 9:39 am

		Title XVIII	Hospi tal	5/24/2023 9: 3 PPS	9 am
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring pr instructions)	ior to October 1 ((see	0 4, 395, 842	
1. 02	DRG amounts other than outlier payments for discharges occurring or instructions)	or after October	1 (see	0	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for dis 1 (see instructions)	scharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for dis October 1 (see instructions)	charges occurring	on or after	0	1. 04
2.00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00
2. 02 2. 03 2. 04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see i Outlier payments for discharges occurring on or after October 1 (see			0 43, 042 0	2. 03
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting	ŕ	ıctions)	2, 273, 483 50. 58	3.00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most rece				
5. 00	or before 12/31/1996. (see instructions) [FTE cap adjustment for qualifing hospitals under §131 of the CAA 20			0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet the cri new programs in accordance with 42 CFR 413.79(e)			0.00	•
6. 26	Rural track program FTE cap limitation adjustment after the cap-bui the CAA 2021 (see instructions)	lding window close	ed under §127 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under ACA \S 5503 reduction amount to the IME cap as specified under 42 CF			0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track protrack programs with a rural track for Medicare GME affiliated progrand 87 FR 49075 (August 10, 2022) (see instructions)			0. 00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic a affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(1998), and 67 FR 50069 (August 1, 2002).			0. 00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots ur report straddles July 1, 2011, see instructions.			0. 00	
8. 02	The amount of increase if the hospital was awarded FTE cap slots frunder § 5506 of ACA. (see instructions)		•	0. 00	8. 02
8. 21 9. 00	The amount of increase if the hospital was awarded FTE cap slots ur instructions)		•	0. 00	
	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (s FTE count for allopathic and osteopathic programs in the current years.	see instructions)		0. 00	
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	ar rrom your recor		0. 00	11.00
13.00	Total allowable FTE count for the prior year.			0. 00	13.00
	Total allowable FTE count for the penultimate year if that year encotherwise enter zero.	led on or after Sep	otember 30, 1997,		14.00
16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instr	uctions)		0. 00	15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count			0.00	17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	ı
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	
22. 00	IME payment adjustment (see instructions)			0	1
22. 01	IME payment adjustment - Managed Care (see instructions)	ho MMA		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of t Number of additional allopathic and osteopathic IME FTE resident ca (f)(1)(iv)(C).		CFR 412. 105	0.00	23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower	of line 23 or line	e 24 (see	0. 00 0. 00	1
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	
	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0.000000	27. 00 28. 00
	IME add-on adjustment amount (see instructions)			0	•
	Total IME payment (sum of lines 22 and 28)			0	29.00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient	days (see instruc	ctions)	2. 30	30.00
31.00	Percentage of Medicaid patient days (see instructions)			21. 73	31.00
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)			24. 03	32. 00 33. 00
	printendario di apriopor trondte andre percentage (aee matructions)		ļ	7. 00	1 33.00

Heal th	Financial Systems JOHNSON MEMORIA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/24/2023 9: 3 PPS	9 alli
				1. 00	
34.00	Disproportionate share adjustment (see instructions)			99, 786	34.00
			Pri or to 10/1		
	Uncompensated Care Payment Adjustment		1. 00	2. 00	
35. 00	Total uncompensated care amount (see instructions)		0	0	35. 00
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zero	o ontor zoro on this lin	0. 000000000 e) 403, 479		
33. 02	(see instructions)	o, enter zero on tilis i i i	403, 479	300, 113	35.02
35. 03	1	UCP (see instructions)	301, 780	92, 785	1
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 thro	394, 565		36.00
40.00	Total Medicare discharges (see instructions)	ar senar ges (Trines Te trine)	0		40. 00
41.00	Total ESRD Medicare discharges (see instructions)		0		41.00
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see instruction Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		41. 01 42. 00
43. 00	Total Medicare ESRD inpatient days (see instructions)	Try for adjustment)	0.00		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instruction	ns)	0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times line 4	,	0		46. 00
47.00	Subtotal (see instructions)	small rural bassitals	4, 933, 235		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	silari rurai nospitars	0		48. 00
				Amount	
49. 00	Total payment for inpatient operating costs (see instruction	ne)		1. 00 4, 933, 235	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a	*)	333, 459	
51.00	Exception payment for inpatient program capital (Wkst. L, P	· · · · · · · · · · · · · · · · · · ·		0	51.00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, I Nursing and Allied Health Managed Care payment	line 49 see instructions)		0	52. 00 53. 00
54. 00	Special add-on payments for new technologies			135, 492	1
54. 01	Islet isolation add-on payment			0	54. 01
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cellular therapy acquisition cost (see instructions)	69)		0	55. 00 55. 01
56. 00	Cost of physicians' services in a teaching hospital (see in	tructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57.00
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	. IV, col. 11 line 200)		0 5, 402, 186	58. 00 59. 00
60.00	Primary payer payments			11, 796	1
61.00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		5, 390, 390	•
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			639, 084 3, 501	•
	Allowable bad debts (see instructions)			63, 845	1
65.00	Adjusted reimbursable bad debts (see instructions)			41, 499	•
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (line 61 plus line 65 minus lines 62 and 63)	structions)		18, 439 4, 789, 304	66. 00 67. 00
68.00	Credits received from manufacturers for replaced devices for	r applicable to MS-DRGs (see instructions)	0	68.00
	Outlier payments reconciliation (sum of lines 93, 95 and 96)).(For SCH see instructio	ns)	0	69.00
69.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	stration) adjustment (see	instructions)	0	70. 00 70. 50
70.00	Rural Community Hospital Demonstration Project (\$410A Demons				70. 75
70. 00 70. 50 70. 75	Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions)	, ,		0	, 0. , 0
70. 00 70. 50 70. 75 70. 87	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration	•		0	70. 87
70. 00 70. 50 70. 75 70. 87 70. 88	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	n			70. 87 70. 88
70. 00 70. 50 70. 75 70. 87	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration	n		0	70. 87
70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91	N95 respirator payment adjustment amount (see instructions) 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 HVBP adjustment amount (see instructions)	n		0 0 0	70. 87 70. 88 70. 89 70. 90 70. 91
70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	N95 respirator payment adjustment amount (see instructions) 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 HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	n		0 0 0 0	70. 87 70. 88 70. 89 70. 90 70. 91 70. 92
70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91	N95 respirator payment adjustment amount (see instructions) 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 HVBP adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	n		0 0 0 0 0 0 -369	70. 87 70. 88 70. 89 70. 90 70. 91

	Financial Systems JOHNSON MEMORIAL			In Lie	u of Form CMS-	2552-
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0001	Peri od: From 01/01/2022 To 12/31/2022		
		Title	: XVIII	Hospi tal	PPS	or an
				(уууу)	Amount	
				Q	1. 00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	C	70. 9
2 07	the corresponding federal year for the period prior to 10/1)			0		
). 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	C	70.
). 98	Low Volume Payment-3	ter 10/1)			C	70.
). 99	HAC adjustment amount (see instructions)				C	1
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			4, 788, 935	71.
1. 01	Sequestration adjustment (see instructions)	,			60, 340	
1. 02	Demonstration payment adjustment amount after sequestration				C	71. (
. 03	Sequestration adjustment-PARHM or CHART pass-throughs					71.
2. 00	Interim payments				4, 606, 834	
2. 01	Interim payments-PARHM or CHART				_	72.
3. 00	Tentative settlement (for contractor use only)	`			C	1
3. 01	Tentative settlement-PARHM or CHART (for contractor use only	,			101 7/1	73.
. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	2, 72, and			121, 761	74.
. 01	Balance due provider/program-PARHM or CHART (see instructions)				74.
. 00	Protested amounts (nonallowable cost report items) in accorda				86, 770	
. 00	CMS Pub. 15-2, chapter 1, §115.2	nee with			00,770	/ / / 5.
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			C	90.
	plus 2.04 (see instructions)					
. 00	Capital outlier from Wkst. L, Pt. I, line 2				C	
	Operating outlier reconciliation adjustment amount (see instr				C	
	Capital outlier reconciliation adjustment amount (see instruc				C	
. 00	The rate used to calculate the time value of money (see instr	uctions)			0.00	
. 00	Time value of money for operating expenses (see instructions)	+ !>			C	
. 00	Time value of money for capital related expenses (see instruc	tions)		Dri or to 10/1	On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount			1.00	2.00	
0. 00	HSP bonus amount (see instructions)			0	C	100.
	HVBP Adjustment for HSP Bonus Payment					
1.00	HVBP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.
2.00	HVBP adjustment amount for HSP bonus payment (see instruction	s)		0	C	102.
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0. 0000	0. 0000	
4. 00	HRR adjustment amount for HSP bonus payment (see instructions)		0	C	104.
	Rural Community Hospital Demonstration Project (§410A Demonst					
0.00	Is this the first year of the current 5-year demonstration pe	rioa unaer	tne ZIST			200.
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement					
1 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	A 49)				201.
	Medicare discharges (see instructions)	· +//				201.
	Case-mix adjustment factor (see instructions)					203.
2.00	Computation of Demonstration Target Amount Limitation (N/A in	first vear	of the curre	ent 5-year demons	trati on	1_55.
	peri od)	Joan				
4. 00	Medicare target amount					204.
	Case-mix adjusted target amount (line 203 times line 204)					205.
	Medicare inpatient routine cost cap (line 202 times line 205)					206.
	Adjustment to Medicare Part A Inpatient Reimbursement					
7.00	Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					207.
						208.

208.00

209.00

210.00

211. 00

212.00

213. 00 218. 00

210.00 Reserved for future use

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

209.00 Adjustment to Medicare IPPS payments (see instructions)

(line 212 minus line 213) (see instructions)

211.00 Total adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Period: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/24/2023 9:39 am

-	Title)	/\/I I I	Hospi tal	5/24/2023 9: 3 PPS	9 am
		AVIII	поѕрі таі	PPS	
				1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1.00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			8, 650, 150	2.00
3. 00	OPPS payments			6, 180, 210	3.00
4.00	Outlier payment (see instructions)			32, 645	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0 000	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5			0.000	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13,	line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0	11.00
	Reasonabl e charges				
12.00	Ancillary service charges			0	12.00
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13. 00 14. 00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for payment for s	ervi ces on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for	servi ces d	on a chargebasis	0	16.00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.000000	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18	exceeds Li	ne 11) (see	0	19.00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only if line 11	exceeds li	ne 18) (see	0	20.00
21. 00	instructions) Lesser of cost or charges (see instructions)			0	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, 212, 855	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 instr	ructions)	1, 009, 289	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum			5, 203, 566	27. 00
00.00	instructions)				00.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28. 00 29. 00
30.00	Subtotal (sum of lines 27 through 29)			5, 203, 566	
31.00	Pri mary payer payments			916	1
32. 00	Subtotal (line 30 minus line 31)			5, 202, 650	32.00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34. 00	Allowable bad debts (see instructions)			78, 528	
35.00	Adjusted reimbursable bad debts (see instructions)			51, 043	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			43, 197	36.00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			5, 253, 693 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			_	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	:	. ±: \	0	39. 97 39. 98
39. 98 39. 99	Partial or full credits received from manufacturers for replaced devices (RECOVERY OF ACCELERATED DEPRECIATION	see Instruc	ctions)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			5, 253, 693	40.00
40. 01	Sequestration adjustment (see instructions)			66, 196	
40. 02	Demonstration payment adjustment amount after sequestration			0	40.02
40. 03 41. 00	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			5, 136, 731	40. 03 41. 00
41. 00	Interim payments Interim payments-PARHM or CHART			5, 150, 751	41.00
42. 00	Tentative settlement (for contractors use only)			0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			50, 766	
43. 01 44. 00	Balance due provider/program-PARHM (see instructions)	Dub 15 2	chanter 1	0	43. 01 44. 00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS §115.2	ι ub. 10-Z,	chapter I,	Ü	44.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 0. 00	91. 00 92. 00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00
	Total (sum of lines 91 and 93)				94.00
			'		•

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022		
				5/24/2023 9:	39 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(0 200. 00

Health Financial Systems JOHNS
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-0001

			'	0 12/31/2022	5/24/2023 9: 3	
		Title	: XVIII	Hospi tal	PPS	
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		4, 606, 834		5, 136, 731	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		C		0	2. 00
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		I.	I.		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02					o	3. 02
3. 03					0	3. 03
3. 04					0	3. 04
3. 05					0	3.05
	Provider to Program		_		_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51					ol	3. 51
3. 52					ol	3. 52
3. 53					ol	3. 53
3. 54					o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				o	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 606, 834		5, 136, 731	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	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. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03			0		0	5. 03
	Provi der to Program		1 -		_	
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		121, 761		50, 766	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 728, 595		5, 187, 497	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8.00

Heal th	Financial Systems JOHNSON	MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0001	Peri od: From 01/01/2022	Worksheet E-	
			To 12/31/2022		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST R				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CA				
1.00	Total hospital discharges as defined in AARA §4102 f	rom Wkst. S-3, Pt. I col. 15 lin	e 14		1.00
2.00 Medicare days (see instructions)					2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 li				5. 00
6.00	Total hospital charity care charges from Wkst. S-10,				6.00
7.00	CAH only - The reasonable cost incurred for the purc	hase of certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instru	ıcti ons)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after seque	estration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instruct	i ons)			30.00
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line	e 30 and line 31) (see instruction	ns)		32.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2023 9:39 am

			o 12/31/2022	Date/lime Pre 5/24/2023 9:3	
		Title XIX	Hospi tal	Cost	7 (1111
		THE SALA	Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	PVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	WIGES FOR TITLES V OR XI	X SERVICES		1
1. 00	Inpatient hospital/SNF/NF services		217, 338		1.00
2. 00	Medical and other services		217, 330	0	
3. 00	Organ acquisition (certified transplant programs only)		0	O	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		217, 338	0	4.00
5. 00	Inpatient primary payer payments		217, 550	O	5.00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		217, 338	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		217, 330	0	7.00
	Reasonable Charges				1
8. 00	Routine service charges		327, 314		8.00
9. 00	Ancillary service charges		439, 763	0	
10. 00	Organ acquisition charges, net of revenue		437, 703	O	10.00
11. 00	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		767, 077	0	
12.00	CUSTOMARY CHARGES		707,077	0	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
13.00	basis	ser vices on a charge		0	13.00
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
00	a charge basis had such payment been made in accordance with 4			, and the second	
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 011 3110. 10(0)	0. 000000	0. 000000	15.00
16. 00	Total customary charges (see instructions)		767, 077	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	549, 739	0	17.00	
	line 4) (see instructions)	,			
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	16)	217, 338	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		217, 338	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	217, 338	0	
32.00	Deducti bl es		0	0	
33.00	Coi nsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	217, 338	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
38.00	Subtotal (line 36 ± line 37)		217, 338	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00			217, 338	0	
41.00	Interim payments	353, 322	0		
42.00	Balance due provider/program (line 40 minus line 41)			0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

		u of Form CMS-2	552-10			
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0001				Peri od:	Worksheet E-5	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/24/2023 9:39	oared: 9 am
			Title XVIII		PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A, Ii	ine 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00	Operating outlier reconciliation adjustment amount	unt (see instr	uctions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)						4.00
5.00 The rate used to calculate the time value of money (see instructions)						5.00
6.00 Time value of money for operating expenses (see instructions)						6.00
7.00 Time value of money for capital related expenses (see instructions)						7.00

Health Financial Systems

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

Provi der CCN: 15-0001

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/24/2023 9:39 am

57		General Fund	Speci fi c	Endowment	5/24/2023 9: 3 Plant Fund	9 am
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS		2.00	0.00		
1. 00	Cash on hand in banks	3, 788, 331	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3. 00 4. 00	Notes recei vable	20 040 400	0	0	0	
4. 00 5. 00	Accounts receivable Other receivable	28, 868, 408 3, 531, 745	1	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	
7. 00	Inventory	3, 003, 345	O	Ö	0	
8.00	Prepai d expenses	148, 808, 665	0	О	0	
9. 00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	188, 000, 494	0	0	0	11.00
12. 00	Land	4, 926, 609	0	0	0	12.00
13. 00	Land improvements	3, 096, 219		Ö	0	
14.00	Accumulated depreciation	-1, 619, 464		o	0	14.00
15. 00	Bui I di ngs	0	0	0	0	15.00
16.00	Accumulated depreciation	-36, 634, 017		0	0	16.00
17.00	Leasehold improvements	105, 541, 099	1	0	0	17.00
18. 00 19. 00	Accumulated depreciation Fixed equipment	15, 086, 526	0	0	0	18. 00 19. 00
20. 00	Accumulated depreciation	-12, 494, 606		0	0	20.00
21. 00	Automobiles and trucks	0	Ö	o	0	21.00
22. 00	Accumul ated depreciation	0	0	O	0	22. 00
23. 00	Maj or movable equipment	42, 679, 286	0	0	0	23. 00
24.00	Accumulated depreciation	-31, 361, 131	0	0	0	24.00
25. 00	Mi nor equipment depreciable	0	0	0	0	25.00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0		U O	0	26. 00 27. 00
28. 00	Accumulated depreciation			0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0		Ö	0	
30.00	Total fixed assets (sum of lines 12-29)	89, 220, 521	0	O	0	30.00
	OTHER ASSETS					
31.00	Investments	-13, 616, 788	l	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	15, 759, 615		0	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	2, 142, 827		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	279, 363, 842		Ö	0	
	CURRENT LI ABI LI TI ES					
37.00	Accounts payable	2, 836, 794		0	0	37.00
38.00	Salaries, wages, and fees payable	2, 953, 615		0	0	
39. 00 40. 00	Payroll taxes payable Notes and Loans payable (short term)	153, 493		U O	0	39. 00 40. 00
41.00	Deferred income	0	0	0	0	41.00
42. 00	Accel erated payments	0		Ÿ.	O	42.00
43.00	Due to other funds	45, 998, 664	0	0	0	1
44.00	Other current liabilities	3, 928, 316		O	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	55, 870, 882	0	0	0	45. 00
	LONG TERM LIABILITIES	1		ما		
46.00	Mortgage payable	12 055 440	0	0	0	46. 00 47. 00
47. 00 48. 00	Notes payable Unsecured Loans	12, 955, 448		0	0	
49. 00	Other long term liabilities			0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	12, 955, 448		Ö	0	
51.00	Total liabilities (sum of lines 45 and 50)	68, 826, 330	0	0	0	51.00
	CAPITAL ACCOUNTS	1				
52.00	General fund balance	210, 537, 512				52.00
53.00	Specific purpose fund		0			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted	•		0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			Ĭ	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
	repl acement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	210, 537, 512	1	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	279, 363, 842	0	0	0	60.00
	<i>>'/</i>	I	ı	I		I

STATEMENT OF CHANGES IN FUND BALANCES

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Provider CCN: 15-0001

Period: Worksheet G-1 From 01/01/2022

Date/Time Prepared: 5/24/2023 9:39 am 12/31/2022 General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 3.00 4.00 2.00 1.00 Fund balances at beginning of period 210, 488, 993 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 48, 519 2.00 3 00 Total (sum of line 1 and line 2) 210, 537, 512 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0 0 0 0 0 5.00 0 6.00 0 6.00 0 7.00 Ω 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 210, 537, 512 Subtotal (line 3 plus line 10) 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 000000 13.00 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 210, 537, 512 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 2.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 0 3.00 Total (sum of line 1 and line 2) 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 5.00 6.00 0 6.00 7.00 0 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 10.00 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00

0

0

19.00

Health Financial Systems Jordannian Systems Jordannian Systems Jordannian Systems AND OPERATING EXPENSES Provider CCN: 15-0001

		'	0 12/31/2022	5/24/2023 9: 3	
	Cost Center Description	Inpatient	Outpati ent	Total	
	•	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	·			
	General Inpatient Routine Services				
1.00	Hospi tal	15, 196, 039		15, 196, 039	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	C		0	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	C		0	5.00
6.00	Swing bed - NF	C		0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	15, 196, 039		15, 196, 039	10.00
	Intensive Care Type Inpatient Hospital Services		1		
11.00	I NTENSI VE CARE UNI T	2, 328, 032		2, 328, 032	11.00
12.00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of line	s 2, 328, 032		2, 328, 032	16. 00
47.00	11-15)	47 504 074		47 504 074	47.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	17, 524, 071		17, 524, 071	17.00
18.00	Ancillary services	54, 698, 797		349, 429, 614	
19.00	Outpati ent servi ces	C	-	0	19.00
20.00	RURAL HEALTH CLINIC	C	_	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		1 "	0 4F1 490	21. 00 22. 00
22. 00	HOME HEALTH AGENCY		451, 680	451, 680	
23. 00	AMBULANCE SERVICES				23.00
24. 00 25. 00					24. 00 25. 00
26. 00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE				26.00
27. 00	OTHER OUTPATIENT	0	12, 824, 505	12, 824, 505	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W	1		380, 229, 870	28.00
20.00	G-3, line 1)	72, 222, 600	300,007,002	300, 229, 070	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		115, 739, 024		29. 00
30.00	ADD (SPECIFY)	l c			30.00
31. 00		1 0			31.00
32. 00		l c	i		32.00
33. 00		l c			33.00
34.00		l c			34.00
35.00		l c			35.00
36.00	Total additions (sum of lines 30-35)		o		36.00
37.00	DEDUCT (SPECIFY)				37.00
38.00		c	i i		38.00
39.00		c)		39.00
40.00] c			40.00
41.00		c			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr	ansfer	115, 739, 024		43.00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAI	In lie	」of Form CMS-2	2552-10	
	IENT OF REVENUES AND EXPENSES	SOTINGON MEMORITAE	Provi der CCN: 15-0001	Peri od:	Worksheet G-3		
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/24/2023 9:3		
					1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part	l column 3 lin	a 28)		380, 229, 870	1, 00	
2.00	Less contractual allowances and discounts on		,		266, 044, 983	2.00	
3.00	Net patient revenues (line 1 minus line 2)	patrents account			114, 184, 887	3.00	
4. 00	Less total operating expenses (from Wkst. G-2	2 Part II line	43)		115, 739, 024		
5. 00	Net income from service to patients (line 3 m		10)		-1, 554, 137	5.00	
0.00	OTHER I NCOME				1,001,107	0.00	
6.00	Contributions, donations, bequests, etc				0	6.00	
7.00							
8.00	8.00 Revenues from telephone and other miscellaneous communication services						
9.00							
10.00	Purchase di scounts				0	10.00	
11.00	Rebates and refunds of expenses				0	11.00	
12.00	Parking Lot receipts				0	12.00	
13.00	Revenue from Laundry and Linen service				0	13.00	
14.00	Revenue from meals sold to employees and gues	sts			0	14.00	
15.00	Revenue from rental of living quarters				0	15.00	
16.00	Revenue from sale of medical and surgical sup	pplies to other t	han patients		0	16.00	
	Revenue from sale of drugs to other than pati				0	17.00	
18.00	Revenue from sale of medical records and abst	tracts			0	18.00	
	Tuition (fees, sale of textbooks, uniforms, e				0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, ar	nd canteen			0	20.00	
21. 00	Rental of vending machines				0	21.00	
22. 00	Rental of hospital space				0	22.00	
23.00	Governmental appropriations				0	23.00	
	OTHER OPERATING INCOME				595, 689		
	NON-OPERATING INCOME				586, 172		
	COVI D-19 PHE Fundi ng				420, 829		
	Total other income (sum of lines 6-24)				1, 602, 656		
26 00	Total (line 5 plus line 25)	//9 510	1 26 00				

48, 519

26.00 27. 00 28. 00 0 48, 519 29. 00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Heal th	Financial Systems		JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 15-0001	Period: From 01/01/2022	Worksheet H-1 Part I	
				HHA CCN:	15-7510	To 12/31/2022		pared:
						Home Health	PPS	7 alli
			Capital Rela	ated Costs	I	Agency I		
		_	·					
		Net Expenses for Cost	Bl dgs & Fi xtures	Movable Equipment	Plant Operation 8		Subtotal (cols. 0-4)	
		Allocation (from Wkst.			Maintenance	:		
		H, col. 10)				1.00	44.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	3.00	4. 00	4A. 00	
1. 00	Capital Related - Bldg. &	0	0				0	1.00
2. 00	Fixtures Capital Related - Movable	0		0			0	2.00
3. 00	Equipment Plant Operation & Maintenance		0	0	,	0	0	3.00
4. 00	Transportation	0	0	0		0 0	0	4.00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	309, 987	0	0)	0 0	309, 987	5.00
6. 00	Skilled Nursing Care	150, 136	0	0		0 0	150, 136	6.00
7. 00	Physical Therapy	143, 155	0	0	1	0 0	143, 155	1
8. 00 9. 00	Occupational Therapy Speech Pathology	72, 737	0	0	1	0 0	72, 737 0	
10.00	Medical Social Services	0	0	0		0 0	0	10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	42, 242 5, 025	0	0		0 0	-	11. 00 12. 00
13.00	Drugs	0	0	0		0	0	13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0)	0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0	•	0 0	0	15.00
16. 00 17. 00	Respiratory Therapy Private Duty Nursing	0	0	0	1	0 0	0	16. 00 17. 00
18. 00	Clinic	0	0	0	1	0 0	0	1
19.00	Health Promotion Activities	0	0	0	1	0 0	0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	
22. 00	Homemaker Service	0	0	0	1	0 0	0	
23. 00 23. 50	All Others (specify) Telemedicine	1, 489 0	0	0		0 0	1, 489 0	1
	Total (sum of lines 1-23)	724, 771	0	0	•	0 0	724, 771	1
		Administrativ e & General	Total (cols. 4A + 5)					
		5. 00	6. 00					
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment							2.00
3. 00	Plant Operation & Maintenance							3.00
4. 00 5. 00	Transportation Administrative and General	309, 987						4. 00 5. 00
	HHA REIMBURSABLE SERVICES							
6. 00 7. 00	Skilled Nursing Care Physical Therapy	112, 204 106, 986	262, 340 250, 141					6. 00 7. 00
8. 00	Occupational Therapy	54, 360	127, 097					8.00
9. 00 10. 00	Speech Pathology Medical Social Services	0	0					9. 00 10. 00
11. 00	Home Heal th Ai de	31, 569	73, 811					11.00
12.00	Supplies (see instructions)	3, 755	8, 780					12.00
13. 00 14. 00	Drugs DME	0 0	0					13. 00 14. 00
45.00	HHA NONREI MBURSABLE SERVI CES	1						1
15. 00 16. 00	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 00 16. 00
17. 00	Private Duty Nursing	0	0					17. 00
18. 00 19. 00	Clinic Health Promotion Activities	0	0					18. 00 19. 00
20.00	Day Care Program	0	0					20.00
21. 00 22. 00	Home Delivered Meals Program Homemaker Service	0	0					21. 00 22. 00
23. 00	All Others (specify)	1, 113	2, 602					23. 00
	Telemedicine Total (sum of lines 1-23)	0	0 724, 771					23. 50 24. 00
24.00	1.0tai (3am 01 111163 1-23)	I	124, 111					1 4.00

Heal th	Financial Systems		JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HHA STATISTICAL BAS	SIS		Provi der C		Peri od:	Worksheet H-1	
				HHA CCN:		From 01/01/2022 To 12/31/2022		
						Home Health	PPS	
						Agency I		
		Capital Rel	ated Costs					
		BI dgs &	Movabl e	PI ant	Transportation	Reconciliatio	Administrativ	
		Fi xtures	Equi pment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
		1. 00	2. 00	(SQUARE FEET) 3.00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	7.00	JA. 00	3.00	
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	l o	0			0		3. 00
4.00	Transportation (see	0	0	C		0		4.00
	instructions)							
5. 00	Administrative and General	0	0) C)	0 -309, 987	414, 784	5.00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	0) C	1	ol o	150, 136	6.00
7. 00	Physical Therapy		0			0 0	143, 155	
8. 00	Occupational Therapy	l o	0	Ö		o o	72, 737	
9.00	Speech Pathology	0	0	o c		0 0	0	9. 00
10.00	Medical Social Services	0	0) c		0 0	0	10.00
11. 00	Home Health Aide	0	0) C		0	42, 242	
12. 00	Supplies (see instructions)	0	0	C	1	0	5, 025	12.00
13.00	Drugs	0	0	1		0	0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0) <u> </u>)	0 0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0) c	1	0 0	0	15. 00
16. 00	Respiratory Therapy		0		1	0 0	0	
17. 00	Private Duty Nursing	l o	0	Ö		o o	ő	17. 00
18. 00	Clinic	0	0	o c		0 0	0	
19.00	Health Promotion Activities	0	0	C)	0 0	0	19. 00
20.00	Day Care Program	0	0	C		0 0	0	20.00
21. 00	Home Delivered Meals Program	0	0) C		0	0	21.00
22. 00	Homemaker Service	0	0	C	•	0	0	22.00
23. 00	All Others (specify)	0	0	<u> </u>	•	0	1, 489	
23. 50	Tel emedi ci ne		0			0 0	414 704	23.50
24. 00 25. 00	Total (sum of lines 1-23) Cost To Be Allocated (per		0		•	0 -309, 987	414, 784 309, 987	
25.00	Westernant II 1 Deset I)	١	U	1	Ί	9	307, 907	25.00

0.000000

0. 000000

0.000000

0.000000

0. 747346 26. 00

24.00 Total (sum of lines 1-23)
25.00 Cost To Be Allocated (per Worksheet H-1, Part I)
26.00 Unit Cost Multiplier

Peri od: Worksheet H-2
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/24/2023 9:39 am HHA CCN: 15-7510 Home Health PPS

						Agency I	PPS	
			CAPI TAL REL	ATED COSTS		Agency 1		
	Cost Center Description	HHA Trial	NEW BLDG &	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ON	DATA	
	cost center bescription	Bal ance (1)	FLXT	WVDLL LQ011	BENEFITS	S	PROCESSI NG	
					DEPARTMENT			
1 00	Administrative and Conoral	0	1. 00	2. 00	4.00	4. 01	4. 02 64, 223	1 00
1. 00 2. 00	Administrative and General Skilled Nursing Care	262, 340	,	91	135, 951	6, 450 0	04, 223	1. 00 2. 00
3. 00	Physical Therapy	250, 141	0	0	Č	o o	0	3.00
4.00	Occupational Therapy	127, 097	0	0	C	o	0	4.00
5.00	Speech Pathology	0	0	0	C	0	0	5.00
6.00	Medical Social Services	0	0	0	C	0	0	6.00
7. 00	Home Heal th Aide	73, 811	0	0		0	0	7.00
8. 00 9. 00	Supplies (see instructions) Drugs	8, 780	0	0			0	8. 00 9. 00
10.00	DME	o o	0	0	Č	o o	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	C	o	0	11.00
12.00	Respiratory Therapy	0	0	0	_	_	0	12.00
13. 00 14. 00	Private Duty Nursing	0	0	0		=	0	13. 00 14. 00
15. 00	Health Promotion Activities	0	0	0		-	0	15. 00
16.00	Day Care Program	0	0	0	C	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	C	0	0	17. 00
18.00	Homemaker Service	0	0	0	C	0	0	18.00
19. 00 19. 50	All Others (specify) Telemedicine	2, 602	0	0		0	0	19. 00 19. 50
20. 00	Total (sum of lines 1-19) (2)	724, 771	15, 814	91	135, 951	6, 450	64, 223	
21. 00	Unit Cost Multiplier: column		., .					21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	I and the second							
	6 decimal places. Cost Center Description	MATERI ALS	ADMI TTI NG	PATI ENT	Subtotal	ADMI NI STRATI V	OPERATION OF	
	6 decimal places.	MANAGEMENT		ACCOUNTI NG		E & GENERAL	PLANT	
1.00	6 decimal places.		ADMI TTI NG 4. 04 1, 848		Subtotal 4A. 05 227, 589	E & GENERAL 5.00		1.00
2.00	6 decimal places. Cost Center Description Administrative and General Skilled Nursing Care	MANAGEMENT 4. 03	4. 04 1, 848 0	4. 05 2, 903 0	4A. 05 227, 589 262, 340	E & GENERAL 5.00 10,709 12,345	PLANT 7. 00 40, 689 0	2.00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0	4. 05 2, 903 0	4A. 05 227, 589 262, 340 250, 141	E & GENERAL 5. 00 10, 709 12, 345 11, 770	PLANT 7. 00 40, 689 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	MANAGEMENT 4. 03 309	4. 04 1, 848 0	4. 05 2, 903 0 0	4A. 05 227, 589 262, 340	E & GENERAL 5. 00 10, 709 12, 345 11, 770	PLANT 7. 00 40, 689 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0	4. 05 2, 903 0	4A. 05 227, 589 262, 340 250, 141	E & GENERAL 5. 00 10, 709 12, 345 11, 770	PLANT 7. 00 40, 689 0 0	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0	4.05 2,903 0 0	4A. 05 227, 589 262, 340 250, 141	E & GENERAL 5. 00 10, 709 12, 345 11, 770 5, 980 0	PLANT 7. 00 40, 689 0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0 0 0 0 0 0	4. 05 2, 903 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097	E & GENERAL 5. 00 10, 709 12, 345 11, 770 5, 980 0 0 3, 473	PLANT 7. 00 40, 689 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0 0 0 0 0 0 0	4. 05 2, 903 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0	E & GENERAL 5. 00 10, 709 12, 345 11, 770 5, 980 0 0 3, 473	PLANT 7. 00 40, 689 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0 0 0 0 0 0 0	4. 05 2, 903 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0	E & GENERAL 5. 00 10, 709 12, 345 11, 770 5, 980 0 0 3, 473	PLANT 7. 00 40, 689 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0 0 0 0 0 0 0	4. 05 2, 903 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0	E & GENERAL 5. 00 10, 709 12, 345 11, 770 5, 980 0 0 3, 473	PLANT 7. 00 40, 689 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0	E & GENERAL 5. 00 10, 709 12, 345 11, 770 5, 980 0 0 3, 473	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0	E & GENERAL 5. 00 10, 709 12, 345 11, 770 5, 980 0 0 3, 473	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	MANAGEMENT 4. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0 73, 811 8, 780 0 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 0 0 0 0	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	MANAGEMENT 4. 03 309	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 0 0 0 0	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 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	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	MANAGEMENT 4. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0 73, 811 8, 780 0 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 0 0 0 0	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	MANAGEMENT 4. 03 0 0 0 0 0 0 0 0 0 0 0 0	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0 73, 811 8, 780 0 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	MANAGEMENT 4. 03 309 0 0 0 0 0 0 0 0 0 0 0 0	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0 73, 811 8, 780 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 1 122	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	MANAGEMENT 4. 03 0 0 0 0 0 0 0 0 0 0 0 0	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 73, 811 8, 780 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 1 122 0 44,812	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	MANAGEMENT 4. 03 309 0 0 0 0 0 0 0 0 0 0 0 0	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 0 73, 811 8, 780 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 1 122 0 44,812	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	MANAGEMENT 4. 03 309 0 0 0 0 0 0 0 0 0 0 0 0	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 73, 811 8, 780 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 1 122 0 44,812	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	MANAGEMENT 4. 03 309 0 0 0 0 0 0 0 0 0 0 0 0	4. 04 1, 848 0 0 0 0 0 0 0 0 0 0 0 0 0	ACCOUNTI NG 4. 05 2, 903 0 0 0 0 0 0 0 0 0 0 0 0	4A. 05 227, 589 262, 340 250, 141 127, 097 73, 811 8, 780 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	E & GENERAL 5.00 10,709 12,345 11,770 5,980 0 3,473 413 0 0 0 0 0 0 0 0 1 122 0 44,812	PLANT 7.00 40,689 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50 20. 00

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

							5/24/2023 9:3	/ uiii
						Home Health Agency I	PPS	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	
		8. 00	9. 00	10. 00	11.00	13. 00	14.00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	8. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9.00 8,972 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11.00 16,542		0 0 0 0 0 0 0 0 0	5. 00 6. 00 7. 00 8. 00
	column 26, fine 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &	Subtotal	Allocated HHA	
	·		RECORDS & LI BRARY		Residents Cost & Post Stepdown Adjustments		A&G (see Part II)	
		15. 00	16. 00	24. 00	25. 00	26. 00	27. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 790 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	306, 291 274, 685 261, 911 133, 077 0 77, 284 9, 193 0 0 0 0 0 0 0 0 0 0 2, 724 0 1, 065, 165		274, 685 261, 911 133, 077 0 0 77, 284 9, 193 0 0 0 0 0 0 0 0 0 0 0 0 0	105, 710 53, 711 0 0 31, 193 3, 710 0 0 0 0 0 0 0 1, 099	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00

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

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HHA CO	ST CENTERS	Provi der	CCN: 15-0001	Peri od: From 01/01/2022	Worksheet H-2 Part I
		HHA CCN:	15-7510	To 12/31/2022	Date/Time Prepared: 5/24/2023 9:39 am
				Home Health	PPS

				Agency I	
	Cost Center Description	Total HHA			
		Costs			
	,	28. 00			
1.00	Administrative and General				1.00
2.00	Skilled Nursing Care	385, 553			2.00
3.00	Physi cal Therapy	367, 621			3.00
4.00	Occupational Therapy	186, 788			4.00
5.00	Speech Pathology	0			5.00
6.00	Medical Social Services	0			6.00
7.00	Home Health Aide	108, 477			7. 00
8.00	Supplies (see instructions)	12, 903			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	Health 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)	3, 823			19. 00
19. 50	Tel emedi ci ne	0			19. 50
20.00	Total (sum of lines 1-19) (2)	1, 065, 165			20.00
21. 00	Unit Cost Multiplier: column				21. 00
	26, line 1 divided by the sum				
	of column 26, line 20 minus				
	column 26, line 1, rounded to				
	6 decimal places.				

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

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO	O HHA COST CENTERS STATISTICAL	Provider CCN: 15-0001	Peri od:	Worksheet H-2
BASIS			From 01/01/2022	Part II
		HHA CCN: 15-7510	To 12/31/2022	Date/Time Prepared:
				5/24/2023 9:39 am
•				550

					Home Health Agency I	PPS	<u> </u>
	CAPITAL REL	ATED COSTS			rigono y r		
Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI ON S (# NON PT PHONES)	DATA PROCESSI NG (WORK ORDERS)	MATERIALS MANAGEMENT (SUPPLY USAGE)	
	1. 00	2. 00	4. 00	4. 01	4. 02	4. 03	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description	1, 305 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	591, 206 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23 0 0 0 0 0 0 0 0 0 0 0 0 0	35 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 237 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.50 20.00 21.00
	4.04	CHARGES)	5A	COST)	7 00	LAUNDRY)	
1.00 Administrative and General 2.00 Skilled Nursing Care 3.00 Physical Therapy 4.00 Occupational Therapy 5.00 Speech Pathology 6.00 Medical Social Services 7.00 Home Health Aide 8.00 Supplies (see instructions) 9.00 Drugs 10.00 DME 11.00 Home Dialysis Aide Services 12.00 Respiratory Therapy 13.00 Private Duty Nursing 14.00 Clinic 15.00 Health Promotion Activities 16.00 Day Care Program 17.00 Home Delivered Meals Program 18.00 Homemaker Service 19.00 All Others (specify) 19.50 Telemedicine 20.00 Total (sum of lines 1-19) 21.00 Total cost to be allocated 22.00 Unit cost multiplier	4. 04 451, 680 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 05 451, 680 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	262, 340 250, 141 127, 097 0 0 73, 811 8, 780 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00 21. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS		Period: Worksheet H-2 From 01/01/2022 Part II
BASI S	HHA CCN: 15-7510	To 12/31/2022 Date/Time Prepared:

Part II Date/Time Prepared: 5/24/2023 9:39 am HHA CCN: 15-7510 Home Health PPS Agency I HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL PHARMACY Cost Center Description (MEALS (HOURS SERVICES & (SQUARE FEET) ADMI NI STRATI O (COSTED SERVED) REQUIS.) PAID) **SUPPLY** N (DI RECT (COSTED NRSING HRS) REQUIS.) 10.00 11. 00 9. 00 13.00 14. 00 15.00 Administrative and General 1.00 1, 305 00 14, 583 0 0 1.00 2.00 Skilled Nursing Care 2.00 3.00 Physical Therapy 0 0 3.00 000000000000000000 0 0 0 4.00 Occupational Therapy 0 0 0 4.00 Speech Pathology 0 0 5.00 5.00 6.00 Medical Social Services 0 6.00 7.00 Home Health Aide 0 0 0 0 0 0 0 0 0 0 7.00 0 8.00 0 8.00 Supplies (see instructions) 0 0 9.00 Drugs 9.00 10.00 DMF 0 10.00 0 11.00 Home Dialysis Aide Services 0 0 0 0 11.00 0 12.00 Respiratory Therapy 0 12 00 13.00 Private Duty Nursing 0 13.00 14.00 Clinic 0 0 0 0 14.00 Health Promotion Activities 15.00 0 0 15.00 0 16.00 0 16.00 Day Care Program 17.00 Home Delivered Meals Program 0 17.00 Homemaker Service 0 0 o 18.00 0 18.00 All Others (specify) 0 0 0 19 00 0 ol 19 00 0 0 0 0 19.50 Tel emedi ci ne C 19.50 20.00 Total (sum of lines 1-19) 1, 305 0 14, 583 0 20.00 21.00 Total cost to be allocated 8,972 0 16, 542 0 0 21.00 0.000000 0.000000 0.000000 Unit cost multiplier 6.875096 1.134334 0.000000 22.00 22.00 Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 1.00 Administrative and General 451, 680 1.00 2.00 Skilled Nursing Care 2.00 0 3.00 Physi cal Therapy 3 00 4.00 Occupational Therapy 4.00 Speech Pathology 5.00 5.00 6.00 Medical Social Services 0 0 0 6.00 7.00 Home Health Aide 7.00 8.00 Supplies (see instructions) 8.00 9.00 0 0 0 0 0 9.00 Drugs 10.00 DMF 10.00 11.00 Home Dialysis Aide Services 11.00 Respiratory Therapy 12.00 12.00 Private Duty Nursing 13.00 13.00 14.00 Clinic 14.00 15.00 Health Promotion Activities 15.00 Day Care Program 0 0 0 16.00 16.00 17.00 Home Delivered Meals Program 17.00 18 00 Homemaker Service 18.00 19.00 All Others (specify) 0 19.00 0 19.50 Tel emedi ci ne 19.50 451, 680 20.00 20.00 Total (sum of lines 1-19) 1, 790 21.00 Total cost to be allocated 21.00 22.00 Unit cost multiplier 0.003963 22.00

Heal th	Financial Systems		JOHNSON MEMOR	I AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2022 To 12/31/2022		pared: 9 am
				Title	: 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	Wkst. H-2,	Costs (from	1 + 2)		(col. 3 ÷	
		0	Part I) 1.00	Part II) 2.00	3.00	4. 00	col . 4) 5.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION	OI AGGREGATE	FROGRAM COST, I	AGGREGATE OF T	IL FROGRAM LIT	WITATION COST, C	DR DENETTCIANT	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	385, 553		385, 55	3 956	403. 30	1.00
2.00	Physical Therapy	3.00					320. 79	2.00
3.00	Occupational Therapy	4.00	186, 788	0	186, 78	8 762	245. 13	3.00
4.00	Speech Pathology	5.00	0	0		0	0.00	4.00
5.00	Medical Social Services	6.00	0			0	0.00	5.00
6.00	Home Health Aide	7.00	108, 477		108, 47	7 36	3, 013. 25	6.00
7.00	Total (sum of lines 1-6)		1, 048, 439		., 0.0, .0			7.00
					Program Visit	S		
			ı					
						rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subj ect to		
					to	Deductibles		
					Deductibles 8	4		
		0	1. 00	2. 00	Coi nsurance 3.00	4. 00	5. 00	
	Limitation Cost Computation] 0	1.00	2.00	3.00	4.00	5.00	
8. 00	Skilled Nursing Care		18020	0	29	1		8. 00
9. 00	Physical Therapy		18020					9. 00
10.00	Occupational Therapy		18020		23			10.00
11. 00	Speech Pathology		18020	0		ō		11.00
12. 00	Medical Social Services		18020	0	•	Ö		12.00
13.00	Home Health Aide		18020	0	1	1		13.00
14.00	Total (sum of lines 8-13)			0	88	3		14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHA	÷ col. 4)	
		col. 28, line	Wkst. H-2,	Costs (from	1 + 2)	Records)		
		_	Part I)	Part II)				
		0	1. 00	2.00	3. 00	4. 00	5. 00	
15 00	Supplies and Drugs Cost Comput		12.002	1	12.00	2 0	0.000000	15 00
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00				3 0		
16.00	Cost of brugs		Program Visits		Cost of	0	0.000000	16.00
			riogiam visits		Servi ces			
			Par	t B	001 VI 003	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	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF TI	HE PROGRAM LII	MITATION COST, (OR BENEFICIARY	
	COST LIMITATION							
	Cost Per Visit Computation	1						
1. 00	Skilled Nursing Care	0				0 117, 360		1.00
2. 00	Physical Therapy	0				0 111, 956		2. 00
3.00	Occupational Therapy	0	232		1	0 56, 870	1	3.00
4.00	Speech Pathology	0	0		1	0		4.00
5.00	Medical Social Services	0	0		1	0 0		5.00
6. 00	Home Health Aide	0	11	l .	•	0 33, 146		6.00
7. 00	Total (sum of lines 1-6)	ı 0	883	1	I	0 319, 332	1	7. 00

Heal th	Financial Systems		JOHNSON MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	TIONMENT OF PATIENT SERVICE COST	ΓS		Provider CO	CN: 15-0001 15-7510	Period: From 01/01/2022 To 12/31/2022	Worksheet H-3 Part I Date/Time Pre 5/24/2023 9:3	pared:
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	0.00	7.00	0.00	9.00	10.00	11.00	
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 8-13)							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
		Progi	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance 7.00	t B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Supplies and Drugs Cost Comput		7.00	0.00	7.00	10.00	11.00	
15. 00 16. 00		0	0			0 0		
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER COST LIMITATION Cost Per Visit Computation		PROGRAM COST, A	AGGREGATE OF TH	HE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	117, 360 111, 956 56, 870 0 33, 146 319, 332						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Cost Center Description	12. 00						
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Limitation Cost Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 8-13)							8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00

Heal th	Financial Systems		JOHNSON MEMORI	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COS	ΓS		Provi der C		Peri od:	Worksheet H-3	
				HHA CCN:	15-7510	From 01/01/2022 To 12/31/2022	Date/Time Pre	
							5/24/2023 9: 3	9 am
						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 FURNISHED E	BY SHARED HOSP	TAL DEPARTME	NTS		
1.00	Physi cal Therapy	66.00	0. 374337	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 378886	0		0 col. 2, line 3	. 00	2.00
3.00	Speech Pathology	68.00	0. 398814	0		0 col. 2, line 4	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 215633	0		0 col. 2, line 1	5. 00	4.00
5.00	Cost of Drugs	73.00	0. 304092	0		0 col. 2, line 1	6. 00	5.00

	Financial Systems JOHNSON MEMORIA ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0001	Peri od:	eu of Form CMS-2 Worksheet H-4	
LOUL	THE STATE OF THE REPORT OF THE STATE OF THE	HHA CCN:	15-7510	From 01/01/202 To 12/31/202	2 Part I-II	pare
		Title	XVIII	Home Health Agency I	PPS	i alli
			D I. A	Pa	irt B	
			Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			1. 00	2. 00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUS	STOMARY CHARGE	S			
00	Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions)			0	0 0	1.
00	Total charges					1
	Customary Charges					
00	Amount actually collected from patients liable for payment f	for services		0	0 0	3.
00	on a charge basis (from your records) Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in			0	0 0	4.
	with 42 CFR §413.13(b)					
00 00	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0. 0000		l .	
)O	Excess of total customary charges over total reasonable cost	t (complete			0 0	
	only if line 6 exceeds line 1)	(00р. 010				
00	Excess of reasonable cost over customary charges (complete of 1 exceeds line 6)	only if line			0	
00	Primary payer amounts			0 Part A	0 0 Part B	9
				Servi ces	Servi ces	
				1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					١.,
00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers				0 0 235, 701	
00	Total PPS Reimbursement - Full Episodes without outliers				0 233, 701	1
00	Total PPS Reimbursement - LUPA Episodes				0 2, 820	
00	Total PPS Reimbursement - PEP Episodes				0 0	14
00	Total PPS Outlier Reimbursement - Full Episodes with Outlier	^S			0	
00	Total PPS Outlier Reimbursement - PEP Episodes				0	
00	Total Other Payments				0	
00	DME Payments				0	
00	Oxygen Payments Prosthetic and Orthotic Payments				0 0	
00	Part B deductibles billed to Medicare patients (exclude coir	nsurance)				1
00	Subtotal (sum of lines 10 thru 20 minus line 21)	isar arice)			0 238, 521	
00	Excess reasonable cost (from line 8)				0 0	1
00	Subtotal (line 22 minus line 23)				0 238, 521	24
00	Coinsurance billed to program patients (from your records)				0	25
	Net cost (line 24 minus line 25)				0 238, 521	
	Allowable bad debts (from your records)				0	
. 01	Adjusted reimbursable bad debts (see instructions)				0	
00	Allowable bad debts for dual eligible (see instructions)	>			0	
00	Total costs - current cost reporting period (see instruction OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	15)			0 238, 521 0 0	1
50	Pioneer ACO demonstration payment adjustment (see instruction	nns)				
99	Demonstration payment adjustment amount before sequestration					
00	Subtotal (see instructions)				0 238, 521	
01	Sequestration adjustment (see instructions)				0 3,675	
. 02	Demonstration payment adjustment amount after sequestration				0 0	1
. 75	Sequestration adjustment for non-claims based amounts (see i	nstructions)			0 0	
. 00	Interim payments (see instructions)				0 234, 846	32
. 00	Tentative settlement (for contractor use only)				0 0	
	Palance due provider/program (Line 21 minus Lines 21 01 21	02 31 75 33	and 33)		ol o	34
. 00 . 00	Balance due provider/program (line 31 minus lines 31.01, 31. Protested amounts (nonallowable cost report items) in accord				ol o	

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED TO PROGRAM BENEFICIARIES	HHAS FOR SERVICES RENDERED	Provider CCN:	: 15-0001	Peri od: From 01/01/2022	Worksheet H-5
TO FROGRAM BENEFICITATIVES		HHA CCN:	15-7510		Date/Time Prepared: 5/24/2023 9:39 am
				Home Health	PPS

					5/24/2023 9: 3	9 am
				Home Health	PPS	
		1	1. D 1. A	Agency I	1.0	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider			0	234, 846	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	i rogi alli to i rovi dei			0	0	3. 01
3. 02				o	0	3. 02
3. 03				O	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50				0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 54 3. 99
3. 99	3. 50-3. 98)			U .	ا	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)			0	234, 846	4.00
1. 00	(transfer to Wkst. H-4, Part II, column as appropriate,				201,010	1.00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	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)					
г 01	Program to Provider					F 01
5. 01 5. 02				0	0	5. 0° 5. 0°
5. 02				0		5. 02
5. 05	Provider to Program			<u> </u>		3.00
5. 50				0	0	5. 50
5. 51				O	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
<i>(</i> 01	the cost report. (1)					4 00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	6. 0° 6. 02
7. 00	Total Medicare program liability (see instructions)			0	234, 846	7.00
7.00	Trotal modicale program trabitity (see thistructions)			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

CALCULATI	ON OF CAPITAL PAYMENT	Provider CCN: 15-0001	Peri od: From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/24/2023 9:3	
		Title XVIII	Hospi tal	PPS	,, (1111
DAI	RT I - FULLY PROSPECTIVE METHOD			1. 00	
	PITAL FEDERAL AMOUNT				1
	pital DRG other than outlier			325, 890	1.0
	del 4 BPCI Capital DRG other than outlier			0	1
2.00 Ca	pital DRG outlier payments			7, 569	2.0
2. 01 Mo	del 4 BPCI Capital DRG outlier payments			0	2.0
4	ital inpatient days divided by number of days in the c	cost reporting period (see ins	structions)	19. 20	
	mber of interns & residents (see instructions)			0. 00	1
	direct medical education percentage (see instructions	,	1!	0.00	
	direct medical education adjustment (multiply line 5 01)(see instructions)	by the sum of lines I and I.C)i, columns i and	0	6.
	ercentage of SSI recipient patient days to Medicare Pa	art A patient days (Worksheet	E. part A line	0.00	7.
) (see instructions)	, , , , , , , , , , , , , , , , , , , ,	, ,		
	rcentage of Medicaid patient days to total days (see	instructions)		0.00	
	m of lines 7 and 8			0. 00	1
	lowable disproportionate share percentage (see instru	uctions)		0.00	
	sproporti onate share adjustment (see instructions)			0	1
2. 00 To	tal prospective capital payments (see instructions)			333, 459	12.
				1. 00	
PAF	RT II - PAYMENT UNDER REASONABLE COST				
	ogram inpatient routine capital cost (see instruction			0	
	ogram inpatient ancillary capital cost (see instructi			0	
	tal inpatient program capital cost (line 1 plus line	2)		0	
	pital cost payment factor (see instructions) tal inpatient program capital cost (line 3 x line 4)			0	1
1.00 110	tal impatrent program capital cost (iiiie 3 x iiiie 4)			0	J.
				1. 00	
	RT III - COMPUTATION OF EXCEPTION PAYMENTS			_	١.
	ogram inpatient capital costs (see instructions)			0	
	ogram inpatient capital costs for extraordinary circu et program inpatient capital costs (line 1 minus line			0	1
	uplicable exception percentage (see instructions)	2)		0. 00	
	pital cost for comparison to payments (line 3 x line	4)		0.00	1
	rcentage adjustment for extraordinary circumstances (,		0.00	
	ljustment to capital minimum payment level for extraor		x line 6)	0	
	pital minimum payment level (line 5 plus line 7)	,	·	0	8.
	irrent year capital payments (from Part I, line 12, as			0	1
	rrent year comparison of capital minimum payment leve			0	
	rryover of accumulated capital minimum payment level	over capital payment (from pr	ri or year	0	11.
	orksheet L, Part III, line 14) et comparison of capital minimum payment level to capi	tal navments (line 10 plus li	ne 11)	0	12.
Z. OU INC	rrent year exception payment (if line 12 is positive,	1 3 1	,	0	
13 00 Cu	rryover of accumulated capital minimum payment level			0	
				l	1
4.00 Ca	fline 12 is negative, enter the amount on this line)				1
14.00 Ca	fline 12 is negative, enter the amount on this line) arrent year allowable operating and capital payment (s			0	15.
4. 00 Ca (i 5. 00 Cu 6. 00 Cu	5 ,	see instructions) ons)		0	16.