Heal th Financial	l Systems	JOHNSON MEMORIAL H	IOSPI TAL	In Lieu	」 of Form CMS-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	re to report can res	ult in all interim	FORM APPROVED
payments made s	ince the beginning of the cost	reporting period being d	eemed overpayments (42 USC 1395g).	OMB NO. 0938-0050
AND SETTLEMENT		T REPORT CERTIFICATION	Provider CCN: 15000	From 01/01/2014	Worksheet S Parts I-III Date/Time Prepared: 5/21/2015 1:31 pm
PART I - COST R	REPORT STATUS				
Provi der	 [X] Electronically filed co 	ost report		Date: 5/21/201	15 Time: 1:31 pm
use only	 [] Manually submitted cost 	report			
	3.[0] f this is an amended r 4.[F]Medicare Utilization. E			resubmitted this co	ost report
Contractor ! use only	 (1) As Submitted (2) Settled without Audit 8. 	Date Received: Contractor No. [N]Initial Report for [N]Final Report for th	this Provider CCN 12		or Code: 4 lumn 1 is 4: Enter es reopened = 0-9.
PART II – CERTI					
ADMI NI STRATI VE PROVI DED OR PRO	ON OR FALSIFICATION OF ANY INF ACTION, FINE AND/OR IMPRISONME CURED THROUGH THE PAYMENT DIRE ACTION, FINES AND/OR IMPRISONM	NT UNDER FEDERAL LAW. FU CTLY OR INDIRECTLY OF A K	RTHERMORE, IF SERVIC	ES IDENTIFIED IN TH	IS REPORT WERE
	CERTIFICATION BY OFFICER OR	ADMINISTRATOR OF PROVIDER	(S)		

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHNSON MEMORIAL HOSPITAL (150001) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

			Date				
			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	34, 467	-76, 016	12, 739	152, 184	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	26, 707	-3		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	61, 174	-76, 019	12, 739	152, 184	200. 00

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

Title

Officer or Administrator of Provider(s)

						From 01/01/ To 12/31/	2014		ime Pre	
	1.00	2.0	00	3.00			4.00	5/21/20	015 1:2	29 pm
00	Hospital and Hospital Health Care Co Street: 1125 WEST JEFFERSON STREET	PO Box:								1.0
20	City: FRANKLIN	State: IN		ode: 4613		nty: JOHNSON				2. (
		Component Nam	ne CCN Numbe	r CBSA		er Date Certified		nt Syst 0, or		
			Numbe	i indilibe	Турс	Gertiffed	V	XVIII		1
	Hospital and Hospital-Based Componer	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospi tal	JOHNSON MEMORIAL	15000	1 99915	5 1	07/01/1966	N	P	0	3.
00	Subprovider - IPF	HOSPI TAL								4.
00	Subprovider - IRF	TODD AIKENS REHAB	15T00	1 99915	5 5	01/01/2005	N	P	0	5.
20	Subaravidar (Other)	CENTER								
00 00	Subprovider - (Other) Swing Beds - SNF									6.
00	Swing Beds - NF									8.
00	Hospital -Based SNF									9.
. 00 . 00	Hospi tal -Based NF Hospi tal -Based OLTC									111.
. 00	Hospital-Based HHA	JOHNSON MEMORIAL H	HOME 15751	0 99915	5	07/01/1997	N	P	N	12.
00	Separately Certified ASC	HEALTH								13.
. 00	Hospi tal -Based Hospi ce									14.
. 00	Hospital-Based Health Clinic - RHC									15.
00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16.
00	Renal Dialysis									18.
00	Other					 From:		Tc)·	19.
						1.00		2.	00	
00 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/2	014 9	12/31	/2014	20.
00	Inpatient PPS Information						7			21.
00	Does this facility qualify and is it							Ν	l	22.
	share hospital adjustment, in accord	iance with 42 CFR §								
	for ves or "N" for no. Is this facil	ity subject to 42								
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, er	iter "Y" for yes or	CFR Section §	§412.06(c)) (2) (Pi ckl	e				
01	amendment hospital?) In column 2, er Did this hospital receive interim ur	iter "Y" for yes or acompensated care p	CFR Section § "N" for no. ayments for 1	§412.06(c))(2)(Pickl reporting	e		Ŷ	,	22.
01	amendment hospital?) In column 2, er	nter "Y" for yes or acompensated care p ves or "N" for no f	CFR Section § "N" for no. ayments for f or the portic	\$412.06(c) this cost on of the)(2)(Pickl reporting cost	e		Ŷ	/	22.
01	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r	nter "Y" for yes or ncompensated care p ves or "N" for no f October 1. Enter i	CFR Section § "N" for no. ayments for f for the portion n column 2, '	\$412.06(c) this cost on of the 'Y" for ye)(2)(Pickl reporting cost es or "N"	e		Y	,	22.
	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to	nter "Y" for yes or compensated care p res or "N" for no f October 1. Enter i reporting period oc	CFR Section § "N" for no. ayments for f for the portion n column 2, " courring on or	\$412.06(c) this cost on of the 'Y" for ye r after Oc)(2)(Pickl reporting cost es or "N" ctober 1.	e Y		Ŷ		
	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc c requires final un c? (see instruction	CFR Section § "N" for no. ayments for for for the portion n column 2, " courring on or compensated on s) Enter in o	\$412.06(c) this cost on of the 'Y" for ye after Oc care payme column 1,)(2)(Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y	e Y Y es N				
	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction ne cost reporting p	CFR Section § "N" for no. ayments for for for the portion n column 2, ' courring on or compensated of s) Enter in of period prior f	\$412.06(c) this cost on of the 'Y" for ye after 00 care paymo column 1, to October)(2)(Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter	e Y Y es				
	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction ne cost reporting p	CFR Section § "N" for no. ayments for for for the portion n column 2, ' courring on or compensated of s) Enter in of period prior f	\$412.06(c) this cost on of the 'Y" for ye after 00 care paymo column 1, to October)(2)(Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter	e Y Y es				
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction the cost reporting p no, for the portion nic reclassificatio	CFR Section § "N" for no. ayments for for for the portion n column 2, ' courring on or compensated of s) Enter in or eeriod prior for on of the cost	\$412.06(c) this cost on of the 'Y" for ye - after Oc care payme column 1, to October t reportin to rural) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu	e Y N es on It N			l	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1.	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un recost reporting p no, for the portio of c reclassificatio statistical areas	CFR Section § "N" for no. ayments for for for the portion n column 2, " courring on or compensated of s) Enter in of the cost on of the cost on from urban adopted by (\$412.06(c) this cost on of the 'Y" for ye cafter 0e care payme column 1, to 0ctober t reportin to rural CMS in FY2) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente	e Y N es on It N		Ν	l	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un recost reporting p no, for the portion of creclassification statistical areas no for the portion 2, "Y" for yes or	CFR Section § "N" for no. ayments for for for the portion n column 2, ' curring on or compensated of s) Enter in of eriod prior i n of the cost adopted by (of the cost "N" for no for	5412.06(c) this cost on of the Y" for ye after of care payme column 1, to October t reportin CMS in FY2 reporting or the poi) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t	e Y es N on It N		Ν	l	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un recost reporting p no, for the portion statistical areas no for the portion 2, "Y" for yes or after October 1.	CFR Section § "N" for no. ayments for for for the portion n column 2, ' curring on or compensated of so Enter in or eriod prior f n of the cost adopted by G of the cost "N" for no for (see instruct	5412.06(c) this cost on of the Y" for yu after O care paymm column 1, to Octobe t reportin to rural CMS in FY2 or the poi ctions) Do) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t poes this	e Y N es N It N he		Ν	l	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction the cost reporting p no, for the portion of creclassification statistical areas no for the portion 2, "Y" for yes or or after October 1. the more than 499 be "Y" for yes or "N"	CFR Section § "N" for no. ayments for for for the portion n column 2, ' courring on or compensated of so Enter in or eriod prior for on of the cost "N" for no for (see instructed for no.	s412.06(c) this cost on of the Y" for ye after Oc care payme column 1, to Octobe t reportin to rural CMS in FY2 reporting or the poi ctions) De ed in acce) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t toes this ordance wi	e Y es N on It N r he th		N	1	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un recost reporting p no, for the portion of creclassification statistical areas no for the portion 2, "Y" for yes or or after October 1. ot more than 499 be "Y" for yes or "N" edicaid days on lin	CFR Section § "N" for no. ayments for for for the portion n column 2, " courring on or compensated of s) Enter in of the cost on of the cost "N" for no for (see instructed for no. the 24 and/or	stantistic sector secto) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t poes this ordance wi ? In colum	e Y es N on It N r he th	2	Ν	1	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Met 1, enter 1 if date of admission, 2 i method of identifying the days in th	hter "Y" for yes or a compensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un recost reporting p no, for the portion of the portion c reclassification statistical areas no for the portion 2, "Y" for yes or after October 1. the more than 499 be "Y" for yes or "N" redicaid days on lin f census days, or nis cost reporting	CFR Section § "N" for no. ayments for for for the portion n column 2, ' curring on or ecompensated of so Enter in or eriod prior for n of the cost "N" for no for (see instruct ds (as counter for no. ues 24 and/or 3 if date of period differ	5412.06(c) this cost on of the Y" for ye after 0 care payme column 1, to 0ctobe t reportin DMS in FYZ reporting or the poi ctions) Do ed in acco 25 below discharge rent from) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t boes this ordance wi ? In colum the metho	e Y es N on It N he th d	2	N	1	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un requires final un recost reporting p no, for the portio nic reclassificatio statistical areas no for the portion 2, "Y" for yes or rafter October 1. to more than 499 be "Y" for yes or "N" dicaid days on lin f census days, or nis cost reporting riod? In column 2,	CFR Section § "N" for no. ayments for to for the portion n column 2, " courring on or compensated of seriod prior to n of the cost "N" for no for (see instruct ds (as counted for no. es 24 and/or 3 if date of period differ enter "Y" for	5412.06(c) this cost on of the Y" for ye after Oc care payme column 1, to October t reportin to rural CMS in FY2 reporting cor the poi ctions) Do ed in acco 25 below discharge rent from or yes or) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t bordance wi ? In colum e. Is the the metho <u>"N" for n</u>	e Y es N on It N r he th n d		N	1	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Met 1, enter 1 if date of admission, 2 i method of identifying the days in th	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction le cost reporting p no, for the portion of creclassification statistical areas no for the portion 2, "Y" for yes or or after October 1. the more than 499 be "Y" for yes or "N" edicaid days on lin f census days, or ais cost reporting iod? In column 2,	CFR Section § "N" for no. ayments for for for the portion n column 2, ' courring on or compensated of so Enter in or eriod prior for on of the cost "N" for no for (see instruct do for no. les 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me	5412.06(c) this cost on of the Y" for ye - after Oc care payme column 1, to Octobee t reportin to rural CMS in FY2 reporting or the poi ctions) De d in acce 25 below discharge cent from or yes or -State dicaid) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t cos this ordance wi ? In colum the metho "N" for n Out-of State	e Y es N on It N r he th n d o. Out-of M State H	2 Nedi cai M0 day	N N d 0	1	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Met 1, enter 1 if date of admission, 2 i method of identifying the days in th	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction le cost reporting p no, for the portion of creclassification statistical areas no for the portion 2, "Y" for yes or or after October 1. the more than 499 be "Y" for yes or "N" edicaid days on lin f census days, or ais cost reporting iod? In column 2,	CFR Section § "N" for no. ayments for to for the portion n column 2, ' curring on or compensated of so Enter in of the cost on of the cost adopted by (of the cost "N" for no for (see instruct do f the cost "N" for no for (see instruct for no. les 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me coald days el	3412.06(c) this cost on of the Y" for ye r after 0 care payme column 1, to October t reportin to rural CMS in FY2 reporting or the poi ctions) Due d in acco 25 below d ischarge rent from or yes or -State d i cai d i gible) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t oes this ordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid	es Y N es N on N I t N r he N th h th o. Out-of N State H Medicaid	ledi cai	N N d 0 rs Med	ı ı ther	22.
02	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Met 1, enter 1 if date of admission, 2 i method of identifying the days in th	nter "Y" for yes or acompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction le cost reporting p no, for the portion of creclassification statistical areas no for the portion 2, "Y" for yes or or after October 1. the more than 499 be "Y" for yes or "N" edicaid days on lin f census days, or ais cost reporting iod? In column 2,	CFR Section § "N" for no. ayments for for for the portion n column 2, ' curring on or compensated of s) Enter in or eriod prior in of the cost "N" for no for (see instruct ds (as counter for no. les 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el	3412.06(c) this cost on of the Y" for ye r after 0 care payme column 1, to October t reportin to rural CMS in FY2 reporting or the poi ctions) Due d in acco 25 below d ischarge rent from or yes or -State d i cai d i gible) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t cos this ordance wi ? In colum the metho "N" for n Out-of State	e Y es N on It N r he th n d o. Out-of M State H	ledi cai	N N d 0 rs Med	I I di cai d	22.
02 03 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	nter "Y" for yes or nompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un requires final un recost reporting p no, for the portio nic reclassificatio statistical areas no for the portio statistical areas no for the portion 2, "Y" for yes or rafter October 1. tot more than 499 be "Y" for yes or "N" edicaid days on lin f census days, or is cost reporting	CFR Section § "N" for no. ayments for to for the portion n column 2, " compensated of seriod prior to n of the cost "N" for no for the cost "N" for no for (see instruct ds (as counted for no. ses 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el u 1.00	stantistic	2) (2) (Pickl reporting cost ess or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t bes this bordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid baid days 3.00	e Y es N on N It N the N th N d Out-of N Medicaid eligible unpaid	ledi cai IMO day	M M d O rs Mec c	I I di cai d days 5. 00	22.
02 03 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting period in the prior cost cost cost cost cost cost cost cost	tter "Y" for yes or icompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction ne cost reporting p no, for the portio ic reclassificatio y statistical areas no for the portion 2, "Y" for yes or or after October 1. ot more than 499 be "Y" for yes or "N" dicaid days on lin f census days, or is cost reporting riod? In column 2, period for the provide the portion f census days or lin f census days, or f cens	CFR Section § "N" for no. ayments for to for the portion n column 2, ' curring on or compensated of so Enter in or enter of the cost of the cost "N" for no for (see instruct ds (as counter for no. res 24 and/or s if date of period differ enter "Y" for In-State In Medicaid paid days	412.06(c) this cost on of the 'Y" for ye after 00 care payme column 1, to octobe t reportin or the point CMS in FYZ or the point ctions) Do ed in acco 25 below discharge rent from or yes or -State dicaid igible I npaid F days) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t oes this ordance wi ? In colum e. Is the the metho <u>"N" for n</u> Out-of State Medicaid paid days	e Y es N on N t N the N th N th N th N th N th N th N th N th	ledi cai IMO day	N d o vs Mec c	I I di cai d days 5. 00	22.
02 03 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting period in -state Medicaid paid days in colum Medicaid eligible unpaid days in col	nter "Y" for yes or icompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un re cost reporting p no, for the portion of the portion creclassification ic reclassification of the portion 2, "Y" for yes or or after October 1. of more than 499 be "Y" for yes or "N" dicaid days on lin f census days, or is cost reporting is cost reporting ind? In column 2, priod? In colum	CFR Section § "N" for no. ayments for to for the portion n column 2, " compensated of seriod prior to n of the cost "N" for no for the cost "N" for no for (see instruct ds (as counted for no. ses 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el u 1.00	state of the second sec	2) (2) (Pickl reporting cost ess or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t bes this bordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid baid days 3.00	e Y es N on N It N the N th N d Out-of N Medicaid eligible unpaid	ledi cai IMO day	M M d O rs Mec c	I I di cai d days 5. 00	22.
02 03 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting perion Medicaid eligible unpaid days in colum out-of-state Medicaid paid days in colum	ter "Y" for yes or icompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un recost reporting p no, for the portion ic reclassification statistical areas no for the portion 2, "Y" for yes or after October 1. ot more than 499 be "Y" for yes or "N" redicaid days on lin f census days, or is cost reporting riod? In column 2, period? In column 2, recolumn 2, column 3,	CFR Section § "N" for no. ayments for to for the portion n column 2, " compensated of seriod prior to n of the cost "N" for no for the cost "N" for no for (see instruct ds (as counted for no. ses 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el u 1.00	state of the second sec	2) (2) (Pickl reporting cost ess or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t bes this bordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid baid days 3.00	e Y es N on N It N the N th N d Out-of N Medicaid eligible unpaid	ledi cai IMO day	M M d O rs Mec c	I I di cai d days 5. 00	22.
02 03 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting perior out-of-state Medicaid paid days in col out-of-state Medicaid paid days in col	nter "Y" for yes or icompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un requires final un recost reporting p no, for the portio nic reclassificatio statistical areas no for the portio ic reclassification statistical areas no for the portion 2, "Y" for yes or r after October 1. ot more than 499 be "Y" for yes or "N" edicaid days on lin f census days, or is cost reporting riod? In column 2, , enter the unn 2, column 3, d days in column	CFR Section § "N" for no. ayments for to for the portion n column 2, " compensated of seriod prior to n of the cost "N" for no for the cost "N" for no for (see instruct ds (as counted for no. ses 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el u 1.00	state of the second sec	2) (2) (Pickl reporting cost ess or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t bes this bordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid baid days 3.00	e Y es N on N It N the N th N d Out-of N Medicaid eligible unpaid	ledi cai IMO day	M M d O rs Mec c	I I di cai d days 5. 00	22.
02 03 00 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting period out-of-state Medicaid paid days in colum column 5, and other Medicaid days in column 5, and other Medicaid days in column 5, and other Medicaid days in column column 5, and other Medicaid days in column 5, and the model column 5, and th	ter "Y" for yes or icompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un ? (see instruction te cost reporting p no, for the portion ic reclassification y statistical areas no for the portion ic reclassification y statistical areas no for the portion 2, "Y" for yes or or after October 1. the more than 499 be "Y" for yes or "N" dicaid days on lin f census days, or is cost reporting iod? In column 2, polumn 3, d days in column the column 6.	CFR Section § "N" for no. ayments for to for the portion n column 2, ' curring on or compensated of so Enter in of the cost on of the cost of the cost of the cost n from urban adopted by (of the cost "N" for no for (see instruct dos (as counter for no. les 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el u 1.00 389	\$412.06(c) this cost on of the Y" for ye care payme column 1, to October treportin to retrong column 1, to October treportin to rural CMS in FY2 reporting to the point to the point contain accord 25 below discharge or yes or -State dicaid igible npaid 93) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t oes this ordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid paid days 3.00 0	e Y es N on N it N he N	ledi cai IMO day	N N (s Mec (c) (330)	I I di cai d days 5. 00	22. 22. 23. 23.
02 03 00 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Med 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting period out-of-state Medicaid paid days in col out-of-state Medicaid paid days in col uum 5, and other Medicaid days in col of this provider is an IRF, enter th	ter "Y" for yes or compensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un re cost reporting p no, for the portion o statistical areas no for the portion 2, "Y" for yes or or after October 1. ot more than 499 be "Y" for yes or "N" dicaid days on lin f census days, or nis cost reporting <u>iod? In column 2,</u> part of the n 1, in-state umn 2, column 3, d days in column t unpaid days in n column 6. he in-state	CFR Section § "N" for no. ayments for to for the portion n column 2, " compensated of seriod prior to n of the cost "N" for no for the cost "N" for no for (see instruct ds (as counted for no. ses 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el u 1.00	state of the second sec	2) (2) (Pickl reporting cost ess or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t bes this bordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid baid days 3.00	e Y es N on N It N the N th N d Out-of N Medicaid eligible unpaid	ledi cai IMO day	M M d O rs Mec c	I I di cai d days 5. 00	22. 22. 23. 23.
02 03 00 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting period out-of-state Medicaid paid days in colum column 5, and other Medicaid days in column 5, and other Medicaid days in column 5, and other Medicaid days in column column 5, and other Medicaid days in column 5, and the model column 5, and th	ter "Y" for yes or icompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un recost reporting p no, for the portion ic reclassification statistical areas no for the portion 2, "Y" for yes or or after October 1. ot more than 499 be "Y" for yes or "N" redicaid days on lin f census days, or is cost reporting is cost reporting. , enter the in 1, in-state umn 2, column 3, d days in column 6. te in-state in-state	CFR Section § "N" for no. ayments for to for the portion n column 2, ' curring on or compensated of so Enter in of the cost on of the cost of the cost of the cost n from urban adopted by (of the cost "N" for no for (see instruct dos (as counter for no. les 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el u 1.00 389	\$412.06(c) this cost on of the Y" for ye care payme column 1, to October treportin to retrong column 1, to October treportin to rural CMS in FY2 reporting to the point to the point contain accord 25 below discharge or yes or -State dicaid igible npaid 93) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t oes this ordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid paid days 3.00 0	e Y es N on N it N he N	ledi cai IMO day	N N (s Mec (c) (330)	I I di cai d days 5. 00	22.
02 03 00 00	amendment hospital?) In column 2, er Did this hospital receive interim ur period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per out-of-state Medicaid paid days in colum 4, Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days ir If this provider is an IRF, enter th Medicaid paid days in column 1, the	ter "Y" for yes or icompensated care p res or "N" for no f October 1. Enter i reporting period oc requires final un r? (see instruction ne cost reporting p no, for the portio nic reclassificatio y statistical areas no for the portion 1, "Y" for yes or "N" dicaid days on lin f census days, or nis cost reporting riod? In column 2, r, enter the unn 2, column 3, d days in column it unpaid days in n column 6. le in-state umn 2, a, out-of-state	CFR Section § "N" for no. ayments for to for the portion n column 2, ' curring on or compensated of so Enter in of the cost on of the cost of the cost of the cost n from urban adopted by (of the cost "N" for no for (see instruct dos (as counter for no. les 24 and/or 3 if date of period differ enter "Y" for In-State In Medicaid Me paid days el u 1.00 389	\$412.06(c) this cost on of the Y" for ye care payme column 1, to October treportin to retrong column 1, to October treportin to rural CMS in FY2 reporting to the point to the point contain accord 25 below discharge or yes or -State dicaid igible npaid 93) (2) (Pickl reporting cost es or "N" ctober 1. ents to be "Y" for y r 1. Enter ng period as a resu 2015? Ente g period rtion of t oes this ordance wi ? In colum e. Is the the metho "N" for n Out-of State Medicaid paid days 3.00 0	e Y es N on N it N he N	ledi cai IMO day	N N (s Mec (c) (330)	I I di cai d days 5. 00	22. 22. 23. 23.

Heal th	Financial Systems JOH	INSON MEMORIA	AL HOSPITAL		1	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATIO	IN DATA	Provi der	F	eriod: rom 01/01/ o 12/31/		Workshe Part I Date/Ti 5/21/20	me Pre	
				· · · · ·	Urban/Rur 1.00			Geogr	
26.00	Enter your standard geographic classification (no		tus at the beg	jinning of the	1.00	1	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" Enter your standard geographic classification (no reporting period. Enter in column 1, "1" for urba	ot wage) sta an or "2" fo	or rural. If ap			1			27.00
35.00	enter the effective date of the geographic reclas If this is a sole community hospital (SCH), enter effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi 2. (
36.00	Enter applicable beginning and ending dates of SC		Subscript line	36 for number	1.00		2.0	,0	36.00
37.00	of periods in excess of one and enter subsequent If this is a Medicare dependent hospital (MDH), e in effect in the cost reporting period.		mber of period	ls MDH status		0			37.00
38.00	Enter applicable beginning and ending dates of ME of periods in excess of one and enter subsequent		Subscript line	38 for number					38.00
	or periods in excess of one and enter subsequent	dates.			Y/N		Y/		
39.00	Does this facility qualify for the inpatient hosp hospitals in accordance with 42 CFR §412.101(b)(2	2)(ii)? Ente	er in column 1	"Y" for yes	1.00 Y		2.0 N		39.00
40.00	or "N" for no. Does the facility meet the mileage CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for Is this hospital subject to the HAC program reduc "N" for no in column 1, for discharges prior to C	yes or "N" ction adjust October 1. E	for no. (see i ment? Enter "Y inter "Y" for y	nstructions) (" for yes or	N		N		40. 00
	no in column 2, for discharges on or after Octobe	er 1. (see i	nstructions)			V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
45.00	Does this facility qualify and receive Capital pawith 42 CFR Section §412.320? (see instructions)	ayment for d	li sproporti onat	e share in acc	cordance	N	N	N	45.00
46.00	Is this facility eligible for additional payment pursuant to 42 CFR §412.348(f)? If yes, complete Pt. III.					N	N	N	46.00
	Is this a new hospital under 42 CFR §412.300 PPS Is the facility electing full federal capital pay Teaching Hospitals					N N	N N	N N	47. 00 48. 00
56.00	Is this a hospital involved in training residents	s in approve	d GME programs	s? Enter "Y" f	for yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporti GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first	' for yes or month of th	"N" for no ir is cost report	n column 1. If ing period? E	column 1 Enter "Y"				57.00
58.00	for yes or "N" for no in column 2. If column 2 i "N", complete Wkst. D, Parts III & IV and D-2, P1 If line 56 is yes, did this facility elect cost r	t. II, if ap reimbursemen	plicable. It for physicia			N			58.00
59.00	defined in CMS Pub. 15-1, § 2148? If yes, complet Are costs claimed on line 100 of Worksheet A? If			Pt. I.		N			59.00
	Are you claiming nursing school and/or allied hea	alth costs f	`or a program t	hat meets the		N			60.00
	provider-operated criteria under §413.85? Enter	Y FOF yes	IME	o. (see instruc Direct GME	IME		Direct	t GME	
		1.00	2.00	3.00	4.00)	5.0	00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00			61.00
61.01	Enter the average number of unweighted primary ca FTEs from the hospital's 3 most recent cost repor ending and submitted before March 23, 2010. (see	are rts	0.00	0.00					61. 01
61. 02	instructions) Enter the current year total unweighted primary of FTE count (excluding OB/GYN, general surgery FTEs and primary care FTEs odded under costion FES2 of	S,	0.00	0.00					61. 02
61. 03	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used f		0.00	0.00	þ				61. 03
61. 04	determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or		0.00	0.00					61. 04
61. 05	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary		0.00	0.00	5				61. 05
	and/or general surgery FTEs and the current year primary care and/or general surgery FTE counts (I 61.04 minus line 61.03). (see instructions)	s i ne	0.00						61 04
01.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprima care or general surgery. (see instructions)		0.00	0.00					61.06

HOSPITAL AND HOSP	ITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	ТА	Provi der	CCN: 150001 P F T	eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/21/2015 1:2	pared:
			Program	n Name	Program Code	Unweighted IME FTE Count		
			1. (00	2.00	3.00	4.00	
special ty, for each ne column 1, t program coo unweighted FTE unweigh 0f the FTEs program spe residents f instruction enter in cc 3, the IME	s in line 61.05, speci scialty, if any, and t for each expanded prog us) Enter in column 1, olumn 2, the program c FTE unweighted count	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00		61. 1
4, direct e	ME FTE unweighted cou	nt.						
							1.00	
	ons Affecting the Hea							
	umber of FTE resident al received HRSA PCRE			τnıs cost	reporting peri	oa tor which	0.00	62.0
2.01 Enter the r during in t	number of FTE resident: his cost reporting pe	s that rotated from a riod of HRSA THC prog	a Teaching H gram. (see i			your hospital	0.00	62.0
3.00 Has your fa	ospitals that Claim Re cility trained reside s or "N" for no in col	nts in nonprovider se	ettings duri		instructions)		N	63.0
					Unwei ghted FTEs Nonprovi der Si te	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
	04 of the ACA Base Yea t begins on or after J				inis base year	is your cost r	eporting	
4.00 Enter in cc in the base resident FT settings. resident FT	Jumn 1, if line 63 is year period, the num Es attributable to ro Enter in column 2 the Es that trained in yo 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweightec ur hospital. Enter in	trained r primary ca all nonprov non-primar column 3 t	esidents re ider y care he ratio	0.00			
		Program Name	Progran	1 Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2. (00	3.00	4.00	5.00	
is yes, or trained res year perioc associated FTEs for ea program in residents. the program col umn 3, t unweighted residents a rotations c non-provide col umn 4, t unweighted resident FT your hospit	Dumn 1, if line 63 your facility sidents in the base l, the program name with primary care which you trained Enter in column 2, n code, enter in the number of primary care FTE stributable to becurring in all re settings. Enter in the number of primary care Es that trained in al. Enter in column o of (column 3				0.00) 0.00	0. 000000	05.00

Heal th	Financial Systems	JOHNSON	MEMORIAL H	OSPI TAL		I	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	ΤA	Provi der	F	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/21/20	me Pre	
					Unweighted FTEs Nonprovider Site 1.00	Unwei gh FTEs i Hospi t 2.00	n al	Ratio (c (col. 1 2)	:ol. 1/ + col.)	<u>> piii</u>
	Section 5504 of the ACA Current		n Nonprovide	er Setting						
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	i ngs. dent	0. 0	0	0. 00	0.	000000	66. 00
		Program Name	Program	1 Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs i Hospi t	n	Ratio (c (col. 3 4))	+ col.	
		1.00	2.0	00	3.00	4.00		5.C		
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)				0.0	0	0.00	0.	000000	67.00
							1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility P			- :		a manufi al a mO				70.00
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b	e facility have an ap	oproved GME	teaching µ	program in the	most	N N		0	70. 00 71. 00
	42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, ente reporting period covers the begi or subsequent academic years of instructions) For cost reporting reporting period covers the begi teaching program in existence, e Inpatient Rehabilitation Facilit	lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching prog periods beginning or nning of the sixth or nter 6 in column 3. (y PPS	lity train (D)? Enter umn 3. (see year, enter gram in exis n or after 0 r any subseq (see instruc	residents "Y" for ye instructio 4 in colur tence, en ctober 1, uent acade tions)	in a new teac es or "N" for ons) If this c nn 3, or if th ter 5. (see 2012, if this emic year of t	hing no. ost e fifth cost				
75.00	Is this facility an Inpatient Re subprovider? Enter "Y" for yes		y (IRF), or	does it co	ontain an IRF		Y			75.00
76.00	If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see in of the fourth year, enter 4 in c teaching program in existence, e on or after October 1, 2012, if any subsequent academic year of instructions)	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N" structions) If this c olumn 3, or if the fi nter 5. (see instruct this cost reporting p	ember 15, 20 new teachin for no. Col cost reporti fth or subs tions) For c period cover	04? Enter g program umn 3: If ng period equent aca ost report s the begi	"Y" for yes o in accordance column 2 is Y covers the be ademic years o ting periods b inning of the	r "N" for with 42 , enter ginning f the new eginning sixth or	N		0	76.00
							-	1. C	0	
	Long Term Care Hospital PPS		<u> </u>	HAR C						00.07
	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? E	nter	N		80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded un				no.	N		85. 00 86. 00

Health Financial Systems JOHNSON MEMORI	AL HOSPITAL		١n	Lieu of Fo	orm CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/20 o 12/31/20	014 Part 014 Date/	Time Pre	pared:
			V		<u>2015 1:2</u> (IX	9 pili
			1.00		. 00	
90.00 Does this facility have title V and/or XIX inpatient hospita	al services? Ei	nter "Y" for	N		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 full or in part? Enter "Y" for yes or "N" for no in the applicable.			N		Ν	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applic	ual certificati				Ν	92.00
93.00 Does this facility operate an ICF/MR facility for purposes of "Y" for yes or "N" for no in the applicable column.		XIX? Enter	N		Ν	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N		Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N C	0. 00	0.00 N	95.00 96.00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the application of the second	plicable colum	ı.	C	0. 00	0. 00	97.00
Rural Providers 105.00 Does this hospital qualify as a Critical Access Hospital (C/ 106.00 If this facility qualifies as a CAH, has it elected the all		and of payment	N			105.00 106.00
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligit		1 5	N			107.00
for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on WI	o in column 1. kst. B, Pt. I,	(see col. 25 and				
the program would be cost reimbursed. If yes complete Wkst. this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or '	ation program [.]	train in the				
instructions) 108.00 Is this a rural hospital qualifying for an exception to the			N			108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal 1.00	Occupational 2.00	Speech 3.00		ratory . 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are	N 1.00	2.00 N	3.00 N	4	. 00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						
				1	. 00	-
110.00 Did this hospital participate in the Rural Community Hospita		on project (410	A Demo)for		N	110.00
the current cost reporting period? Enter "Y" for yes or "N"	for no.				_	
			-	1.00 2.00) 3.00	1
Miscellaneous Cost Reporting Information						
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.	. If column 2 i nt for long te	is "E", enter i rm care (includ	n column les	N	0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu			N" for	N Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence pol				2		118.00
claim-made. Enter 2 if the policy is occurrence.		Premiums	Losses	Insu	irance	
		1.00	2.00	3	. 00	
118.01 List amounts of malpractice premiums and paid losses:		373, 583		0		118.01
			1.00		00	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher			1.00 N	2	. 00	118.02
and amounts contained therein. 119.00 DO NOT USE THIS LINE						110.00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold	d Harmless prov	vision in ACA	N		N	119.00 120.00
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment	ualifies for th	ne Outpatient				
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla		ŗ	Y			121.00
patients? Enter "Y" for yes or "N" for no. Transplant Center Information		for no 15				105 00
125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, end the second	-		N			125.00 126.00
in column 1 and termination date, if applicable, in column 1 127.00 f this is a Medicare certified heart transplant center, en	2.					126.00
in column 1 and termination date, if applicable, in column 2						27.00

SPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 150001		1/01/2014	Worksheet S-: Part I	
				To 12	2/31/2014	Date/Time Pr 5/21/2015 1::	epared 29 pm
					1.00	2.00	-
8.00 If this is a Medicare certified li			cation date				128.0
in column 1 and termination date, 9.00 f this is a Medicare certified Lu	ing transplant center, er	nter the certific	cation date	in			129.0
column 1 and termination date, if	applicable, in column 2.						130. 0
0.00 If this is a Medicare certified pa date in column 1 and termination of	late, if applicable, in o	column 2.					
1.00 If this is a Medicare certified in date in column 1 and termination of			erti fi cati on				131.0
2.00 If this is a Medicare certified is	slet transplant center, e	enter the certifi	cation date				132.0
in column 1 and termination date, 3.00 If this is a Medicare certified of			cation date				133. 0
in column 1 and termination date, 4.00 If this is an organ procurement or			n column 1				134.0
and termination date, if applicabl							
All Providers 0.00Are there any related organization	n or home office costs as	s defined in CMS	Pub. 15-1,		N		140. 0
chapter 10? Enter "Y" for yes or '	N" for no in column 1. I	If yes, and home	office cost	s			
are claimed, enter in column 2 the 1.00	2	. 00	i i		3.00		
If this facility is part of a cha home office and enter the home of	5		5	name and	address	of the	
1.00Name:	Contractor's Name:			tor's Nu	mber:		141.0
2.00Street: 3.00City:	PO Box: State:		Zip Code	. .			142. 0 143. 0
3. 00 or ty.							145.0
4.00 Are provider based physicians' cos	sts included in Worksheet	t A?				1.00 Y	144.0
			nonto for in	noti ont			145. 0
5.00 f costs for renal services are cl only? Enter "Y" for yes or "N" for		ine /4, are the o	COSTS FOR TH	patrent	servi ces	N	145.0
5.00 f costs for renal services are cl only? Enter "Y" for yes or "N" for		ine 74, are the o					
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for in	no. gy changed from the previ n column 1. (See CMS Pub.	iously filed cos	t report?		services 1.00 N	N 2.00	_
6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for in the approval date (mm/dd/yyyy) in	no. y changed from the previncolumn 1. (See CMS Pub. column 2.	iously filed cos 15-2, § 4020)	t report? f yes, ente		1.00 N		146. (
 only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 	no. y changed from the prevint column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" 1	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" fo	t report? f yes, ente no. pr no.	r	1.00 N N N		146. 0 147. 0 148. 0
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti	no. y changed from the prevint column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" 1	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" fo	t report? f yes, ente no. pr no.	r	1.00 N		146. 0 147. 0 148. 0
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi	no. y changed from the prevint column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" 1	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" fo Enter "Y" for ye Part A	t report? f yes, ente or no. es or "N" fo Part B	r r T	1.00 N N N N itle V	2.00 Title XIX	146. 0 147. 0 148. 0
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi no.	no. y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" fo Enter "Y" for ye Part A 1.00 an exemption fro	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic	r r T	1.00 N N N N itle V 3.00 The Lowe	2.00 Title XIX 4.00 er of costs	146. 0 147. 0 148. 0
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi no. Does this facility contain a provi or charges? Enter "Y" for yes or	no. y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" fo Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A	t report? f yes, enter no. or no. es or "N" for Part B 2.00 m the applic and Part B.	r r T	1.00 N N N itle V 3.00 the Lowe 2 CFR §413	2.00 Title XIX 4.00 er of costs 3.13)	146. (147. (148. (149. (
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi no.	no. y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" fo Enter "Y" for ye Part A 1.00 an exemption fro	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic	r r T	1.00 N N N N itle V 3.00 The Lowe	2.00 Title XIX 4.00 er of costs	146. 0 147. 0 148. 0 149. 0 155. 0
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifino. Does this facility contain a provior or charges? Enter "Y" for yes or " 5.00 Hospital	no. y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N	t report? f yes, enter no. or no. es or "N" for Part B 2.00 m the applic and Part B. N	r r T	1.00 N N N itle V 3.00 the Lowe 2.CFR §413 N	2.00 Title XIX 4.00 er of costs 3.13) N	146. C 147. C 148. C 149. C 149. C 155. C 156. C 157. C
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER	no. y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	iously filed cos 15-2, § 4020) i r yes or "N" for for yes or "N" f Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N	r r T	1.00 N N N N itle V 3.00 the Lowe CFR §413 N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N	146. C 147. C 148. C 149. C 155. C 155. C 157. C 158. C
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statistististististististististiction 8.00 Was there a change to the simplifin 10.00 Subprovider - IPF 10.00 Subprovider - IRF 10.00 SNF	no. y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	iously filed cos 15-2, § 4020) 1 r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N	r r T	1.00 N N N itle V 3.00 F the Iowe CFR §413 N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N N	146. 0 147. 0 148. 0 149. 0 155. 0 155. 0 156. 0 157. 0 158. 0 158. 0 158. 0 158. 0
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statististististiction 8.00 Was there a change to the simplifind 9.00 Was there a change to the simplifind 10.00 Was there a change to the simplified 10.00 Subprovider - 1PF 10.00 Subprovider - 1PF 10.00 Subprovider - 1PF 10.00 Subprovider - 1PF 10.00 SubPROVIDER 10.00 HOME HEALTH AGENCY	no. y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	iously filed cos 15-2, § 4020) i r yes or "N" for for yes or "N" f Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N	r r T	1.00 N N N N itle V 3.00 the Lowe CFR §413 N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N	146. (147. (148. (149. (149. (155. (155. (157. (158. (159. (159. (159. (159. (159. (159. (159. (159. (150. (159. (150. (15
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statististististiction 8.00 Was there a change to the simplifind 9.00 Was there a change to the simplifind 10.00 Was there a change to the simplified 10.00 Subprovider - 1PF 10.00 Subprovider - 1PF 10.00 Subprovider - 1PF 10.00 Subprovider - 1PF 10.00 SubPROVIDER 10.00 HOME HEALTH AGENCY	no. y changed from the previ column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for ed cost finding method? der that qualifies for a	iously filed cos 15-2, § 4020) 1 r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N	r r T	1.00 N N N N itle V 3.00 The Lowe CFR §413 N N N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N	146. (147. (148. (149. (149. (155. (155. (157. (158. (159. (159. (159. (159. (159. (159. (159. (159. (150. (159. (150. (15
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statistis 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus	<pre>^ no. gy changed from the previous column 1. (See CMS Public column 2. cal basis? Enter "Y" for f allocation? Enter "Y" for ed cost finding method? der that qualifies for a N" for no for each composition of the previous for the previous for a N" for no for each composition for the previous for a N" for no for the previous for the previous for a N" for no for the previous for the previous for a N" for no for the previous for the previous for a N" for no for the previous for the previs</pre>	iously filed cos 15-2, § 4020) i r yes or "N" for for yes or "N" fo Enter "Y" for ye <u>Part A</u> 1.00 an exemption fro onent for Part A N N N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N	r T ation of (See 42	1.00 N N N N N S the V 3.00 The Iowe 2 CFR §413 N N N N N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N	146. 0 147. 0 148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 159. 0 160. 0 161. 0
only? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statistis 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC	<pre>^ no. gy changed from the previous column 1. (See CMS Public column 2. cal basis? Enter "Y" for f allocation? Enter "Y" for ed cost finding method? der that qualifies for a N" for no for each composition of the previous for the previous for a N" for no for each composition for the previous for a N" for no for the previous for the previous for a N" for no for the previous for the previous for a N" for no for the previous for the previous for a N" for no for the previous for the previs</pre>	iously filed cos 15-2, § 4020) i r yes or "N" for for yes or "N" fo Enter "Y" for ye <u>Part A</u> 1.00 an exemption fro onent for Part A N N N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N	r T ation of (See 42	1.00 N N N N N S the V 3.00 The Iowe 2 CFR §413 N N N N N N N	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N	146. (147. (148. (149. (149. (155. (155. (157. (158. (159. (159. (159. (159. (159. (159. (159. (159. (150. (159. (150. (15
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statististististication 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multication 5.00 Is this hospital part of a Multication 1.00 Is Is this hospital part of a Multication 1.00 Is	no. y changed from the previous column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for alloca	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N N N N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N N N N State Z	r T ation of (See 42 erent CB	1.00 N N N N N 1 tl e V 3.00 T the I owe CFR §413 N N N N N N N SAs? CBSA	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	146. (147. (148. (149. (149. (155. (156. (157. (158. (159. (159. (160. (161. (
onl y? Enter "Y" for yes or "N" for 6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7. 00 Was there a change in the statistis 3. 00 Was there a change in the order of 9. 00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5. 00 Hospital 5. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC Multicampus 5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	no. y changed from the previous column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for allocation? Enter "Y" for a cost finding method? der that qualifies for a 'N" for no for each compa- mpus hospital that has o	iously filed cos 15-2, § 4020) 1 r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N N N	r T ation of (See 42	1.00 N N N N N SAs?	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	146. 0 147. 0 148. 0 149. 0 155. 0 155. 0 157. 0 158. 0 159. 0 161. 0 161. 0 165. 0
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statistis 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 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	no. y changed from the previous column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for alloca	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N N N N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N N N N State Z	r T ation of (See 42 erent CB	1.00 N N N N N 1 tl e V 3.00 T the I owe CFR §413 N N N N N N N SAs? CBSA	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	146. (147. (148. (148. (149. (149. (155. (156. (157. (158. (159. (161. (165. (- -
onl y? Enter "Y" for yes or "N" for 5.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statististististication 8.00 Was there a change in the order of 9.00 Was there a change to the simplifind 10.00 Subprovider - IPF 10.00 Subprovider - IPF 10.00 Subprovider - IRF 10.00 SNF 10.00 SNF 10.00 SNF 10.00 CMHC 10.00 CMHC 5.00 Is this hospital part of a Multication Enter "Y" for yes or "N" for no. 5.00 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,	no. y changed from the previous column 1. (See CMS Pub. column 2. cal basis? Enter "Y" for allocation? Enter "Y" for alloca	iously filed cos 15-2, § 4020) r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N N N N N N	t report? f yes, enter no. or no. es or "N" fo Part B 2.00 m the applic and Part B. N N N N N N N N N State Z	r T ation of (See 42 erent CB	1.00 N N N N N 1 tl e V 3.00 T the I owe CFR §413 N N N N N N N SAs? CBSA	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	146. 0 147. 0 148. 0 149. 0 155. 0 155. 0 157. 0 158. 0 159. 0 161. 0 161. 0 165. 0
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statististististic 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or "S 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 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)	<pre>^ no. gy changed from the previous column 1. (See CMS Puble column 2. cal basis? Enter "Y" for f allocation? Enter "Y" for ed cost finding method? der that qualifies for a 'N" for no for each comparison 'N" for n</pre>	iously filed cos 15-2, § 4020) I r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N N N N N N	t report? f yes, enterno. pr no. es or "N" forno. Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	r T T T T T T T T T T T T T T T T T T T	1.00 N N N N N 1 tl e V 3.00 T the I owe CFR §413 N N N N N N N SAs? CBSA	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	146. (147. (148. (149. (149. (155. (155. (157. (157. (157. (157. (157. (157. (160. (161. (161. (161. (165. (165. (165. (165. (166. (166. (167. (166. (167. (177. (
onl y? Enter "Y" for yes or "N" for 6.00 Has the cost allocation methodol og Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statistis 8.00 Was there a change in the order of 9.00 Was there a change to the simplifin no. Does this facility contain a provious or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 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)	<pre>^ no. gy changed from the previous column 1. (See CMS Public column 2. cal basis? Enter "Y" for allocation? Enter "Y" for allocation? Enter "Y" for der that qualifies for a 'N" for no for each comparison ampus hospital that has contained Name 0 0 0 0 0 0 0 0 0 0 0 0 0</pre>	iously filed cos 15-2, § 4020) i r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N N N N N N	t report? f yes, enter no. or no. es or "N" foi Part B 2.00 m the applic and Part B. N N N N N N N State Z 2.00 d Reinvestme yes or "N"	r r ation of (See 42 erent CB ip Code 3.00	1.00 N N N N N The I owe CER §413 N N N N N SAS? CBSA 4.00	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	146. (147. (148. (148. (149. (149. (155. (156. (157. (159. (159. (161. (165. (- -

Health Financial Systems	JOHNSON MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA	Provider CCN: 150001	Period: From 01/01/2014	Worksheet S-2	2
				Date/Time Pre	pared:
				5/21/2015 1:2	<u>9 pm</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	g date and ending date	for the reporting	01/01/2014	12/31/2014	170.00
				1.00	
171.00 If line 167 is "Y", does this provider hav	ve any days for individ	duals enrolled in secti	on 1876	Y	171.00
Medicare cost plans reported on Wkst. S-3, (see instructions)	Pt. I, line 2, col. 6	5? Enter "Y" for yes ar	nd "N" for no.		

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi o	ler CCN: 150001	Peri od:	Worksheet S-2	2
				From 01/01/2014 To 12/31/2014		epare
					5/21/2015 1:2	
				Y/N	Date	
	- - - - - - - - - -			1.00	2.00	
	General Instruction: Enter Y for all YES resp	oonses. Enter N for all NO	responses. Ente	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation					-
00	Has the provider changed ownership immediated	y prior to the beginning	of the cost	N	1	1.
	reporting period? If yes, enter the date of					
			Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in		N			2.
	yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.	on and th corumn 3, V to	ſ			
0	Is the provider involved in business transac	tions, including managemen	t N			3.
	contracts, with individuals or entities (e.g.	, chain home offices, dru	q			
	or medical supply companies) that are related		č			
	officers, medical staff, management personnel					
	of directors through ownership, control, or	family and other similar				
	relationships? (see instructions)		Y/N	Tuno	Dete	_
			1.00	Type 2.00	Date 3.00	
	Financial Data and Reports		1.00	2.00		
0	Column 1: Were the financial statements pre	pared by a Certified Publi	с Ү	Α	04/30/2015	4.
	Accountant? Column 2: If yes, enter "A" for					
	or "R" for Reviewed. Submit complete copy or					
	column 3. (see instructions) If no, see instr					
00	Are the cost report total expenses and total		N			5.
	those on the filed financial statements? If	yes, submit reconciliation		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities			1.00		
0	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is	the provider is	s N	1	6.
	the legal operator of the program?	-				
0	Are costs claimed for Allied Health Programs'			N		7.
0	Were nursing school and/or allied health prog		wed during the	N		8.
0	cost reporting period? If yes, see instruction		aget report? If	N		
00	Are costs claimed for Intern-Resident program yes, see instructions.	is crarilled on the current	cost report? IT	N		9.
00	Was an Intern-Resident program been initiated	d or renewed in the curren	t cost reporting	N N		10.
00	period? If yes, see instructions.			,		10.
00	Are GME cost directly assigned to cost center	rs other than I & R in an	Approved	N		11.
	Teaching Program on Worksheet A? If yes, see	instructions.				
					Y/N	_
	Bad Debts				1.00	
00	Is the provider seeking reimbursement for bac	debts? If ves see instr	uctions		Y	12.
00	If line 12 is yes, did the provider's bad del			ost reporting	N N	13.
00	period? If yes, submit copy.	st control points, onang	o ddiring tino oc	or ropor ring		
	If line 12 is yes, were patient deductibles a	and/or co-payments waived?	If yes, see ins	structions.	N	14.
00						
00	Bed Complement					
	Bed Complement Did total beds available change from the prid	pr cost reporting period?			N	
			Pa	art A	Part B	
		Description	Pa Y/N	art A Date	Part B Y/N	
	Did total beds available change from the pric		Pa	art A	Part B	
00	Did total beds available change from the prio	Description	Pa Y/N 1.00	Date 2.00	Part B Y/N 3.00	15.
00	Did total beds available change from the pric	Description	Pa Y/N	art A Date	Part B Y/N	15.
00	Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R	Description	Pa Y/N 1.00	Date 2.00	Part B Y/N 3.00	15.
00	Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Description	Pa Y/N 1.00	Date 2.00	Part B Y/N 3.00	15.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	Description	Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	15.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R	Description	Pa Y/N 1.00	Date 2.00	Part B Y/N 3.00	15.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records	Description	Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	15.
00	Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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	Description	Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	15.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records	Description	Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	15.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see 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 in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments	Description	Y/N 1.00 Y	Date 2.00	Part B Y/N 3.00 Y	15. 16. 17.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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 in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional	Description	Pa Y/N 1.00 Y N	Date 2.00	Part B Y/N 3.00 Y	15. 16. 17.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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 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	Description	Pa Y/N 1.00 Y N	Date 2.00	Part B Y/N 3.00 Y	15. 16. 17.
00	Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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 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	Description	Pa Y/N 1.00 Y N	Date 2.00	Part B Y/N 3.00 Y	15. 16. 17.
00	Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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 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.	Description	Pa Y/N 1.00 Y N N	Date 2.00	Part B Y/N 3.00 Y N	15. 16. 17. 18.
00	Did total beds available change from the price PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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 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. If line 16 or 17 is yes, were adjustments	Description	Pa Y/N 1.00 Y N	Date 2.00	Part B Y/N 3.00 Y	15. 16. 17. 18.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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 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, were adjustments made to PS&R Report data for corrections. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of	Description	Pa Y/N 1.00 Y N N	Date 2.00	Part B Y/N 3.00 Y N	15. 16. 17. 18.
00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see 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 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. 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	Description	Pa Y/N 1.00 Y N N	Date 2.00	Part B Y/N 3.00 Y N	15. 16. 17.
	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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 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, were adjustments made to PS&R Report data for corrections. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of	Description	Pa Y/N 1.00 Y N N	Date 2.00	Part B Y/N 3.00 Y N	15. 15. 16. 17. 18. 19. 20.
00 00 00 00	Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 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 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. 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.	Description 0	Pa Y/N 1.00 Y N N N	Date 2.00	Part B Y/N 3.00 Y N N	15. 16. 17. 18.

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:				Period: From 01/01/2014 To 12/31/2014	Worksheet S- Part II	2 epared:
				Pa	rt A	Part B	
		Descri		Y/N	Date	Y/N	
		C)	1.00	2.00	3.00	
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 HOSPIT Capital Related Cost	ALS ONLY (EXCE	PT CHILDRENS F	IOSPI TALS)		1.00	_
	Have assets been relifed for Medicare purpose Have changes occurred in the Medicare depreci			sals made duri	ng the cost		22. 00 23. 00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing If yes, see instructions	g leases entere	ed into during	this cost repo	orting period?		24.00
25.00	Have there been new capitalized leases entered instructions.	ed into during	the cost repor	rting period?	lfyes, see		25.00
	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	0		0 1	5		26.00
27.00	Has the provider's capitalization policy char copy. Interest Expense	iged during the		ng period? if g	yes, submit		27.00
28.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit en	itered into dur	ring the cost	reporting		28.00
	Did the provider have a funded depreciation a treated as a funded depreciation account? If	yes, see instr	ructions				29.00
	Has existing debt been replaced prior to its instructions. Has debt been recalled before scheduled matur		3	5			30.00
01.00	Purchased Services						
	Have changes or new agreements occurred in pa arrangements with suppliers of services? If y	/es, see instru	icti ons.	C C			32.00
33.00	If line 32 is yes, were the requirements of S no, see instructions.	Sec. 2135.2 app	olied pertainir	ng to competiti	ive bidding? If		33.00
24 00	Provider-Based Physicians Are services furnished at the provider facili	ty under an ar	rangement with	nrovi dor bas	od physicians?		34.00
34.00	If yes, see instructions.	ty under an ar	rangement with		eu physicians:		54.00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?		0 0	nts with the p	rovi der-based		35.00
		<i>r</i> .			Y/N	Date	
					1.00	2.00	
	Home Office Costs						2 2 4 00
	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta If yes, see instructions.	•	epared by the	home office?			36.00 37.00
38.00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the f						38.00
	If line 36 is yes, did the provider render se see instructions.						39.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the	home office?	If yes, see			40.00
			1	00	2	00	-
	Cost Report Preparer Contact Information				2.		
	Enter the first name, last name and the title held by the cost report preparer in columns 1		BOB		BRANDENBURG		41.00
42.00	respectively. Enter the employer/company name of the cost r preparer.	report	BKD, LLP				42.00
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		317. 383. 4000		BBRANDENBURG@B	KD. COM	43.00

	Financial Systems	JOHNSON MEMOR					In Lieu	u of Form CMS	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Pro	vider C	CN: 15000	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet S- Part II Date/Time Pr 5/21/2015 1:	epared:
		Part B							
		Date							
		4.00							
	PS&R Data								_
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	03/27/2015							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 in columns 2 and 4. (see instructions)								17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.								18.00
	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.								19.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:								20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						1		21.00
				3.0	0				
	Cost Report Preparer Contact Information			0.0					
	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		PARTNER						41.00
42.00	Enter the employer/company name of the cost i	report							42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv								43.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	JOHNSON MEMORI	AL II		CCN: 150001	Pe	eriod:	u of Form CMS-2552-10 Worksheet S-3		
1103111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC.			TTOWNEE			om 01/01/2014	Part I Date/Time Pre 5/21/2015 1:2	эра	
								I/P Days / O/F Visits / Trips		
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available		CAH Hours	Title V		
		1.00		2.00	3.00		4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00		80	29, 2	00	0.00	C)	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider									2.00
4.00 5.00	HMO IRF Subprovider							C		4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF									5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			80	29, 2	00	0.00	(7.00
8.00 9.00	INTENSIVE CARE UNIT	31.00		6	2, 1	90	0.00	(8.00
9.00 10.00 11.00 12.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)								1	9.00 10.00 11.00 12.00
13.00	NURSERY	43.00						C		13.00
14.00	Total (see instructions)	10.00		86	31, 3	90	0.00	(14.00
15.00	CAH visits							C) 1	15.00
16.00	SUBPROVIDER - IPF								1	16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	41.00		15	5, 4	75		C		17.00 18.00
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY								1	19.00 20.00
21.00	OTHER LONG TERM CARE									21.00
22.00	HOME HEALTH AGENCY	101.00						C		22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)									23.00
24.00 24.10	HOSPICE HOSPICE (non-distinct part)	30, 00								24.00 24.10
25.00	CMHC - CMHC	30.00								24. 10 25. 00
26.00	RURAL HEALTH CLINIC									26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER									26. 25
27.00	Total (sum of lines 14-26)			101						27. OC
28.00	Observation Bed Days							C		28.00
29.00	Ambul ance Trips									29.00
30.00	Employee discount days (see instruction)								3	30.00
31.00	Employee discount days - IRF								3	31.00
32.00	Labor & delivery days (see instructions)			0		0			3	32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)								3	32. 01
33.00	LTCH non-covered days								3	33.00

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 283	303	6, 09		10.00	1.0
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)	05/	0.40				
2.00	HMO and other (see instructions)	956 0	840 0				2.0
3.00 1.00	HMO IPF Subprovider HMO IRF Subprovider	68	38				4.0
i. 00	Hospital Adults & Peds. Swing Bed SNF	00	38 0		0		5.0
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		6.0
. 00	Total Adults and Peds. (exclude observation	3, 283	303		-		7.0
. 00	beds) (see instructions) INTENSIVE CARE UNIT	267	50	1, 02	6		8. (
. 00	CORONARY CARE UNIT			.,	-		9.0
D. 00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12. (
3.00	NURSERY		35	70	7		13.0
4.00	Total (see instructions)	3, 550	388	7, 82	. 00	529.59	14. (
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF	702	175	1, 44	.7 0.00	11.64	
3. 00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	2, 954	120	5, 93	6 0.00	10. 78	
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00		0	0		0		24.
4. 10 5. 00	HOSPICE (non-distinct part)	0	0		0		24.
	CMHC - CMHC						25.
6.00 6.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER						26.
7.00	Total (sum of lines 14-26)				0.00	552.01	
3.00	Observation Bed Days		10	97		552.01	28.
9.00	Ambulance Trips	0	10	77	0		29.
7.00 D.00	Employee discount days (see instruction)	0			0		30.0
1.00	Employee discount days (see first detroit)				0		31.0
2.00	Labor & delivery days (see instructions)	0	86		-		32.0
2.00	Total ancillary labor & delivery room	0	80		0		32.0
	outpatient days (see instructions)				-		
3 00	LTCH non-covered days	o					33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Prep 5/21/2015 1:29	
		Full Time Equivalents		Di se	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	89	04 0	2, 186	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			17	72 71		2.00 3.00 4.00 5.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6. 00 7. 00
8.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits	0.00	0	89	04 0	2, 186	13. 00 14. 00 15. 00
16.00 17.00 18.00 19.00 20.00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY	0. 00	0	e	50 11	117	16.00 17.00 18.00 19.00 20.00
21.00 22.00 23.00 24.00 24.10	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	0.00					21.00 22.00 23.00 24.00 24.10
25. 00 26. 00 26. 25	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER						25. 00 26. 00 26. 25
27.00 28.00 29.00 30.00 31.00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0.00					27.00 28.00 29.00 30.00 31.00
32. 0032. 0133. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days						32.00 32.01 33.00

PI T.	Financial Systems AL WAGE INDEX INFORMATION		JOHNSON MEMOR		F	Period: From 01/01/2014 To 12/31/2014		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Sal ari es (col.2 ± col.	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
0	Total salaries (see	200.00	33, 598, 085	C	33, 598, 085	5 1, 148, 174. 00	29.26	1.00
0	instructions) Non-physician anesthetist Part		C	c c	, c	0.00	0.00	2.00
0	A		C			0.00	0.00	2.00
0	Non-physician anesthetist Part		C	0	c	0.00	0.00	3.00
0	Physician-Part A -		C	0	c	0.00	0.00	4.00
1	Administrative		C	0		0.00	0.00	4.01
1 0	Physicians - Part A - Teaching Physician-Part B			-	-	0.00		
	Non-physician-Part B		C	0	C	0.00		
0	Interns & residents (in an	21.00	C	0 0	C	0.00	0. 00	7.00
1	approved program) Contracted interns and residents (in an approved		C	o c	c	0.00	0. 00	7.01
0	programs) Home office personnel		C			0.00	0.00	8.00
0	SNF	44.00	C			0.00		
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		10, 462, 777	-125, 850	10, 336, 927			
	Contract Labor: Direct Patient		1, 073, 077	' C	1, 073, 077	7 12, 931.00	82.98	11.00
~ ~	Care							
00	Contract labor: Top level management and other management and administrative services		C) C	C	0.00	0.00	12.00
00	Contract Labor: Physician-Part		127, 012	. 0	127, 012	1, 689. 00	75. 20	13.00
~ ~	A - Administrative							
00	Home office salaries & wage-related costs		C	0 0	C	0.00	0.00	14.00
00	Home office: Physician Part A		C	o o	c	0.00	0. 00	15.00
00	- Administrative Home office and Contract Physicians Part A - Teaching		C	с	c	0.00	0. 00	16. 0
	WAGE-RELATED COSTS			1	1		1	
00	Wage-related costs (core) (see instructions)		6, 048, 920	0	6, 048, 920)		17.0
00	Wage-related costs (other)		C	o c	c)		18.0
	(see instructions)							
	Excluded areas		1, 522, 568		.,			19.0
00	Non-physician anesthetist Part A		C	0 0	C			20.0
00	Non-physician anesthetist Part		C	0	c	D		21.0
00	B Physician Part A -		C	0				22.0
00	Admi ni strati ve		C					22.0
	Physician Part A - Teaching		C		C	D		22.0
	Physician Part B		C	, s		0		23.0 24.0
	Wage-related costs (RHC/FQHC) Interns & residents (in an		C					24.0
	approved program)		-					
	OVERHEAD COSTS - DIRECT SALARIE		2 202 2/5	105.050	2 400 115	152 220 00		
	Employee Benefits Department Administrative & General	4.00 5.00	3, 282, 265 1, 871, 323					
00	Administrative & General under contract (see inst.)		187, 812			1, 084. 00	173. 26	28. 0
	Maintenance & Repairs	6.00	C	-	0			
	Operation of Plant Laundry & Linen Service	7.00 8.00	643, 881 113, 414		643, 881 113, 414			
	Housekeepi ng	9.00	627, 961		627, 961			
00	Housekeeping under contract		C	0	C	0.00	0. 00	33.0
~~	(see instructions)	10.00	740.000	410 (54	220.244	20 512 00	1/ 0/	24.0
	Dietary Dietary under contract (see	10.00	742, 998	-413, 654	329, 344	4 20, 512.00 0.00		
	instructions)		C				0.00	33.0
	Cafeteria	11.00	C	413, 654	413, 654			
	Maintenance of Personnel	12.00	1 224 542		C 1, 234, 543	0.00		37.0 38.0
	Nursing Administration Central Services and Supply	13.00 14.00	1, 234, 543 78, 144					
00		11.00			1 , 0, 171	., 522.00	1 10.00	1 27.0

Health Financial Systems		JOHNSON MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION					Period:	Worksheet S-3		
					rom 01/01/2014			
					Го 12/31/2014			
						5/21/2015 1:2		
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly		
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
			(from	(col.2 ± col.	Salaries in	col. 5)		
			Worksheet A-6)	3)	col. 4			
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00 Medical Records & Medical Records Library	16.00	509, 664	. 0	509, 664	4 27, 770. 00	18. 35	41.00	
42.00 Soci al Servi ce	17.00	O	0	(0.00	0.00	42.00	
43.00 Other General Service	18.00	0	0	(0.00	0.00	43.00	

Heal th	Financial Systems		JOHNSON MEMOR	IAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014	Worksheet S-3 Part III		
						To 12/31/2014			
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		33, 785, 897	0	33, 785, 89	7 1, 149, 258. 00	29.40	1.00	
	instructions)								
2.00	Excluded area salaries (see		10, 462, 777	-125, 850	10, 336, 92	7 230, 889. 00	44.77	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		23, 323, 120	125, 850	23, 448, 97	0 918, 369. 00	25. 53	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		1, 200, 089	0	1, 200, 08	9 14, 620. 00	82.09	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		6, 048, 920	0	6, 048, 92	0 0.00	25.80	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		30, 572, 129						
7.00	Total overhead cost (see		9, 755, 363	125, 850	9, 881, 21	3 420, 626. 00	23. 49	7.00	
	instructions)								

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provider CCN:	150001	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Pre 5/21/2015 1:2	pared:
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
4 00	RETIREMENT COST					0	4 00
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribut					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see in					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instr PLAN ADMINISTRATIVE COSTS (Paid to External Or					0	4.00
5.00	401K/TSA Plan Administration fees	gani zati on)				739, 919	5.00
5.00 6.00	Legal /Accounting/Management Fees-Pension Plan					739, 919	5.00 6.00
7.00	Employee Managed Care Program Administration F	005				326, 501	7.00
7.00	HEALTH AND INSURANCE COST	ees				320, 301	7.00
8.00	Health Insurance (Purchased or Self Funded)					2, 837, 011	8.00
9.00	Prescription Drug Plan					2,037,011	9,00
	Dental, Hearing and Vision Plan					0	10.00
11.00	Life Insurance (If employee is owner or benefi	ci arv)				23, 305	
12.00	Accident Insurance (If employee is owner or be					20,000	12.00
	Disability Insurance (If employee is owner or					67, 799	
14.00	Long-Term Care Insurance (If employee is owner					0	
15.00	'Workers' Compensation Insurance					183, 373	
16.00	Retirement Health Care Cost (Only current year	, not the extrao	rdi narv accrual	reaui re	d by FASB 106.	0	16.00
	Non cumulative portion)		5		5		
	TAXES						
	FICA-Employers Portion Only					1, 818, 737	17.00
	Medicare Taxes - Employers Portion Only					0	
	Unemployment Insurance					30, 295	
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER						
	Executive Deferred Compensation (Other Than Reinstructions))	etirement Cost Re	ported on lines	1 throu	gh 4 above. (see	0	
	Day Care Cost and Allowances					0	
	Tuition Reimbursement					22, 082	
24.00	Total Wage Related cost (Sum of lines 1 -23)					6, 049, 022	24.00
	Part B - Other than Core Related Cost						
25.00	EXCLUDED BENEFITS					1, 522, 466	25.00

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150001	Peri od:	Worksheet S-3	
					From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/21/2015 1:2	
	Cost Center Description				Contract Labor		<u> 7 piii</u>
	obst center bescription				1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identi	fication:					
1.00	Total facility's contract labor and benefit	cost			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovider - IPF					1	3.00
4.00	Subprovider - IRF				0	0	4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF					1	8.00
9.00	Hospital-Based NF					1	9.00
10.00	Hospi tal -Based OLTC					1	10.00
11.00	Hospital-Based HHA				0	0	11.00
12.00	Separately Certified ASC					1	12.00
13.00	Hospi tal -Based Hospi ce					1	13.00
14.00	Hospital-Based Health Clinic RHC					1	14.00
15.00	Hospital-Based Health Clinic FQHC					1	15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis					1	17.00
18.00	Other				0	0	18.00

	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA				Period: From 01/01/2014		
			Component	t CCN: 157510	To 12/31/2014	5/21/2015 1:2	pared: 9 pm
					Home Health Agency I	PPS	
					1	00	
0.00	County				JOHNSON		0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00		4.00		
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0 0.00					•
2.00		0.00	147.00		loyees (Full Ti		2.00
		Enter the numb your normal		Staff	Contract	Total	
		your norman	NOT R WEEK				
		C)	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	1.0	6 0.00	1.06	3.00
4.00	Director(s) and Assistant Director(s)			0.0			
5.00 6.00	Other Administrative Personnel Direct Nursing Service			2.0			•
7.00	Nursing Supervisor			0.0	0.00	0.00	7.00
8.00 9.00	Physical Therapy Service Physical Therapy Supervisor			1.2			•
9.00 10.00	Occupational Therapy Service			1.0			•
11.00	Occupational Therapy Supervisor			0.0			
12.00 13.00	Speech Pathol ogy Servi ce Speech Pathol ogy Supervi sor			0.0			
14.00	Medical Social Service			0.0	1 0.00	0.01	14.00
15.00 16.00	Medical Social Service Supervisor Home Health Aide			0.00			
17.00	Home Heal th Aide Supervisor			0.0			
18.00	Other (specify)			0.0	0.00	0.00	18.00
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost						
20.00	reporting period. List those CBSA code(s) in column 1 serviced			18020			20.00
	during this cost reporting period (line 20						
20. 01	contains the first code).			26900			20. 01
		Full Ep				T L L L	
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 382	C	1.	4 0	1, 396	21.00
22.00	Skilled Nursing Visit Charges	284, 884	C			287, 188	22.00
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	900 217, 769		25		901 218, 019	•
25.00	Occupational Therapy Visits	510			1 0	511	25.00
26.00 27.00	Occupational Therapy Visit Charges Speech Pathology Visits	125,001	0	25		125, 251 7	
28.00	Speech Pathology Visit Charges	, 1, 750	0			, 1, 750	•
29.00	Medical Social Service Visits	5	0		0 0	5	
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	1, 350 134				1, 350 134	
32.00	Home Health Aide Visit Charges	13, 103			o o	13, 103	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2, 938	C	1	0	2, 954	33.00
34.00	Other Charges	0	O		o o	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	643, 857	C	2, 80	4 0	646, 661	35.00
36.00	Total Number of Episodes (standard/non	166		.	4 O	170	36.00
37.00	outlier) Total Number of Outlier Episodes		C		0	о	37.00
	Total Non-Routine Medical Supply Charges	2, 458	0) (o o		38.00

Heal th	Financial Systems JOHNSON MEMORIAL HO	SPI TAL		In Lie	eu of Form CMS-	2552-10
		Provider (CCN: 150001	Peri od:	Worksheet S-1	
				From 01/01/2014		nored.
				To 12/31/2014	Date/Time Pre 5/21/2015 1:2	9 pm
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lin	e 202 columr	18)	0. 325418	1.00
2.00	Medicaid (see instructions for each line) Net revenue from Medicaid				8, 166, 867	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental j	payments f	rom Medicaid	?	Ý	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from 1				0	
6.00	Medi cai d charges				16, 072, 679	6.00
7.00	Medicaid cost (line 1 times line 6)				5, 230, 339	
8.00	Difference between net revenue and costs for Medicaid program (I	ine 7 minu	s sum of lir	ies 2 and 5; if	0	8.00
	< zero then enter zero)	6				-
9.00	State Children's Health Insurance Program (SCHIP) (see instruction Net revenue from stand-alone SCHIP	ons for ea	ch iine)		0	9.00
	Stand-allone SCHIP charges					
	Stand-alone SCHIP cost (line 1 times line 10)				0	
	Difference between net revenue and costs for stand-alone SCHIP (line 11 mi	nus line 9:	if < zero then	0	
	enter zero)					
	Other state or local government indigent care program (see instru				1	
	Net revenue from state or local indigent care program (Not inclu				0	
14.00	Charges for patients covered under state or local indigent care	program (N	ot included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line 14)				0	15.00
	Difference between net revenue and costs for state or local india		nrogram (lir	e 15 minus line	-	
10.00	13; if < zero then enter zero)	gent cure				10.00
	Uncompensated care (see instructions for each line)					
	Private grants, donations, or endowment income restricted to fund					17.00
	Government grants, appropriations or transfers for support of hos				0	
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	i ndi gent	care program	ns (sum of lines	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (a		8, 502, 59	1, 223, 364	9, 725, 962	20.00
21 00	charges excluding non-reimbursable cost centers) for the entire		2 7// 00	200 105	2 1/5 002	21 00
21.00	Cost of initial obligation of patients approved for charity care times line 20)	(The T	2, 766, 89	398, 105	3, 165, 003	21.00
22.00	Partial payment by patients approved for charity care		265, 98	249, 232	515, 219	22.00
	Cost of charity care (line 21 minus line 22)		2, 500, 91			
		•	· · ·			
					1.00	
24.00	Does the amount in line 20 column 2 include charges for patient of		d a length c	of stay limit		24.00
25 00	imposed on patients covered by Medicaid or other indigent care pu					25 00
	If line 24 is "yes," charges for patient days beyond an indigen Total bad debt expense for the entire hospital complex (see inst		gram s rengi	n or stay limit		
	Medicare bad debts for the entire hospital complex (see instruction)				6, 629, 615 131, 399	
	Non-Medicare and non-reimbursable Medicare bad debt expense (line		line 27)		6, 498, 216	
	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (rink			28)	2, 114, 636	
	Cost of uncompensated care (line 23 column 3 plus line 29)	、 -		,	4, 764, 420	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			4, 764, 420	31.00

Cost Center Description Salaries Other Total (col. 1) (col. 2) Reclassificatil (ns (See A-6) Tr (see A-6) 1.00 2.00 3.00 4.00 1.01 00100 (AP REL COSTS-RUGE & FLXT (see A-6) 1.706, 743 1.706, 743 0 1.01 00101 (AP REL COSTS-RUGE & FLXT (see A-6) 1.706, 743 1.706, 743 1.706, 743 0 1.01 00101 (AP REL COSTS-RUGE & FLXT (see A-6) 1.706, 743 1.706, 743 1.706, 743 0 1.01 00101 (AP REL COSTS-RUGE & FLXT (see A-6) 1.71, 732 2.718, 529 1.45, 487 1.01 00401 (AP REL COSTS-SIN & (see A-6) 1.714 7.624, 777 6 6.657 145, 487 1.02 00402 (DATA PROCESTS NG (see A-6) 718, 481 6.919 1.718, 494 9.52, 77 0 1.00 00403 (DATA PROCESTS NG (see A-6) 1.814 7.7 64, 669 77 0 1.02 00403 (DATA PROCESTS NG (see A-6) 1.814 7.7 96 189, 335 0 1.00 00700 (DECATINO OF PLANT 643, 881 2.246, 895 <	Date/Time Prepared 5/21/2015 1: 29 pm Reclassified Frial Balance (col. 3 +- col. 4) 5.00 1,706,743 1. 86,509 1. 2,718,329 2. 8,430,209 4. 465,557 4. 1,390,420 4. 312,653 4. 609,372 4. 1,404,427 4. 9,562,797 5. 2,890,776 7. 189,383 8. 744,981 9. 463,643 10. 582,328 11. 1,370,237 13.
Cost Center Description Salaries Other Total (col. 1) (sec 4.6) Tecal assi fi cati (sec 4.6) Tecal assi fi cati (sec 4.6) Tecal assi fi cati (sec 4.6) 1.00 00100 CAP REL COST-BLDG & FLXT 1.00 1.00 2.00 3.00 4.00 1.01 00101 CAP REL COST-BLDG & FLXT 1.00 1.706, 743 1.706, 743 0 2.00 02200 CAP REL COST-SHDG & FLXT 1.00 1.706, 743 0 8.509 0 2.01 02200 CAP REL COST-SHDG & FLXT 1.00 1.706, 743 1.706, 743 0 2.01 02200 CAP REL COST-SHDG & FLXT 1.00 1.706, 743 1.706, 743 0 2.01 02200 CAP REL COST-SHDG & FLXT 1.00 1.717, 933 1.300, 420 0 2.01 02401 CMAR PROCESTING 1.17, 933 1.300, 420 0 0 0.718, 229 0 3.00 0403 DMAI NISTRATIVE & CENERAL 1.1871, 233 1.614, 474 9, 562, 328 0 0 3.00 06030 DETAR 7.418, 493 1.300, 277 0 7.44, 491 0 3.00 06030 DETAR 0000 OS00 DETAR 0.0000 OS000 DETAR<	Recl assi fi ed (ri al Bal ance (col. 3 +- col. 4) - 5.00 - 1, 706, 743 1. 86, 509 1. 2, 718, 329 2. 8, 430, 209 4. 465, 557 4. 312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
CENERAL SERVICE COST CENTERS 1.00 ODIO CAP REL COSTS-BLDG & FIXT 1,706,743 1,706,743 0,718,329 2,718,329 0,716,318,318,318 0,718,329 0,718,329 0,718,329 0,718,329 0,718,318,318 0,718,318,318,318 0,718,318,318,318 0,718,318,318,318 0,714,319,312,453 0,714,319,312,453 0,714,319,312,453 0,714,318,318,310,312,414,318 0,714,319,312,453	5.00 1,706,743 1,86,509 1,2,718,329 2,718,329 4,45,557 4, 1,390,420 4,312,653 4, 609,372 4, 1,404,427 4, 9,562,797 5, 2,890,776 7, 189,383 8, 744,981 9, 463,643 10, 582,328 11.
1.00 00100 CAP REL COSTS-BLDG & FLXT 1, 706, 743 0, 706, 743 0 0.010 CAP REL COSTS-MDUE FOUP 86, 509 86, 509 2, 718, 329 0 0.010 COMO CAP REL COSTS-MDUE FOUP 2, 718, 329 2, 718, 329 0 0 0.010 COMUNIC ATIONS 190, 811 7, 622, 771 8, 284, 722 145, 487 0.010 COMUNIC ATIONS 190, 811 7264, 743 45, 910 312, 653 0 4.02 00403 MATERIALS MANAGEMENT 266, 743 482, 236 25, 136 609, 372 0 4.05 00404 ADMITTING 800, 037 544, 390 1, 404, 427 0 5.00 00500 ADMINISTRATIVE & GENERAL 1, 871, 323 7, 691, 474 9, 562, 797 0 0.00 00000 OPERATION OF PLANT 643, 881 2, 246, 695 2, 890, 776 0 0.00 000000 HUSEKEPING 627, 961 117, 020 744, 981 0 0.00 000000 HUSEKEPING 627, 961 177, 407 155, 551 0 0.00 000000 CHETARY XTARY	86, 509 1. 2, 718, 329 2. 8, 430, 209 4. 465, 557 4. 1, 390, 420 4. 312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
1.01 00101 CAP REL COSTS -MUBLE COULP 86, 509 00 0.00 00400 CAP REL COSTS -MUBLE FOULP 7, 422, 718, 329 2, 718, 329 2, 718, 329 2, 718, 329 0 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 661, 951 7, 622, 718, 329 0 0 4.02 00402 DATA PROCESSING 718, 447 671, 931 1, 390, 420 0 4.03 00404 MATTERIALS MANAGEMEENT 266, 743 45, 910 312, 653 0 4.04 00404 AMITTIN C 584, 233 25, 136 609, 372 0 5.00 00500 AMIN INSTRATIVE & GENERAL 1, 871, 223 7, 691, 474 9, 62, 797 0 7.00 00700 OPERATION OF PLANT 643, 881 2, 246, 895 2, 890, 776 0 0.00 00300 AUMINEY & LINEN SERVICE 13, 414 75, 669 189, 983 0 1.00 01000 CAFEEN A C 0 0 582, 328 133, 694 1, 70, 237 1, 645,	86, 509 1. 2, 718, 329 2. 8, 430, 209 4. 465, 557 4. 1, 390, 420 4. 312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 661,951 7,22,771 8,284,722 145,487 4.01 00401 COMUNIC CATLONS 190,811 274,746 465,557 0 4.02 00402 DATA PROCESSI NG 718,487 671,933 1,390,420 0 4.04 00404 ADMI TERI ALS MANAGEMENT 266,743 45,910 312,653 0 4.05 00405 PATI ENT ACCOUNTI NG 860,037 544,390 1,404,427 0 5.00 00500 ADMI NI STRATI IVE & GENERAL 1,871,323 7,691,474 9,562,797 0 7.00 00700 OPERATI ON OF PLANT 643,881 2,246,895 2,890,776 0 9.00 000000 LUNRY SERVICE 113,414 75,969 189,383 0 0 9.00 10100 CAFTERI A 0 0 0 582,328 0 0 2,923,285 0 11.00 01100 CAFTERI A SERVICES & SUPLY 78,144 77,407 155,551 0 12.00 01300 AURSI NG ADMINI STRATION 1,234,543 3,680,130	8, 430, 209 4. 465, 557 4. 1, 390, 420 4. 312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
4.01 00401 COMUNICATIONS 190, 811 274, 746 465, 557 0 4.02 00402 DATA PROCESSING 718, 487 671, 933 1, 390, 420 0 4.03 00403 MATERI ALS MANAGEMENT 266, 743 45, 910 312, 653 0 4.04 00404 ADMI ITING 584, 236 25, 136 609, 972 0 5.00 00500 ADMIN ISTRATIVE & GENERAL 1, 871, 323 7, 691, 474 9, 562, 797 0 7.00 00700 OPERATION OF PLANT 643, 881 2, 246, 895 2, 980, 776 0 8.00 00800 LUNRY & LINEN SERVICE 113, 414 75, 969 189, 383 0 9.00 009000 HOUSEKEEPING 627, 961 117, 020 744, 981 0 10.00 01000 CARTERIA 0 0 0 582, 328 13.00 10300 NURSING ADMINI STRATION 1, 234, 543 175, 664 1, 370, 237 0 14.00 01400 CENTRAL SERVICES & SUPPLY 78, 144 77, 407 155, 551 0 <td< td=""><td>465, 557 4. 1, 390, 420 4. 312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.</td></td<>	465, 557 4. 1, 390, 420 4. 312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
4.02 00402 DATA PROCESSING 718.487 671.933 1.990.420 0 4.03 00404 AMMATERIALS MANAGEMENT 266.743 45.910 312.653 0 4.04 00404 AMMINITING 880.037 544.390 1.404.427 0 5.00 00500 ADMINISTRATIVE & GENERAL 1.871.323 7.691.474 9.562.797 0 7.00 00700 DEMATION OF PLANT 643.881 2.246.895 2.890.776 0 8.00 00800 LUNDRY & LINEN SERVICE 113.414 75.669 189.333 0 9.00 00900 DUSKEEEPING 627.961 177.020 744.981 0 9.00 0100 CATTRAL SERVICES & SUPPLY 78.144 77.607 155.551 0 11.00 O1100 CATTRAL SERVICES & SUPPLY 78.144 77.407 155.551 0 12.00 01300 ADUI CAL RECORDS & LI BRARY 509.664 254.711 764.375 0 13.00 03000 ADUL CAL RECORDS & LI BRARY 509.664 254.711 764.375 0 0 <td< td=""><td>1, 390, 420 4. 312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.</td></td<>	1, 390, 420 4. 312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
4.03 00403 MATERI ALS MANAGEMENT 266, 743 64, 910 312, 653 0 4.04 00440 ADMI TI NG 584, 236 25, 136, 609, 372 0 5.00 00500 ADMI NI STRATI VE & GENERAL 1, 871, 323 7, 691, 474 9, 562, 797 0 7.00 00700 OPERATI NO F PLANT 643, 881 2, 246, 895 2, 890, 776 0 8.00 00800 HAUDRY & LINEN SERVICE 113, 414 75, 969 189, 333 0 9.00 00900 HOUSEXEEPING 627, 961 117, 020 744, 981 0 0 10.00 01000 DETARY 742, 998 302, 973 1, 045, 971 -582, 328 13.00 01030 NUESING ADMI NISTRATI ON 1, 234, 543 135, 694 1, 370, 237 14.00 1000 CENTRAL SERVICES & SUPPLY 78, 144 77, 407 155, 551 0 15.00 01500 PHARMACY 463, 358 3, 680, 130 4, 143, 488 0 16.00 10400 SUBPROVIDER - LIRF 509, 664 24, 711 764, 375 0 1	312, 653 4. 609, 372 4. 1, 404, 427 4. 9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
4.05 00405 PATIENT ACCOUNTING 860.037 544.390 1. 404.427 0 5.00 00500 DOMINISTRATIVE & GENERAL 1. 871.323 7. 691.474 9. 562.797 0 7.00 00700 OPERATION OF PLANT 643.881 2. 246.895 2. 890.776 0 8.00 00800 LAUNDRY & LI NEN SERVICE 113.414 75.699 189.883 0 9.00 00900 HUNDRY & LI NEN SERVICE 113.414 75.699 189.883 0 10.00 01000 DI ETARY 742.998 302.973 1.045.971 -582.328 13.00 01000 CENTRAL SERVICES & SUPPLY 78.144 77.407 155.551 0 14.00 1000 OLO CENTRAL SERVICE COST CENTERS 509.664 254.711 764.375 0 10.00 10000 INEDICAL RECORDS & LI BRARY 509.664 254.711 764.375 0 10.00 1000 SUBPROVIDER - I RF 640.538 178.947 819.485 0 30.00 03000 ADULTS & PEDI ATRIC S 2.741.389 348.935 2.433.803 0 10.00 100 SUBPROVIDER - I RF	1, 404, 427 9, 562, 797 2, 890, 776 189, 383 744, 981 9, 463, 643 10. 582, 328
5.00 00500 ADMI NI STRATI VE & GENERAL 1,871,323 7,991,474 9,562,797 0 7.00 00700 OPERATI ON OF PLANT 643,881 2,266,895 2,890,776 0 8.00 00800 LAUNRY & LI NEN SERVI CE 113,414 75,969 189,383 0 9.00 00900 DUESKEEPI NG 627,961 117,020 744,981 0 9.01 00100 CARTERN 0 0 742,998 302,973 1,045,971 -582,328 11.00 01100 CAFETERIA 0 0 0 582,328 11.00 01400 CRITRAL SERVICES & SUPPLY 78,144 77,407 155,551 0 15.00 01500 PHARMACY 463,358 3,680,130 4,143,488 0 10 041000 CRITRAL SERVICE COST CENTERS 509,664 254,171 764,475 0 10 04100 NEBRON DER - 1 IFF 1,048,517 2,16,3875 2,433,803 0 10 04300	9, 562, 797 5. 2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
7.00 00700 0PERATION OF PLANT 643,881 2,246,895 2,890,776 0 8.00 00800 LAUNDRY & LINEN SERVICE 113,414 75,969 189,383 0 9.00 00900 HUUSEKEEPI NG 627,961 117,020 744,981 0 10.00 01000 CAFETERIA 0 0 0 0582,328 13.00 01300 NURSI NG ADMI NI STRATI ON 1,234,543 135,694 1,370,237 0 14.00 01400 CENTRAL SERVI CES & SUPPLY 78,144 77,407 155,551 0 15.00 01500 PHARMACY 463,358 3,680,130 4,143,488 0 16.00 01001 CAL RECORDS & LI BRARY 509,664 254,711 764,375 0 INPATI ENT ROUTINE SERVI CE COST CENTERS 2 741,389 348,935 3,090,324 -196,211 10.0 03000 NURSERY 0 0 0 0 196,211 0 03000 SUGNSO PERATI NG ROOM 1,669,928	2, 890, 776 7. 189, 383 8. 744, 981 9. 463, 643 10. 582, 328 11.
8.00 00800 LAUNDRY & LI NEN SERVICE 113, 414 75, 969 189, 383 0 9.00 00900 HOUSEKEEPI NG 627, 961 117, 020 744, 981 0 10.00 01000 DI ETARY 742, 998 302, 973 1, 045, 971 -582, 328 11.00 01100 CAFETERIA 0 0 0 582, 328 13.00 01300 NURSI NG ADMIN IS TRATI ON 1, 234, 543 135, 694 1, 370, 237 0 14.00 01400 CENTRAL SERVICES & SUPPLY 78, 144 77, 407 155, 551 0 15.00 01500 PHARMACY 463, 358 3, 680, 130 4, 143, 488 0 00 03000 ADULTS & SERVICE COST CENTERS 509, 664 254, 711 764, 375 0 010 03100 INTENSI VE CARE UNI T 1, 048, 517 216, 459 1, 264, 976 0 0 196, 211 31.00 04300 NRSERY 0 0 26, 332 26, 332 0 0 26, 332 26, 332 0 0 0 196, 211 ANCI LLARY S	189, 3838.744, 9819.463, 64310.582, 32811.
9.00 00000 HOUSEKEEPI NG 627, 961 117, 020 744, 981 0 10.00 01000 DETARY 742, 998 302, 973 1, 045, 971 -582, 328 13.00 01100 CAFETERIA 0 0 582, 328 13.00 01000 CAFETERIA 78, 144 77, 407 155, 551 0 14.00 01400 CENTRA 763, 375 3680, 130 4, 143, 488 0 15.00 01500 PHARMACY 463, 358 3, 680, 130 4, 143, 488 0 10.00 03000 MULTS SERVICE COST CENTERS 2, 741, 389 348, 935 3, 090, 324 -196, 211 30.00 03000 NURSPROVIDER - 1 RF 640, 558 178, 947 819, 485 0 41.00 04100 SUBPROVIDER - 1 RF 640, 533 178, 947 819, 485 0 50.00 05000 PERATI NG ROOM 1, 669, 928 763, 875 2, 433, 803 0 61.00 06000 ANDILLARY SERVICE COST CEN	744, 981 9. 463, 643 10. 582, 328 11.
11.00 01100 CAFETERIA 0	582, 328 11.
13:00 01300 NURSI NG ADMI NI STRATI ON 1, 234, 543 135, 694 1, 370, 237 0 14:00 01400 CENTRAL SERVI CES & SUPPLY 78, 144 77, 407 155, 551 0 15:00 01500 PHARMACY 463, 358 3, 680, 130 4, 143, 488 0 16:00 01600 MEDI CAL RECORDS & LIBRARY 509, 664 254, 711 764, 375 0 10:00 03000 ADULTS & PEDI ATRI CS 2, 741, 389 348, 935 3, 090, 324 -196, 211 11:00 03100 INTENSI VE CARE UNI T 1, 048, 517 216, 459 1, 264, 976 0 0 03100 NURSERY 0 0 0 0 196, 211 11:00 AVIO SUBRY OND IER - IRF 640, 538 178, 947 819, 485 0 50:00 05000 OPERATI NG ROM 1, 669, 928 763, 875 2, 433, 803 0 0 60:00 06000 LABRATORY 1, 279, 363 1, 889, 737 3, 169, 100 0 61:00 06000 RSPI RATORY THERAPY 717, 019 33, 550, 552	
14.00 CISNTRAL SERVICES & SUPPLY 78,144 77,407 155,551 0 15.00 01500 PHARMACY 463,358 3,680,130 4,143,488 0 16.00 01600 MEDI CAL RECORDS & LI BRARY 509,664 254,711 764,375 0 30.00 03000 ADULTS & PEDI ATRICS 2,741,389 348,935 3,090,324 -196,211 31.00 03100 INTENSI VE CARE UNI T 1,048,517 216,459 1,264,976 0 41.00 04100 SUBPROVI DER - IRF 640,538 178,947 819,485 0 30.00 05000 OPERATI NG ROOM 1,669,928 763,875 2,433,803 0 51.00 05000 OPERATI NG ROOM 1,264,976 0 0 0 53.00 05000 NESPI NORY 1,279,363 178,947 819,485 0 64.00 04300 NADILARY SERVICE COST CENTERS 1,968,309 995,479 2,963,788 0 53.00 05000 RESPI RATORY THERAPY 1,279,363 1,889,737 3,169,100 0 64.00	1, 3/0, 23/1 13.
15.00 01500 PHARMACY 463, 358 3, 680, 130 4, 143, 488 0 16.00 01600 MEDI CAL RECORDS & LI BRARY 509, 664 254, 711 764, 375 0 30.00 03000 ADULTS & PEDI ATRI CS 2, 741, 389 348, 935 3, 090, 324 -196, 211 31.00 03000 INTENSI VE CARE UNI T 1, 048, 517 216, 459 1, 264, 976 0 43.00 04300 NURSERY 0 0 0 196, 211 ANCI LLARY SERVICE COST CENTERS 50.00 05000 PERATIN G 1, 669, 928 763, 875 2, 433, 803 0 53.00 05300 ANESTHESI OLOGY 1, 968, 309 995, 479 2, 963, 788 0 60.00 06000 LABORATORY 1, 279, 363 1, 889, 733 1, 169, 100 0 65.00 06500 RESPI RATORY THERAPY 850, 914 152, 188 1, 003, 102 0 66.00 06400 PHYSI CAL THERAPY 205, 640 -1, 331 204, 309 0 69.00 06200 RESPI RATORY THERAPY 205, 640 -1, 331	155, 551 14.
16.00 01600 MEDI CAL RECORDS & LIBRARY 509,664 254,711 764,375 0 100 03000 DUTI NE SERVI CE COST CENTERS 3,090,324 -196,211 11.00 03100 INTENSI VE CARE UNI T 1,048,517 216,459 1,264,976 0 11.00 04100 SUBPROVI DER - I RF 640,538 178,947 819,485 0 0 196,211 ANCILLARY SERVI CE COST CENTERS 0 0 0 196,211 0 0 196,211 ANCILLARY SERVI CE COST CENTERS 0 0 0 2,433,803 0 0 50.00 05300 ANESTHESI OLOGY 0 26,332 26,332 0 0 60.00 06500 RESPI RATORY THERAPY 1,279,363 1,889,737 3,169,100 0 0 61.00 06500 RESPI RATORY THERAPY 717,019 33,533 750,552 0 <td< td=""><td>4, 143, 488 15.</td></td<>	4, 143, 488 15.
30.00 03000 ADULTS & PEDIATRICS 2,741,389 348,935 3,090,324 -196,211 31.00 INTENSIVE CARE UNIT 1,048,517 216,459 1,264,976 0 41.00 OUSDROVIDER - IRF 640,538 178,947 819,485 0 0 ANCILLARY SERVICE COST CENTERS 0 0 0 196,211 0 0 0 196,211 ANCILLARY SERVICE COST CENTERS 0 0 26,332 26,332 0 0 50.00 05300 ANESTHESI OLOGY 0 26,332 26,332 0 54.00 06400 LABORATORY 1,2968,309 995,479 2,963,788 0 65.00 06500 RESPI RATORY THERAPY 1,279,363 1,889,73 3,169,100 0 66.00 06600 PHYSI CAL THERAPY 717,019 33,533 750,552 0 67.00 0CCUPATI ONAL THERAPY 205,640 -1,331 204,309 0 68.00 06800 SPECLEN PATHOLOGY 128,337 57 128,394 0 69.00 06900 <	764, 375 16.
31.00 03100 INTENSI VE CARE UNIT 1,048,517 216,459 1,264,976 0 41.00 OU100 SUBPROVI DER - IRF 640,538 178,947 819,485 0 43.00 AUSCILLARY SERVICE COST CENTERS 0 0 196,211 50.00 OPERATI NG ROM 1,669,928 763,875 2,433,803 0 53.00 05000 OPERATI NG ROM 1,968,309 995,479 2,963,788 0 60.00 06000 LABORATORY 1,279,363 1,889,737 3,169,100 0 65.00 06500 RESPI RATORY THERAPY 717,019 33,533 750,552 0 67.00 06700 OCUPATI ONAL THERAPY 717,019 33,533 750,552 0 68.00 OBORO ELECTROCARDI OLOGY 128,337 57 128,394 0 69.00 06900 LECTROCARDI OLOGY 341,538 417,148 758,686 0 71.00 07300 DRUGACHPHALOGRAPHY 46,765 9,060 55,825 0 71.00 07300 DRUGA SUPPLIES CHARGED TO PATI ENT 0	
41.00 04100 SUBPROVI DER - I RF 640, 538 178, 947 819, 485 0 43.00 04300 NURSERY 0 0 0 196, 211 ANCI LLARY SERVI CE COST CENTERS	2, 894, 113 30.
43.00 04300 NURSERY 0 0 196, 211 ANCLLLARY SERVICE COST CENTERS 50.00 OPERATING ROM 1, 669, 928 763, 875 2, 433, 803 0 53.00 05300 ANESTHESI OLOGY 0 26, 332 26, 332 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 968, 309 995, 479 2, 963, 788 0 60.00 LABORATORY 1, 279, 363 1, 889, 737 3, 169, 100 0 65.00 06500 RESPI RATORY THERAPY 717, 019 33, 533 750, 552 0 67.00 06700 OCCUPATI ONAL THERAPY 717, 019 33, 533 750, 552 0 68.00 D6800 SPEECH PATHOLOGY 128, 337 57 128, 394 0 69.00 06900 ELECTROCARDI OLOGY 341, 538 417, 148 758, 686 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 1, 305, 191 73.00 07200 DRU	1, 264, 976 31. 819, 485 41.
50.00 05000 OPERATI NG ROOM 1, 669, 928 763, 875 2, 433, 803 0 53.00 05300 ANESTHESI 0LOGY 0 26, 332 26, 332 0 54.00 05400 RADI 0LOGY-DI AGNOSTI C 1, 968, 309 995, 479 2, 963, 788 0 60.00 06000 LABORATORY 1, 279, 363 1, 889, 737 3, 169, 100 0 65.00 06500 RESPI RATORY THERAPY 850, 914 152, 188 1, 003, 102 0 66.00 06600 PHYSI CAL THERAPY 717, 019 33, 533 750, 552 0 67.00 0C700 OCUPATI ONAL THERAPY 205, 640 -1, 331 204, 309 0 68.00 06800 SPECH PATHOLOGY 128, 337 57 128, 394 0 69.00 06900 ELECTROCARDI OLOGY 341, 538 417, 148 758, 686 0 71.00 07100 MEUG CAL SUPPLI ES CHARGED TO PATI ENT 0 3, 101, 069 3, 101, 069 -1, 305, 191 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 <	196, 211 43.
53.00 05300 ANESTHESI OLOGY 0 26, 332 26, 332 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 968, 309 995, 479 2, 963, 788 0 60.00 06000 LABORATORY 1, 279, 363 1, 889, 737 3, 169, 100 0 65.00 06500 RESPI RATORY THERAPY 850, 914 152, 188 1, 003, 102 0 66.00 06600 PHYSI CAL THERAPY 717, 019 33, 533 750, 552 0 67.00 06700 OCCUPATI ONAL THERAPY 205, 640 -1, 331 204, 309 0 68.00 06800 SPEECH PATHOLOGY 128, 337 57 128, 394 0 69.00 06900 ELECTROCARDI OLOGY 341, 538 417, 148 758, 686 0 71.00 07000 ELECTROCARDERDERAPHY 46, 765 9, 060 55, 825 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 3, 101, 069 -1, 305, 191 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 7	
54.00 05400 RADI OLOGY-DI AGNOSTI C 1,968,309 995,479 2,963,788 0 60.00 06000 LABORATORY 1,279,363 1,889,737 3,169,100 0 65.00 06500 RESPI RATORY THERAPY 850,914 152,188 1,003,102 0 66.00 06600 PHYSI CAL THERAPY 717,019 33,533 750,552 0 67.00 0CCUPATI ONAL THERAPY 205,640 -1,331 204,309 0 68.00 06800 SPEECH PATHOLOGY 128,337 57 128,394 0 69.00 06900 ELECTROCARDI OLOGY 341,538 417,148 758,686 0 70.00 O7000 ELECTROCARDI OLOGY 341,538 417,148 758,686 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 3,101,069 3,101,069 -1,305,191 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 76.90 07697 CARDI AC REHABI LI TATI ON 93,855 8,626 102,481 0 0.00	2, 433, 803 50.
60.00 06000 LABORATORY 1, 279, 363 1, 889, 737 3, 169, 100 0 65.00 06500 RESPI RATORY THERAPY 850, 914 152, 188 1, 003, 102 0 66.00 06600 PHYSI CAL THERAPY 717, 019 33, 533 750, 552 0 67.00 06700 OCUPATI ONAL THERAPY 205, 640 -1, 331 204, 309 0 68.00 O6800 SPEECH PATHOLOGY 128, 337 57 128, 394 0 69.00 06900 ELECTROCARDI OLOGY 341, 538 417, 148 758, 686 0 71.00 07000 ELECTROENCEPHALOGRAPHY 46, 765 9, 060 55, 825 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 1, 305, 191 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73.00 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74.00 0.00 0.00 0 0 0 0 0 76.00 0.020 ON	26, 332 53. 2, 963, 788 54.
65.00 06500 RESPI RATORY THERAPY 850, 914 152, 188 1, 003, 102 0 66.00 06600 PHYSI CAL THERAPY 717, 019 33, 533 750, 552 0 67.00 06700 0CCUPATI ONAL THERAPY 205, 640 -1, 331 204, 309 0 68.00 06800 SPEECH PATHOLOGY 128, 337 57 128, 394 0 69.00 06900 ELECTROCARDI OLOGY 341, 538 417, 148 758, 686 0 70.00 O7000 ELECTROCARDI OLOGY 341, 538 417, 148 758, 686 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 3, 101, 069 3, 101, 069 -1, 305, 191 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 1, 305, 191 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 76.00 03020 ONCOLOGY 195, 362 29, 203 224, 565 0 76.00 03020 ONCOLOGY 195, 362 29, 203 224, 565 0 <	3, 169, 100 60.
67.00 06700 0CCUPATI ONAL THERAPY 205, 640 -1, 331 204, 309 0 68.00 06800 SPEECH PATHOLOGY 128, 337 57 128, 394 0 69.00 06900 ELECTROCARDI OLOGY 341, 538 417, 148 758, 686 0 70.00 07000 ELECTROENCEPHALOGRAPHY 46, 765 9, 060 55, 825 0 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 3, 101, 069 3, 101, 069 -1, 305, 191 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 76.00 03020 ONCOLOGY 195, 362 29, 203 224, 565 0 0 76.01 07697 CARDI AC REHABI LI TATI ON 93, 855 8, 626 102, 481 0 0 70.00 OP000 CLI NI C 572, 857 1, 831, 573 2, 404, 430 0 0 70.00 O9100 EMERGENCY 1, 707, 964 349,	1,003,102 65.
68.00 06800 SPEECH PATHOLOGY 128, 337 57 128, 394 0 69.00 06900 ELECTROCARDI OLOGY 341, 538 417, 148 758, 686 0 70.00 07000 ELECTROENCEPHALOGRAPHY 46, 765 9, 060 55, 825 0 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 3, 101, 069 -1, 305, 191 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 1, 305, 191 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 76.00 03020 ONCOLOGY 195, 362 29, 203 224, 565 0 76.97 CARDI AC REHABI LI TATI ON 93, 855 8, 626 102, 481 0 0UTPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 572, 857 1, 831, 573 2, 404, 430 0 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1 0 1 0 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 1 0 1 0 92.00 092000 </td <td>750, 552 66.</td>	750, 552 66.
69.00 06900 ELECTROCARDIOLOGY 341, 538 417, 148 758, 686 0 70.00 07000 ELECTROENCEPHALOGRAPHY 46, 765 9, 060 55, 825 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 3, 101, 069 3, 101, 069 -1, 305, 191 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 1, 305, 191 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 76.00 03202 ONCOLOGY 195, 362 29, 203 224, 565 0 76.97 OR697 CARDIAC REHABILITATION 93, 855 8, 626 102, 481 0 0UTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 572, 857 1, 831, 573 2, 404, 430 0 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0 0 0 92.00 092000 OBSERVATION BEDS (NON-DI STINCT PART 0 0 0 0 91.00 10100 HMBURSABLE COST CENTERS 0 0 0 0 <td>204, 309 67.</td>	204, 309 67.
70.00 07000 ELECTROENCEPHALOGRAPHY 46,765 9,060 55,825 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 3,101,069 3,101,069 -1,305,191 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 1,305,191 73.00 07300 DRUGS CHARGED TO PATIENTS 0	128, 394 68. 758, 686 69.
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 1, 305, 191 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 03020 DRUGS CHARGED TO PATI ENTS 0 0 0 0 76.00 03020 ONCOLOGY 195, 362 29, 203 224, 565 0 76.97 O7697 CARDI AC REHABI LI TATI ON 93, 855 8, 626 102, 481 0 0UTPATI ENT SERVI CE COST CENTERS 0 1, 707, 964 349, 587 2, 404, 430 0 90.00 09100 EMERGENCY 1, 707, 964 349, 587 2, 057, 551 0 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 91.00 10100 HOME HEALTH AGENCY 641, 537 168, 106 809, 643 0 92.00 0BSECI AL PURPOSE COST CENTERS 0 0 0 0 0	55, 825 70.
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 76.00 03020 ONCOLOGY 195, 362 29, 203 224, 565 0 76.97 07697 CARDIAC REHABILITATION 93, 855 8, 626 102, 481 0 0UTPATIENT SERVICE COST CENTERS 0 97, 857 1, 831, 573 2, 404, 430 0 90.00 09000 CLINIC 572, 857 1, 831, 573 2, 057, 551 0 91.00 09100 EMERGENCY 1, 707, 964 349, 587 2, 057, 551 0 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0 0 0 91.00 10100 HOME HEALTH AGENCY 641, 537 168, 106 809, 643 0	1, 795, 878 71.
76.00 03020 ONCOLOGY 195, 362 29, 203 224, 565 0 76.97 O7697 CARDIAC REHABILITATION 93, 855 8, 626 102, 481 0 OUTPATIENT SERVICE COST CENTERS 0 93, 855 1, 831, 573 2, 404, 430 0 90.00 09000 CLINIC 572, 857 1, 831, 573 2, 057, 551 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 707, 964 349, 587 2, 057, 551 0 01.00 HOME HEALTH AGENCY 641, 537 168, 106 809, 643 0 SPECIAL PURPOSE COST CENTERS	1, 305, 191 72.
76. 97 07697 CARDI AC REHABI LI TATI ON 93, 855 8, 626 102, 481 0 OUTPATI ENT SERVICE COST CENTERS 0 00000 CLI NI C 572, 857 1, 831, 573 2, 404, 430 0 91. 00 09100 EMERGENCY 1, 707, 964 349, 587 2, 057, 551 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 101.00 HOME HEALTH AGENCY 641, 537 168, 106 809, 643 0 SPECI AL PURPOSE COST CENTERS 0 0 0 0 0	0 73. 224, 565 76.
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 572, 857 1, 831, 573 2, 404, 430 0 91. 00 09100 EMERGENCY 1, 707, 964 349, 587 2, 057, 551 0 92. 00 O92000 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 01.00 THER REI MBURSABLE COST CENTERS 0 </td <td>102, 481 76.</td>	102, 481 76.
91.00 09100 EMERGENCY 1,707,964 349,587 2,057,551 0 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 1 1 1 1 1 1 1 1 1 0 1	
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART Image: Constraint of the state of th	2, 404, 430 90.
OTHER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 641, 537 168, 106 809, 643 0 SPECI AL PURPOSE COST CENTERS	2, 057, 551 91.
101. 00 10100 HOME HEALTH AGENCY 641, 537 168, 106 809, 643 0 SPECIAL PURPOSE COST CENTERS	92.
	809, 643 101.
113.00 11300 I NTEREST EXPENSE 11, 286 0	11, 286 113.
118.00 SUBTOTALS (SUM OF LINES 1-117) 24, 417, 383 38, 808, 609 63, 225, 992 145, 487 NONREI MBURSABLE COST CENTERS	<u>63, 371, 479</u> 118.
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 57, 144 48, 521 105, 665 0	105, 665 190.
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 8, 348, 922 2, 805, 648 11, 154, 570 0	11, 154, 570 192.
192.01 SOUTH CLINIC 0 15 15 0	15 192.
192. 02 19202 WEST CLINIC 0 0 0 0	01100
192.03 19203 DI ABETES CENTER 86,052 6,742 92,794 0 193.00 19300 NONPAI D WORKERS 0 0 0 0 0	0 192.
193. 01 19301 ADULT/CHI LD CARE 526, 161 82, 100 608, 261 -145, 487	92, 794 192.
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 0 0 0	
193. 03 19303 OPTI FAST/FOUNDATI ON 0 784, 999 0	92, 794 192. 0 193. 462, 774 193. 0 193.
194. 00 07950 PARTNERSHI P HFC 46, 044 6, 256 52, 300 0	92, 794 192. 0 193. 462, 774 193. 0 193. 784, 999 193.
194. 01 07951 TRAFALGAR CLINIC 0 0 0 194. 02 07952 EDI NBURGH 0 0 0 0	92, 794 192. 0 193. 462, 774 193. 0 193. 784, 999 193. 52, 300 194.
194. 03 07953 JAI L 0 53, 031 53, 031 0	92, 794 192. 0 193. 462, 774 193. 0 193. 784, 999 193. 52, 300 194. 0 194.
194. 04 07954 ATHLETI C TRAI NERS 116, 379 27, 825 144, 204 0	92, 794 192. 0 193. 462, 774 193. 0 193. 784, 999 193. 52, 300 194.
200. 00 TOTAL (SUM OF LINES 118-199) 33, 598, 085 42, 623, 746 76, 221, 831 0	92, 794 192. 0 193. 462, 774 193. 0 193. 784, 999 193. 52, 300 194. 0 194. 0 194.

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (JOHNSON MEMOR	IAL H		CCN: 150001	In Lie Period:	u of Form CMS Worksheet A	-2552-10
						From 01/01/2014 To 12/31/2014	Date/Time Pr 5/21/2015 1:	
	Cost Center Description	Adjustments		Expenses Allocation			372172013 1.	
		(See A-8) 6.00	FOL	7.00				
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT	83, 232		1, 789, 975				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - TOWER	0		86, 509				1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0		2,718,329				2.00
4.00 4.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS	-158, 486		8, 271, 723				4.00 4.01
4.01	00402 DATA PROCESSI NG	-16, 338		449, 219 1, 390, 420				4.01
4.02	00403 MATERIALS MANAGEMENT	0		312, 653				4.02
4.04	00404 ADMITTING	0		609, 372				4.04
4.05	00405 PATIENT ACCOUNTING	0		1,404,427				4.05
5.00	00500 ADMINISTRATIVE & GENERAL	-834, 876		8, 727, 921				5.00
7.00	00700 OPERATION OF PLANT	-41, 564		2, 849, 212				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0		189, 383				8.00
9.00	00900 HOUSEKEEPI NG	0	•	744, 981				9.00
10.00	01000 DI ETARY	-405		463, 238				10.00
11.00		-276, 298		306, 030				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-68		1, 370, 169				13.00 14.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	-5, 025	•	155, 551 4, 138, 463				14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-20, 789		743, 586				16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20,707		743, 300				10.00
30.00	03000 ADULTS & PEDIATRICS	0		2,894,113				30.00
31.00	03100 INTENSIVE CARE UNIT	385		1, 265, 361				31.00
41.00	04100 SUBPROVIDER - IRF	-2, 689		816, 796				41.00
43.00	04300 NURSERY	0		196, 211				43.00
	ANCI LLARY SERVI CE COST CENTERS							
50.00	05000 OPERATING ROOM	-38, 184		2, 395, 619				50.00
53.00	05300 ANESTHESI OLOGY	0		26, 332				53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	-3, 132		2, 960, 656 3, 169, 100				54.00 60.00
65.00	06500 RESPIRATORY THERAPY	-7,000		996, 102				65.00
66.00	06600 PHYSI CAL THERAPY	-7,000		750, 552				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		204, 309				67.00
68.00	06800 SPEECH PATHOLOGY	0		128, 394				68.00
69.00	06900 ELECTROCARDI OLOGY	-59, 350		699, 336				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		55, 825				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1, 795, 878				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		1, 305, 191				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0				73.00
76.00	03020 ONCOLOGY	0		224, 565				76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0		102, 481				76.97
90 00	OUTPATIENT SERVICE COST CENTERS	-135, 461		2, 268, 969				90.00
	09100 EMERGENCY	-131, 739		1, 925, 812				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	10117.07		1, 20, 012				92.00
	OTHER REIMBURSABLE COST CENTERS	-						
101.00	10100 HOME HEALTH AGENCY	0		809, 643				101.00
	SPECIAL PURPOSE COST CENTERS	- F						
	11300 INTEREST EXPENSE	-11, 286		0				113.00
118.00		-1, 659, 073	6	51, 712, 406				118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	105, 665				190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0		103, 003				192.00
	19201 SOUTH CLINIC	0		15				192.01
	19202 WEST CLINIC	0		0				192.02
	19203 DI ABETES CENTER	0		92, 794				192.03
193.00	19300 NONPAI D WORKERS	0		0				193.00
	19301 ADULT/CHI LD CARE	0		462, 774				193. 01
	19302 PHYSICIAN OFFICE BUILDING	0		0				193.02
	19303 OPTI FAST/FOUNDATI ON	0		784, 999				193.03
	07950 PARTNERSHIP HFC	0		52, 300				194.00
	07951 TRAFALGAR CLINIC	0		0				194.01
	207952 EDI NBURGH	0		0 52 021				194.02
	07953 JAI L 07954 ATHLETI C TRAI NERS			53, 031 144, 204				194. 03 194. 04
200.00		-1, 659, 073	.	144, 204 74, 562, 758				200.00
200.00		1 .,007,070	. '	., 332, 730				1200.00

Heal th	Financial Systems		JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provi der	CCN: 150001	Peri od:	Worksheet A-	6
						From 01/01/2014 To 12/31/2014	Date/Time Pr	epared:
		Inoracoo					5/21/2015 1:	29 pm
		Increases	6.1	0.11	-			
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A – CAFETERIA RECLASS							
1.00	CAFETERI A	11.00	413, 654	168, 674				1.00
	TOTALS		413, 654	168, 674				
	B - CHILD CARE RECLASS		· · · · · · · · · · · · · · · · · · ·					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	125, 850	19, 637				1.00
	TOTALS		125, 850	19, 637				
	C – NURSERY RECLASS							
1.00	NURSERY	43.00	169, 363	26, 848				1.00
	TOTALS		169, 363	26, 848				
	D - IMPLANTABLE DEVICE RECLAS	SS						
1.00	IMPL. DEV. CHARGED TO	72.00	0	1, 305, 191				1.00
	PATI ENTS							
	TOTALS			1, 305, 191]			
500.00	Grand Total: Increases		708, 867	1, 520, 350	1			500.00

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SEFECATIONS			Provi der	CCN: 150001	Period:	Worksheet A-	6
						From 01/01/2014 To 12/31/2014	Date/Time Pr 5/21/2015 1:	epared: 29 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA RECLASS							
1.00	DI ETARY	10.00	413, 654	<u>168, 6</u> 74		0		1.00
	TOTALS		413, 654	168, 674				
	B - CHILD CARE RECLASS							
1.00	ADULT/CHI LD_CARE	193.01	125, 850	1 <u>9, 6</u> 37		0		1.00
	TOTALS		125, 850	19, 637				
	C – NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	169, 363	26, 848		0		1.00
	TOTALS		169, 363	26, 848				
	D - IMPLANTABLE DEVICE RECLAS	S						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 305, 191		0		1.00
	PATI ENT							
	TOTALS		0	1, 305, 191				
500.00	Grand Total: Decreases		708, 867	1, 520, 350				500.00

	Financial Systems	JOHNSON MEMORI				u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	3, 141, 963	0		0 0	0	
2.00	Land Improvements	1, 604, 444	0		0 0	579	
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	65, 603, 416	3, 616, 100	-480, 76	6 3, 135, 334	0	4.00
5.00	Fixed Equipment	11, 410, 038	280, 245		0 280, 245	0	5.00
6.00	Movable Equipment	36, 763, 492	1, 266, 514	480, 76	6 1, 747, 280	2, 283, 742	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	118, 523, 353	5, 162, 859		0 5, 162, 859	2, 284, 321	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	118, 523, 353	5, 162, 859		0 5, 162, 859	2, 284, 321	10.00
		Endi ng Bal ance	Fully				
		-	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	3, 141, 963	0				1.00
2.00	Land Improvements	1, 603, 865	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	68, 738, 750	0				4.00
5.00	Fixed Equipment	11, 690, 283	0				5.00
6.00	Movable Equipment	36, 227, 030	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	121, 401, 891	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	121, 401, 891	0				10.00

Heal th	Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150001	Period: From 01/01/2014	Worksheet A-7 Part II		
					To 12/31/2014		pared:	
						5/21/2015 1:2	9 pm	
			SL	JMMARY OF CAP	1 TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)			
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUN	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	1, 706, 743			0 0	0	1.00	
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	86, 509			0 0	0	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	2, 718, 329			0 0	0	2.00	
3.00	Total (sum of lines 1-2)	4, 511, 581	0		0 0	0	3.00	
		SUMMARY O						
	Cost Center Description		Total (1) (sum					
		Capi tal -Rel ate						
		d Costs (see	through 14)					
		instructions)	15.00	-				
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUN						
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 706, 743				1.00	
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	86, 509				1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 718, 329	•			2.00	
3.00	Total (sum of lines 1-2)	0	4, 511, 581				3.00	

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS			F	veriod: rom 01/01/2014 o 12/31/2014	Date/Time Prep 5/21/2015 1:29	
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI			1	1		
1.00	CAP REL COSTS-BLDG & FIXT	85, 174, 861	0	85, 174, 861			1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	C	0.000000		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	36, 227, 030	0	36, 227, 030			2.00
3.00	Total (sum of lines 1-2)	121, 401, 891	0	121, 401, 891			3.00
			TION OF OTHER (OF CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	C	1, 789, 975	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	C	86, 509	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	C	2, 718, 329	0	2.00
3.00	Total (sum of lines 1-2)	0	0	C	4, 594, 813	0	3.00
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
	1	11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI			1	1		
1.00	CAP REL COSTS-BLDG & FIXT	0	0	-	0 0	1, 789, 975	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0	0	0	86, 509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	C C	0	2, 718, 329	2.00
3.00	Total (sum of lines 1-2)	0	0	() C	0	4, 594, 813	3.00

	Financial Systems MENTS TO EXPENSES			I AL HOSPI TAL Provi der CCN: 150001	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2014 To 12/31/2014		
				Expense Classification o To/From Which the Amount is		10/21/2010 11.2	2 011
			A	Cont Contor			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.
01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - TOWER (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	1.
00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
00	Investment income - other (chapter 2)		0		0.00	0	3.
00	Trade, quantity, and time		0		0.00	0	4.
00	discounts (chapter 8) Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.
00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.
00	Tel ephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.
00	Television and radio service (chapter 21)		0		0.00	0	8.
00 . 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -777, 639		0.00	0	9. 10.
. 00	adjustment Sale of scrap, waste, etc.	N 0 2	0		0.00		
00	(chapter 23) Related organization	A-8-1	0			0	12
. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13
. 00	Cafeteria-employees and guests		0		0.00	0	14
00	Rental of quarters to employee and others		0		0.00	0	15
00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16
. 00	Sale of drugs to other than		0		0.00	0	17
. 00	patients Sale of medical records and		0		0.00	0	18
00	abstracts Nursing school (tuition, fees, books, etc.)		0		0.00	0	19
. 00 . 00	Vending machines Income from imposition of interest, finance or penalty		0 0		0. 00 0. 00		20. 21.
. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22
. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25
. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26
01	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT -	1.01	0	26
00	COSTS-BLDG & FIXT - TOWER Depreciation - CAP REL COSTS-MVBLE EQUIP		0	TOWER CAP REL COSTS-MVBLE EQUIP	2.00	0	27
00	Non-physician Anesthetist		0	*** Cost Center Deleted ***			28
. 00 . 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29 30
. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30

Hoal th	Financial Systems		JOHNSON MEMORIAL		Inlie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES		JOHNSON MEMORIAL		Period:	Worksheet A-8	
ADJUJI	MENTS TO EXTENSES				From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/21/2015 1:2	
				Expense Classification or	Worksheet A	0,21,2010 112	
			То	/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3		EECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest						
33.00	JMH PAIN CARE CENTER REV	В	-132, 810CL	INIC	90.00	0	33.00
24.00	OPERATING F		(201	FTADV	10.00		24.00
34.00	JMH NUTR SVCS DISCOUNTS OPERATING FU	В	63011	ETARY	10.00	0	34.00
35.00	JMH PURCHASES DI SCOUNTS	В	-4 257 AD	MINISTRATIVE & GENERAL	5.00	0	35.00
55.00	OPERATING FU	D	-4, 237 ADI	MINI STRATIVE & GENERAL	5.00	0	33.00
36, 00	JMH SALE OF FILM	В	-132 RAI	DI OLOGY-DI AGNOSTI C	54.00	0	36.00
37.00	JMH CAFETERIA REV OPERATING	В	-276, 298 CAI		11.00		37.00
	FUND						
38.00	JMH CATERING REV OPERATING	В	-468 DI I	ETARY	10.00	0	38.00
	FUND						
39.00	JMH MISC PHARM REVENUE	В	-5, 025 PH	ARMACY	15.00	0	39.00
	OPERATI NG FUN	_				_	
40.00	JMH RENT OF SPACE	В		ERATION OF PLANT	7.00		
41.00	JMH MEDICAL RECORD FEES	В	-20, 789MEI	DI CAL RECORDS & LI BRARY	16.00	0	41.00
42.00	JMH GEN ACCOUNTING REV	В	-6 622 40	MINISTRATIVE & GENERAL	5.00	0	42.00
42.00	OPERATING FUN	D D	0, 022 AD		5.00	0	42.00
43.00	JMH RETURNED CHECK FEES	В	- 350 ADI	MINISTRATIVE & GENERAL	5.00	0	43.00
	OPERATING FU						
44.00	JMH EDUCATION PROGRAMS	В	-68 NUI	RSING ADMINISTRATION	13.00	0	44.00
	OPERATING FUN						
45.00	1993 AHA LIFE ADJUSTMENT	A		P REL COSTS-BLDG & FIXT	1.00		
45.01	MED STAFF OTHER EXP	A		MINISTRATIVE & GENERAL	5.00		
45.02	CABLE SERVICES	A		ERATION OF PLANT	7.00		
45.03	TELEPHONE SERVICES	A		P REL COSTS-BLDG & FIXT	1.00		45.03
45.04 45.05	TELEPHONE SERVICES COMMUNICATIONS	A		MINISTRATIVE & GENERAL MMUNICATIONS	5.00		
45.05 45.06	ADVERTISING EXP-A&G	A		MINISTRATIVE & GENERAL	4.01		45.05
45.08 45.08	ADVERTISING EXP-A&G	A		BPROVIDER - IRF	41.00		
45.08	ADVERTISING EXP-WOUND CARE	A	-2, 651 CL		90.00		
45.13	DAYCARE	B		PLOYEE BENEFITS DEPARTMEN			
45.14	LOBBYING EXPENSE-AHA	A		MINISTRATIVE & GENERAL	5.00		45.14
45.15	LOBBYING EXPENSE-I HHA	A		MINISTRATIVE & GENERAL	5.00		
45.16	PROF - BUILDING	A		ERATION OF PLANT	7.00		
45.17	PROF - BUILDING	A		PLOYEE BENEFITS DEPARTMEN			45.17
45.19	INTEREST INCOME	В	-11, 286 I N	TEREST EXPENSE	113.00	0	45.19
50.00	TOTAL (sum of lines 1 thru 49)		-1, 659, 073				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(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.
(2) Additional adjustments much be median binor 23 thru 40 and subservice thereaft.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste	ems	JOHNSON MEMOR	REAL HOSPETAL		In Li	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT				Peri od:	Worksheet A-8	3-2
						From 01/01/2014 To 12/31/2014		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	7 pm
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	537, 555	537, 555	(225, 300	0	1.00
2.00		INTENSIVE CARE UNIT	-25	- 385	360			2.00
3.00	41.00	SUBPROVIDER – IRF	106, 480	0				3.00
4.00	50.00	OPERATING ROOM	42,083	30, 083				4.00
5.00		RADI OLOGY-DI AGNOSTI C	3,000			225, 300		5.00
6.00		LABORATORY	110,004		110, 00			6,00
7.00		RESPI RATORY THERAPY	7,000	7,000				7.00
8.00		ELECTROCARDI OLOGY	59, 350			225, 300		8.00
8.00 9.00		EMERGENCY	136, 387					8.00 9.00
	91.00 0.00	EWERGENCT						
10.00	0.00		0	-		-	-	10.00
200.00			1,001,834					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	0.00	0.00	0.00	Education	12	11.00	
1.00	1.00	2.00 ADMINISTRATIVE & GENERAL	8.00	9.00	12.00	13.00	14.00	1 00
1.00			0	-			-	
2.00		I NTENSI VE CARE UNI T	650				-	2.00
3.00		SUBPROVIDER - IRF	105, 284			0	0	3.00
4.00		OPERATING ROOM	3, 899			0	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0		0	0	5.00
6.00		LABORATORY	163, 331	8, 167		0 0	0	6.00
7.00		RESPI RATORY THERAPY	0	0		0 0	0	7.00
8.00		ELECTROCARDI OLOGY	0	-		0 0	0	8.00
9.00		EMERGENCY	7, 799	390	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			280, 963			,	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMINISTRATIVE & GENERAL	0			537, 555		1.00
2.00		INTENSIVE CARE UNIT	0			-385		2.00
3.00	41.00	SUBPROVIDER – IRF	0			5 1, 196		3.00
4.00	50.00	OPERATING ROOM	0	3, 899	8, 10	1 38, 184		4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(3, 000		5.00
6.00	60.00	LABORATORY	0	163, 331	(o o		6.00
7.00	65.00	RESPI RATORY THERAPY	0	0		7,000		7.00
8.00		ELECTROCARDI OLOGY	0	0				8.00
9.00		EMERGENCY	0	7, 799	(131, 739		9.00
10.00	0.00		0				1	10.00
200.00	51.00		0	280, 963	9, 29	-		200.00
		1				,,		

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Pre	pared:
		CAP	ITAL RELATED C	OSTS	5/21/2015 1:2	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	1, 789, 975	1, 789, 975	1			1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNI CATIONS 4.02 00402 DATA PROCESSING 4.03 00403 MATERIALS MANAGEMENT 4.04 00404 ADMITTING 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	86, 509 2, 718, 329 8, 271, 723 449, 219 1, 390, 420 312, 653 609, 372 1, 404, 427 8, 727, 921 2, 849, 212 189, 383	0 19, 102 2, 516 40, 074 24, 492 14, 333 42, 570 60, 981 159, 783 15, 389	86, 50 1, 842 1, 842 12, 498	2, 718, 329 2, 197 0 1, 115, 117 5, 759 2 0 2, 074 3 36, 200 4, 783	8, 293, 022 48, 229 181, 603 67, 421 147, 670 217, 380 472, 990 162, 745 28, 666	$\begin{array}{c} 1. \ 01 \\ 2. \ 00 \\ 4. \ 00 \\ 4. \ 01 \\ 4. \ 02 \\ 4. \ 03 \\ 4. \ 04 \\ 4. \ 05 \\ 5. \ 00 \\ 7. \ 00 \\ 8. \ 00 \end{array}$
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	744, 981 463, 238	11, 952 25, 075			158, 722 83, 244	
11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS	403, 238 306, 030 1, 370, 169 155, 551 4, 138, 463 743, 586	23, 073 26, 701 63, 164 10, 876 13, 098 24, 832		0 0 33, 285 0 35, 482 0 4, 069	104, 554 104, 554 312, 039 19, 751 117, 117 128, 821	11.00 13.00 14.00 15.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 894, 113	176, 535			650, 098	1
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	1, 265, 361 816, 796 196, 211	50, 483 43, 294 4, 001	7, 599	9 14, 963	265, 020 161, 900 42, 808	41.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	2, 395, 619	292, 942	802	2 459, 721	422, 086	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	26, 332 2, 960, 656 3, 169, 100	2, 522 105, 830 51, 526	(12, 062	29, 710 2 271, 096	0 497, 504 323, 368	53.00 54.00
65. 00 06500 RESPI RATORY THERAPY	996, 102	21, 599			215, 074	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	750, 552 204, 309	40, 573 8, 546			181, 232 51, 977	
68.00 06800 SPEECH PATHOLOGY	128, 394	531	93	3 358	32, 438	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	699, 336 55, 825	6, 914 1, 165			86, 326 11, 820	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 795, 878	0) (21, 161	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	1, 305, 191 0	0			0	
76. 00 03020 ONCOLOGY	224, 565	44, 804	. (6, 565	49, 379	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	102, 481	16, 074	. (3, 093	23, 723	76.97
90. 00 09000 CLI NI C	2, 268, 969	73, 720			144, 794	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 925, 812	63, 593	10, 860	62, 527	431, 700	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	809, 643	8, 354	. () 963	162, 153	101.00
113.00 11300 I NTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	61, 712, 406	1, 567, 944	84, 600	2, 689, 689	6, 004, 352	113. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	105, 665	8, 303				190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLINI C	11, 154, 570 15	165, 960 0			2, 110, 241 0	192.00 192.01
192. 02 19202 WEST CLINIC	0	0) (0 0	0	192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	92, 794	2, 573	452			192.03 193.00
193. 01 19301 ADULT/CHI LD CARE	462, 774	30, 932	. (0	101, 181	193. 01
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0 784, 999	0				193.02 193.03
194. 00 07950 PARTNERSHI P HFC	52, 300	14, 263			11, 638	194.00
194. 01 07951 TRAFALGAR CLI NI C 194. 02 07952 EDI NBURGH	0	0				194.01 194.02
194. 03 07953 JAI L	53, 031	0			0	194.03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	144, 204	0		0	29, 416	194. 04 200. 00
201.00Negative Cost Centers202.00TOTAL (sum Lines 118-201)	74, 562, 758	0 1, 789, 975) (86, 509	0 2, 718, 329		201.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS				Period:	Worksheet B	2002 10
				From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	pared:
Cost Center Description	COMMUNI CATI ONS	DATA	MATERIALS	ADMI TTI NG	5/21/2015 1:2 PATI ENT	9 pm
cost center bescription	COMMUNICATIONS	PROCESSING	MANAGEMENT	ADMITTING	ACCOUNTING	
	4.01	4.02	4.03	4.04	4.05	
1.00 GENERAL SERVICE COST CENTERS						1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - TOWER						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	100.0/1					4.00
4. 01 00401 COMMUNI CATI ONS 4. 02 00402 DATA PROCESSI NG	499, 964 59, 200	2, 786, 414				4.01 4.02
4. 03 00403 MATERIALS MANAGEMENT	10, 694	33, 673		2		4.02
4. 04 00404 ADMI TTI NG	9, 167	146, 266				4.04
4. 05 00405 PATIENT ACCOUNTING	31, 701	366, 189			2, 066, 849	4.05
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	28, 646 14, 896	271, 486 31, 568			0	5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 910	7, 366			0	8.00
9. 00 00900 HOUSEKEEPI NG	5, 347	C	-/-/		0	9.00
10. 00 01000 DI ETARY	9, 549	76, 816			0	10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0 16, 042	85, 234		0 2 0	0	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	03, 234	3, 97		0	14.00
15. 00 01500 PHARMACY	6, 493	22, 098	6, 87	2 0	0	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	15, 660	155, 736	35	9 0	0	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	37, 812	203, 088	12, 12	5 61, 767	137, 214	30.00
31. 00 03100 I NTENSI VE CARE UNI T	10, 694	63, 136			23, 020	•
41. 00 04100 SUBPROVI DER – I RF	6, 875	59, 979	93	B 9, 214	20, 468	41.00
43.00 04300 NURSERY	0	C		3, 211	7, 134	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	30, 937	212, 559	29, 93	4 148, 362	329, 585	50.00
53. 00 05300 ANESTHESI OLOGY	0	0			30, 290	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 861	146, 266			408, 843	•
	25, 972	98, 913			300, 731	•
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	6, 875 8, 021	87, 339 31, 568			66, 657 38, 603	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 528	1, 052		9,420	20, 927	67.00
68.00 06800 SPEECH PATHOLOGY	1, 528	6, 314		1 2, 990	6, 643	•
69. 00 06900 ELECTROCARDI OLOGY	15, 278	77, 868			62, 825	•
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	764	3, 157 0			2, 149 72, 600	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		23, 165	51, 460	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		69, 305	153, 960	•
76.00 03020 ONCOLOGY	14, 132	30, 516			12, 228	•
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	42	4 1, 851	4, 111	76.97
90. 00 09000 CLI NI C	6, 875	109, 436	21, 96	8 42, 731	94, 927	90.00
91. 00 09100 EMERGENCY	21, 389	85, 234	5, 82	2 92, 530	205, 554	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	8, 021	46, 300	88	7, 616	16, 920	101.00
SPECIAL PURPOSE COST CENTERS				.,	,	
113.00 11300 INTEREST EXPENSE	405 0/7	2 450 457	400 75	1 020 201	2 0// 040	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	425, 867	2, 459, 157	439, 75	1 930, 381	2, 066, 849	00 .811
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 729	33, 673	6	0 0	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	58, 437	208, 350	14, 45			192.00
192. 01 19201 SOUTH CLINIC	0	0		1 0		192.01
192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER	0 1, 146	9, 470				192. 02 192. 03
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
193. 01 19301 ADULT/CHI LD CARE	5, 729	34, 725				193. 01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0	0				193. 02 193. 03
193. 03 19303 0P11 FAS17 FOUNDATION 194. 00 07950 PARTNERSHIP HFC	3, 056	41, 039				193.03
194. 01 07951 TRAFALGAR CLINIC	0	0		o o		194.01
194. 02 07952 EDI NBURGH	0	C		0 0		194. 02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C_TRAI NERS	0	0	5			194. 03 194. 04
200.00 Cross Foot Adjustments	0	U				200.00
201.00 Negative Cost Centers	0	C		o c		201.00
202.00 TOTAL (sum lines 118-201)	499, 964	2, 786, 414	454, 693	930, 381	2, 066, 849	202.00

	nancial Systems DCATION - GENERAL SERVICE COSTS	JOHNSON MEMORI		CCN: 150001 P	In Lie Period:	u of Form CMS- Worksheet B	2552-10
COST ALLC	SATION - GENERAL SERVICE COSTS		TTOVIGET	F	rom 01/01/2014 o 12/31/2014	Part I Date/Time Pre	
	Cost Center Description	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	5/21/2015 1:2 HOUSEKEEPI NG	29 pm
0.5		4A. 05	5.00	7.00	8.00	9.00	
	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT	1		1			1.00
	101 CAP REL COSTS-BLDG & FIXT - TOWER						1.00
	200 CAP REL COSTS-MVBLE EQUIP						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	401 COMMUNI CATI ONS						4.01
	402 DATA PROCESSING 403 MATERIALS MANAGEMENT						4.02
	404 ADMITTING						4.03
	405 PATIENT ACCOUNTING						4.05
	500 ADMI NI STRATI VE & GENERAL	9, 583, 877	9, 583, 877				5.00
	700 OPERATION OF PLANT	3, 266, 991	481, 855				7.00
	800 LAUNDRY & LI NEN SERVI CE 900 HOUSEKEEPI NG	248, 829	36, 700				8.00
	000 DI ETARY	931, 042 681, 065	137, 321 100, 452				1
	100 CAFETERI A	437, 285	64, 496				1
	300 NURSING ADMINISTRATION	1, 883, 105	277, 743				
	400 CENTRAL SERVICES & SUPPLY	225, 635	33, 279				
	500 PHARMACY	4, 308, 210	635, 427				1
	600 MEDICAL RECORDS & LIBRARY PATIENT ROUTINE SERVICE COST CENTERS	1, 075, 728	158, 661	65, 275	0	20, 461	16.00
	000 ADULTS & PEDIATRICS	4, 389, 244	647, 378	464, 058	99, 840	145, 466	30.00
	100 I NTENSI VE CARE UNI T	1, 793, 470	264, 522				1
	100 SUBPROVIDER – IRF	1, 142, 026	168, 440	113, 806	13, 491	35, 674	41.00
	300 NURSERY	253, 365	37, 369	10, 517	0	3, 297	43.00
	CI LLARY SERVI CE COST CENTERS	4 222 547	637, 541	770, 053	57, 194	241, 384	50.00
	300 ANESTHESI OLOGY	4, 322, 547 102, 891	15, 176				1
	400 RADI OLOGY-DI AGNOSTI C	4, 627, 024	682, 449				
	000 LABORATORY	4, 301, 305	634, 408				
	500 RESPI RATORY THERAPY	1, 459, 813	215, 311			,	1
	600 PHYSI CAL THERAPY	1,077,722	158, 955				
	700 OCCUPATI ONAL THERAPY 800 SPEECH PATHOLOGY	301, 178 179, 290	44, 421 26, 444				
	900 ELECTROCARDI OLOGY	1, 039, 845	153, 369				1
	000 ELECTROENCEPHALOGRAPHY	80, 675	11, 899				1
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 137, 811	315, 310	C	0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	1, 379, 816	203, 512		-	-	
	300 DRUGS CHARGED TO PATIENTS	223, 265	32, 930		-	-	
	020 ONCOLOGY 697 CARDI AC REHABI LI TATI ON	388, 211 151, 757	57, 258 22, 383				1
	TPATIENT SERVICE COST CENTERS	101,707	22,000	12,201		10,210	10.77
	000 CLINIC	2, 795, 968	412, 383				90.00
	100 EMERGENCY	2, 905, 021	428, 467	167, 167	45, 900	52, 401	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS	0					92.00
	100 HOME HEALTH AGENCY	1, 060, 850	156, 467	21,960	0	6, 884	101.00
	ECIAL PURPOSE COST CENTERS	.,			-		
	300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	58, 754, 861	7, 252, 326	3, 165, 192	320, 498	969, 646	118.00
	NREIMBURSABLE COST CENTERS 000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	171, 771	25, 335	21, 826	0	6 842	190.00
	200 PHYSICIANS' PRIVATE OFFICES	13, 738, 035	2, 026, 263				
	201 SOUTH CLINIC	195	29		0		192.01
	202 WEST CLINIC	0	C	-	0		192. 02
	203 DI ABETES CENTER	128, 211	18, 910	6, 765	0		192.03
	300 NONPAI D WORKERS 301 ADULT/CHI LD CARE	635, 596	93, 745	81, 312			193.00 193.01
	302 PHYSI CI AN OFFICE BUILDING	033, 370	, 740	01, 512	0		193.02
	303 OPTI FAST/FOUNDATI ON	784, 999	115, 781		0		193.03
194.0007	950 PARTNERSHI P HFC	122, 389	18, 051	37, 492	0	11, 752	194.00
1	951 TRAFALGAR CLINIC	0	C	C	0		194.01
	952 EDI NBURGH	0	C 7 000		0		194.02
194.0307	953 JAIL 954 ATHLETIC TRAINERS	53, 031 173, 670	7, 822 25, 615		0		194.03 194.04
200.00	Cross Foot Adjustments	173, 870	20,010				200.00
201.00	Negative Cost Centers	0	C	-	0		201.00
202.00	TOTAL (sum lines 118-201)	74, 562, 758	9, 583, 877	3, 748, 846	325, 983	1, 152, 600	202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2014	Worksheet B Part I	
			T	0 12/31/2014	Date/Time Pre 5/21/2015 1:2	pared: 9 pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
1.00 OO100 CAP REL COSTS-BLDG & FIXT						1.00
1. 0100101CAPRELCOSTS-BLDG& FIXTTOWER2. 0000200CAPRELCOSTS-MVBLEEQUIP4. 0000400EMPLOYEEBENEFITSDEPARTMENT4. 0100401COMMUNICATIONS4. 0200402DATAPROCESSING						1. 01 2. 00 4. 00 4. 01 4. 02
4. 03 00403 MATERIALS MANAGEMENT 4. 04 00404 ADMITTING 4. 05 00405 PATIENT ACCOUNTING 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT						4. 03 4. 04 4. 05 5. 00 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	873, 123					8.00 9.00 10.00
11. 00 01100 CAFETERI A	0,3,123	593, 971				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	16, 553 3, 229		299, 695		13.00 14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY I NPATI ENT ROUTI NE SERVICE COST CENTERS	0	9, 776 20, 745			4, 998, 635 0	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	573, 766 96, 585	73, 929 27, 303			0	
41. 00 04100 SUBPROVIDER - IRF	136, 217	18, 079	206, 944	0	0	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	66, 555	4, 555	52, 144	0	0	43.00
50. 00 05000 OPERATI NG ROOM	0	45, 357			0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C 48, 849	0		0	53.00 54.00
60. 00 06000 LABORATORY	0	45, 102	2 0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	21, 748 17, 697			0	65.00 66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	4, 851	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	2, 656 7, 866		0	0	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 336	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C			0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	4, 998, 635	73.00
76. 00 03020 ONCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	0	5, 539 2, 308			0	•
OUTPATIENT SERVICE COST CENTERS	Y					
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	19, 603 42, 485		0	0	90.00 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	Ŭ	12, 100		J		92.00
OTHER REIMBURSABLE COST CENTERS 101.0010100 HOME HEALTH AGENCY	0	16, 757	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS			-	-1		1
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	873, 123	456, 323	2, 395, 487	299, 695	4, 998, 635	113.00 118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 471 100, 728		0		190.00 192.00
192. 01 19200 PHTSTCLANS PRIVATE OFFICES	0	100, 728		0		192.00
192. 02 19202 WEST CLINIC	0)	0	0		192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPALD WORKERS	0	2, 070 (0		192.03 193.00
193. 01 19301 ADULT/CHI LD CARE	0	22, 224	0	0	0	193. 01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0	C		0		193. 02 193. 03
194. 00 07950 PARTNERSHI P HFC	0	5, 512		Ő	0	194.00
194. 01 07951 TRAFALGAR CLINIC 194. 02 07952 EDI NBURGH	0	((0		194.01 194.02
194. 03 07953 JAI L	0	C	0	0	0	194.03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	4, 643	0	0	0	194.04 200.00
201.00 Negative Cost Centers	0		0	0		201.00
202.00 TOTAL (sum lines 118-201)	873, 123	593, 971	2, 395, 487	299, 695	4, 998, 635	202.00

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150001	Period: From 01/01/2014	Worksheet B Part I
				To 12/31/2014	Date/Time Prepared:
Cost Center Description	MEDI CAL	Subtotal	Intern &	Total	5/21/2015 1:29 pm
	RECORDS &		Residents Cos	st	
	LI BRARY		& Post Stepdown		
			Adjustments		
GENERAL SERVICE COST CENTERS	16.00	24.00	25.00	26.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER					1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2.00
4. 01 00401 COMMUNI CATI ONS					4. 01
4. 02 00402 DATA PROCESSI NG					4. 02
4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG					4.03
4. 05 00405 PATIENT ACCOUNTING					4.05
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON					11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY					13.00
15. 00 01500 PHARMACY					15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 340, 870				16.00
30. 00 03000 ADULTS & PEDI ATRICS	89, 015	7, 328, 932		0 7, 328, 932	30.00
31. 00 03100 I NTENSI VE CARE UNI T	14, 933	2, 703, 735		0 2, 703, 735	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	13, 278 4, 628	1, 847, 955 432, 430	1	0 1, 847, 955 0 432, 430	
ANCI LLARY SERVICE COST CENTERS	4,020	432, 430	1	432,430	43.00
50. 00 05000 OPERATI NG ROOM	213, 811	6, 784, 018		0 6, 784, 018	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 650 265, 276	146, 425 6, 008, 905		0 146, 425 0 6, 008, 905	
60. 00 06000 LABORATORY	195, 093	5, 353, 812		0 5, 353, 812	60.00
65. 00 06500 RESPI RATORY THERAPY	43, 242	1, 814, 688		0 1, 814, 688	65.00
66. 00 06600 PHYSI CAL THERAPY	25,043	1, 421, 288	1	0 1, 421, 288	
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	13, 576 4, 309	393, 533 214, 534		0 393, 533 0 214, 534	
69. 00 06900 ELECTROCARDI OLOGY	40, 756	1, 268, 444		0 1, 268, 444	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1, 394	99, 327		0 99, 327 0 2, 799, 913	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	47, 097 33, 384	2, 799, 913 1, 616, 712		0 2, 799, 913 0 1, 616, 712	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	99, 878	5, 354, 708		0 5, 354, 708	
	7,933	613, 637		0 613, 637	76.00
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	2,667	234, 614		0 234, 614	76. 97
90. 00 09000 CLI NI C	61, 582	3, 545, 775		0 3, 545, 775	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	133, 349	4, 256, 290		0 4, 256, 290 0	91.00
OTHER REIMBURSABLE COST CENTERS			1	0	92.00
101.00 10100 HOME HEALTH AGENCY	10, 976	1, 273, 894		0 1, 273, 894	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 340, 870	55, 513, 569		0 55, 513, 569	
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	228, 245 16, 443, 521		0 228, 245 0 16, 443, 521	
192. 01 19201 SOUTH CLINIC	0	224		0 224	
192. 02 19202 WEST CLINIC	0	0		0 0	192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	0	158, 077		0 158, 077	192. 03 193. 00
193. 01 19301 ADULT/CHI LD CARE	0	858, 365		0 858, 365	193.00
193. 02 19302 PHYSICIAN OFFICE BUILDING	0	0		0 0	193.02
	0	900, 780		0 900, 780	
194. 00 07950 PARTNERSHI P_HFC 194. 01 07951 TRAFALGAR_CLI NI C	0	195, 196 0		0 195, 196 0 0	194.00
194. 02 07952 EDI NBURGH	0	0		0 0	194. 02
194. 03 07953 JAI L	0	60, 853		0 60, 853	
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	203, 928 0		0 203, 928 0 0	194. 04 200. 00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118-201)	1, 340, 870	74, 562, 758	1	0 74, 562, 758	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	JOHNSON MEMORI			eriod:	u of Form CMS- Worksheet B	2552-10
			Fi To	rom 01/01/2014 o 12/31/2014	Part II Date/Time Pre	
		САР	I TAL RELATED CC	ISTS	5/21/2015 1:2	29 pm
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	Subtotal	
	Related Costs	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS		1.00	1.01	2.00	20	
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS	0	19, 102 2, 516		2, 197 0	21, 299 2, 516	
4. 02 00402 DATA PROCESSING	0	40, 074		1, 115, 117	1, 155, 191	
4. 03 00403 MATERIALS MANAGEMENT	0	24, 492		5, 759	30, 251	4.03
4. 04 00404 ADMI TTI NG 4. 05 00405 PATI ENT ACCOUNTI NG	0	14, 333 42, 570		0 2, 074	16, 175 44, 644	
5. 00 00500 ADMI NI STRATI VE & GENERAL	0	60, 981		12, 041	73, 022	
7.00 00700 OPERATION OF PLANT	0	159, 783		36, 200	208, 481	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	15, 389 11, 952		4, 783 2, 493	20, 172 15, 382	
10. 00 01000 DI ETARY	0	25, 075	554	22, 176	47, 805	10.00
11.00 01100 CAFETERIA	0	26, 701		0	26, 701 96, 449	
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	63, 164 10, 876		33, 285 35, 482	46, 358	
15.00 01500 PHARMACY	0	13, 098	3 0	4, 069	17, 167	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	24, 832	2 0	6, 734	31, 566	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	176, 535	19, 566	196, 926	393, 027	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	50, 483	8, 861	92, 792	152, 136	31.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	43, 294		14, 963 0	65, 856	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	4, 001	0	0	4, 001	43.00
50. 00 05000 OPERATI NG ROOM	0			459, 721	753, 465	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 522 105, 830		29, 710 271, 096	32, 232 388, 988	
60. 00 06000 LABORATORY	0	51, 526		113, 004	171, 454	
65. 00 06500 RESPI RATORY THERAPY	0	21, 599		27, 625	50, 427	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	0	40, 573 8, 546		8, 485 3, 419	49, 058 11, 965	
68. 00 06800 SPEECH PATHOLOGY	0	531		358	982	
69. 00 06900 ELECTROCARDI OLOGY	0	6, 914		58, 266	65, 279	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 165		4, 553 21, 161	5, 922 21, 161	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
76. 00 03020 0NCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	0			6, 565 3, 093		76.00 76.97
OUTPATIENT SERVICE COST CENTERS				0,070		
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	73, 720		32, 052		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	63, 593	10, 860	62, 527	136, 980 0	
OTHER REIMBURSABLE COST CENTERS			1			
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	8, 354	0	963	9, 317	101.00
113.00 11300 INTEREST EXPENSE						113.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	1, 567, 944	84, 600	2, 689, 689	4, 342, 233	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 303	1, 457	2, 440	12, 200	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	165, 960	0	26, 021	191, 981	192.00
192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC	0	0		179 0		192. 01 192. 02
192. 03 19203 DI ABETES CENTER	0	2, 573		0		192.02
193. 00 19300 NONPAI D WORKERS	0	C	0	0	0	193.00
193. 01 19301 ADULT/CHI LD CARE	0	30, 932	0	0		193. 01 193. 02
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0			0		193.02
194. 00 07950 PARTNERSHI P HFC	0	14, 263	0	0	14, 263	194.00
194. 01 07951 TRAFALGAR CLINIC	0		0	0		194.01
194. 02 07952 EDI NBURGH 194. 03 07953 JAI L				0		194. 02 194. 03
194. 04 07954 ATHLETI C TRAI NERS	0	C		0	0	194.04
200.00 Cross Foot Adjustments		_		~	0	200. 00 201. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0	1, 789, 975	86, 509	0 2, 718, 329		
						•

Heal th	Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II	
					To 12/31/2014	Date/Time Pre	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	DATA PROCESSI NG	MATERI ALS MANAGEMENT	<u>5/21/2015 1: 2</u> ADMI TTI NG	
		4.00	4.01	4.02	4.03	4.04	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - TOWER						1.01
	00200 CAP REL COSTS-MVBLE EQUIP	21 200					2.00 4.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS	21, 299					4.00
	00402 DATA PROCESSING	466			3		4. 02
	00403 MATERIALS MANAGEMENT	173				77 451	4.03
	00404 ADMI TTI NG 00405 PATI ENT ACCOUNTI NG	379				77, 451 0	4.04 4.05
	00500 ADMINISTRATIVE & GENERAL	1, 214				0	
	00700 OPERATION OF PLANT	418				0	
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	74 408			6 130 0 646	0	
	01000 DI ETARY	214				0	10.00
	01100 CAFETERI A	268			0 0	0	
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	801	85		0 310 0 389	0	13.00 14.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	51				0	14.00
	01600 MEDICAL RECORDS & LIBRARY	331				0	•
	INPATIENT ROUTINE SERVICE COST CENTERS					5.440	
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1,669				5, 142 863	30.00 31.00
	04100 SUBPROVI DER – I RF	416				767	41.00
43.00	04300 NURSERY	110	0		0 0	267	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1,084	163	88, 18	2 2, 926	12, 350	50.00
	05300 ANESTHESI OLOGY	0			0 39	1, 135	
	05400 RADI OLOGY-DI AGNOSTI C	1, 277				15, 324	
	06000 LABORATORY	830				11, 269	1
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	552				2, 498 1, 446	
	06700 OCCUPATI ONAL THERAPY	133				784	67.00
	06800 SPEECH PATHOLOGY	83				249	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	222		32, 30		2, 354 81	69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 21,067	2, 720	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	1, 928	•
	07300 DRUGS CHARGED TO PATIENTS	0			0 0	5, 769	•
	03020 ONCOLOGY 07697 CARDI AC REHABI LI TATI ON	127			0 50 0 41	458 154	•
	OUTPATIENT SERVICE COST CENTERS				- <u>-</u>		1
		372					90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 108	113	35, 36	0 569	7, 702	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	416	42	19, 20	8 86	634	101.00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	15, 415	2, 249	1, 020, 20	8 42, 988	77, 451	118.00
	NONREI MBURSABLE COST CENTERS	27	20	12.04	0	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	37 5, 425					190. 00 192. 00
	19201 SOUTH CLINIC	0		00,10	0 0		192.01
	19202 WEST CLINIC	0			0 0		192.02
	19203 DI ABETES CENTER 19300 NONPAI D WORKERS	56		3, 92	9 3		192. 03 193. 00
	19301 ADULT/CHI LD CARE	260		14, 40	6 25		193.00
193.02	19302 PHYSICIAN OFFICE BUILDING	0			0 0	0	193. 02
	19303 OPTI FAST/FOUNDATI ON	0		17.00	0 0		193.03
	07950 PARTNERSHIP HFC 07951 TRAFALGAR CLINIC	30		17, 02	0 0		194. 00 194. 01
	07952 EDI NBURGH	0	-		0 0		194.01
	07953 JAI L	0			0 0		194.03
194.04 200.00	07954 ATHLETIC TRAINERS Cross Foot Adjustments	76	0	1	0 5	0	194. 04 200. 00
200.00		0	0		0 0	0	200.00
202.00		21, 299	2, 640	1, 155, 97	3 44, 449		202.00

Health Financial Systems	JOHNSON MEMORI				u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2014	Worksheet B Part II	
			T	o 12/31/2014	Date/Time Pre 5/21/2015 1:2	pared: 9_pm
Cost Center Description	PATI ENT ACCOUNTI NG	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	4. 05	5.00	7.00	8. 00	9.00	
1. 00 OO100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNICATIONS						4.00 4.01
4. 02 00402 DATA PROCESSI NG						4. 02
4. 03 00403 MATERIALS MANAGEMENT 4. 04 00404 ADMITTING						4.03 4.04
4. 05 00405 PATI ENT ACCOUNTI NG	197, 534					4. 05
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	0	187, 975 9, 451				5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	720				8.00
9.00 00900 HOUSEKEEPI NG	0	2, 694			25, 418	1
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	1, 970 1, 265		411 0	456 485	10.00
13.00 01300 NURSING ADMINISTRATION	0	5, 448			1, 148	
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	653			198	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0			0	238 451	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	10.111					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSIVE CARE UNIT	13, 114 2, 200			8, 166 1, 643	3, 208 917	30.00 31.00
41. 00 04100 SUBPROVIDER - IRF	1, 956				787	41.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	682	733	650	0	73	43.00
50. 00 05000 OPERATING ROOM	31, 500	12, 505	47, 561	4, 677	5, 322	50.00
53. 00 05300 ANESTHESI OLOGY	2, 895				46	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	39, 069 28, 743	13, 386 12, 444			1, 923 936	54.00 60.00
65. 00 06500 RESPI RATORY THERAPY	6, 371	4, 223		0	392	
66. 00 06600 PHYSI CAL THERAPY	3, 689			146	737	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	2,000 635			0	155 10	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	6, 005				126	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	205 6, 939	233 6, 185		-	21 0	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 918			0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	14, 715			-	0	73.00
76. 00 03020 ONCOLOGY 76. 97 07697 CARDIAC REHABILITATION	1, 169 393				814 292	76.00 76.97
OUTPATIENT SERVICE COST CENTERS	0.070				1.010	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	9, 073 19, 646			139 3, 754		90.00 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	,					92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	1, 617	3, 069	1, 356	0	152	101.00
SPECIAL PURPOSE COST CENTERS	1,017	3,007	1, 330		132	101.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117)	197, 534	140 050	105 494	26, 211	21 202	113.00
NONREI MBURSABLE COST CENTERS	197, 334	142, 253	195, 486	20, 211	21, 303	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	497				190.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 01 19201 SOUTH CLINIC	0	39, 734 1	26, 944 0	449 0		192. 00 192. 01
192.02 19202 WEST CLINIC	0	C	0	0	0	192. 02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPALD WORKERS	0	371	418	0		192. 03 193. 00
193. 01 19301 ADULT/CHI LD CARE	0	1, 839	5, 022	0		193.00
193. 02 19302 PHYSI CI AN OFFICE BUILDING	0	0	0	0		193.02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	0	2, 271 354		0		193. 03 194. 00
194. 01 07951 TRAFALGAR CLI NI C	0	C	0	0	0	194. 01
194. 02 07952 EDI NBURGH 194. 03 07953 JAI L	0	0 153		0		194. 02 194. 03
194. 03 07953 JATE 194. 04 07954 ATHLETI C TRAI NERS	0	502		0		194. 03 194. 04
200.00 Cross Foot Adjustments	_	-	_	_		200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0 197, 534	0 187, 975		0 26, 660		201. 00 202. 00
			,	-, - 50	-,	

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lieu	」of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eriod: com 01/01/2014	Worksheet B Part II	
			To		Date/Time Pre 5/21/2015 1:2	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVI CE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	1					1.00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 1. 01 00101 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS 4. 02 00402 DATA PROCESSI NG						1.00 1.01 2.00 4.00 4.01 4.02
4. 03 00403 MATERIALS MANAGEMENT 4. 04 00404 ADMI TTI NG 4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL						4.03 4.04 4.05 5.00
7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						7.00 8.00 9.00
10. 00 01000 DI ETARY	86, 885	33, 054				10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	33, 054 921				11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	180		49, 595 0	40 710	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	0	544 1, 154		0	42, 713 0	
30. 00 03000 ADULTS & PEDIATRICS	57,096	4, 114	53, 264	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	9, 611	1, 519	19, 671	0	0	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	13, 555 6, 623	1, 006 254		0	0	41.00 43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0	2, 524 0		0	0	50.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 718		0	0	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	2, 510 1, 210		0	0	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	985		0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	270 148		0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	438		0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	74 0		0 49, 595	0	70.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	-	49, 393	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 ONCOLOGY	0	0 308		0	42, 713 0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	128		0	0	
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00_09000 CLI NI C	0	1 001		0		
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0	1, 091 2, 364		0	0	1
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	0	933	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	86, 885	25, 393	150, 777	49, 595	42, 713	113.00 118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	138 5, 606		0		190. 00 192. 00
192. 01 19201 SOUTH CLINIC	0	3, 000 0		0		192.00
192. 02 19202 WEST CLINIC	0	0	-	0		192. 02 192. 03
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	0	115 0		0		192.03
193. 01 19301 ADULT/CHI LD CARE	0	1, 237		0		193.01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0 0	0		193. 02 193. 03
194. 00 07950 PARTNERSHI P HFC	0	307	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	0	0	194.03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	258	0	0	0	194. 04 200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0 86, 885	0 33, 054	0 150, 777	0 49, 595		201. 00 202. 00
202.00 101AL (Sum 11165 110-201)	00,000	55, 054	1 150,777	47, 575	42,713	202.00

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 150001	Peri od:	Worksheet B
				From 01/01/2014 To 12/31/2014	Date/Time Prepared:
Cost Center Description	MEDI CAL	Subtotal	Intern &	Total	5/21/2015 1:29 pm
	RECORDS &		Residents Cos		
	LI BRARY		& Post		
			Stepdown Adjustments		
	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS			1		1.00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01 00401 COMMUNI CATI ONS					4.01
4. 02 00402 DATA PROCESSI NG 4. 03 00403 MATERI ALS MANAGEMENT					4.02
4. 04 00404 ADMI TTI NG					4.03
4. 05 00405 PATIENT ACCOUNTING					4.05
5.00 00500 ADMINI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY					13.00
15. 00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	105, 372				16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	(000	/ 70 70/		0 (70,70)	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	6, 999 1, 174	672, 796 230, 414		0 672, 796 0 230, 414	
41. 00 04100 SUBPROVI DER – I RF	1,044	134, 859		0 134, 859	41.00
43. 00 04300 NURSERY	364	17, 039		0 17, 039	43.00
ANCI LLARY SERVI CE COST CENTERS	16, 811	1, 010, 298	1	0 1, 010, 298	50.00
53. 00 05300 ANESTHESI OLOGY	1, 545	38, 599		0 1, 010, 298	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	20, 802	565, 123		0 565, 123	54.00
60. 00 06000 LABORATORY	15, 339	300, 530		0 300, 530	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	3, 400 1, 969	109, 566 81, 466		0 109, 566 0 81, 466	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 067	19, 077		0 19,077	67.00
68.00 06800 SPEECH PATHOLOGY	339	5, 678		0 5, 678	
69. 00 06900 ELECTROCARDI OLOGY	3, 204	114, 822		0 114, 822	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	110 3, 703	8, 186 111, 370		0 8, 186 0 111, 370	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,625	13, 463		0 13, 463	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 853	71, 696		0 71, 696	73.00
76.00 03020 ONCOLOGY	624	76, 051		0 76, 051	76.00
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	210	23, 495		0 23, 495	76. 97
90. 00 09000 CLINIC	4, 842	194, 324		0 194, 324	90.00
91. 00 09100 EMERGENCY	10, 485	268, 272		0 268, 272	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0	92.00
101.00 10100 HOME HEALTH AGENCY	863	37, 693		0 37, 693	101.00
SPECIAL PURPOSE COST CENTERS			1		
113.00 11300 INTEREST EXPENSE	105 272	4 104 017		0 4 104 017	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	105, 372	4, 104, 817		0 4, 104, 817	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28, 376		0 28, 376	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	361, 313		0 361, 313	
192. 01 19201 SOUTH CLINIC	0	180		0 180	
192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER	0	7, 970		0 7,970	192. 02 192. 03
193. 00 19300 NONPAI D WORKERS	0	0		0 0	193.00
193. 01 19301 ADULT/CHI LD CARE	0	54, 313		0 54, 313	193. 01
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG	0	0	1		193.02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	0	2, 271 34, 579		0 2, 271 0 34, 579	193. 03 194. 00
194. 01 07951 TRAFALGAR CLINIC	0	0		0 0	194.00
194. 02 07952 EDI NBURGH	0	0		0 0	194. 02
194. 03 07953 JALL	0	153		0 153 0 841	
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments		841 0		0 841 0 0	194. 04 200. 00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118-201)	105, 372	4, 594, 813		0 4, 594, 813	

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS	JOHNSON MEMOR		F	eriod: rom 01/01/2014	u of Form CMS-2 Worksheet B-1	
		CAD	ITAL RELATED CO		o 12/31/2014	Date/Time Pre 5/21/2015 1:2	
	Cost Center Description	BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	DEPARTMENT	COMMUNI CATI ONS	
					(GROSS SALARI ES)	PHONES)	
	GENERAL SERVICE COST CENTERS	1.00	1.01	2.00	4.00	4. 01	
1.00	00100 CAP REL COSTS-BLDG & FIXT	279, 616					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - TOWER	0	76, 991	2 451 250			1.01
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 984	0	2, 451, 250 1, 981			2.00
4.01	00401 COMMUNI CATI ONS	393		(1, 309	4.01
4.02	00402 DATA PROCESSI NG	6, 260		1, 005, 557		155	
4.03 4.04	00403 MATERIALS MANAGEMENT 00404 ADMITTING	3, 826 2, 239		5, 193		28	4.03
4.04	00405 PATIENT ACCOUNTING	6,650		1, 870		83	4.02
5.00	00500 ADMI NI STRATI VE & GENERAL	9, 526		10, 858		75	
7.00	00700 OPERATION OF PLANT	24, 960				39	7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	2, 404		4, 313 2, 248		5	8.00 9.00
10.00	01000 DI ETARY	3, 917				25	
11.00	01100 CAFETERI A	4, 171				0	
13.00	01300 NURSI NG ADMI NI STRATI ON	9, 867		30, 015		42	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1,699				0	14.00 15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 879		6, 072		41	
	INPATIENT ROUTINE SERVICE COST CENTERS	-	1		1		
30.00	03000 ADULTS & PEDIATRICS	27, 577				99	
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	7,886				28	
43.00	04300 NURSERY	625				0	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	45, 761		414, 553		81	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	394 16, 532		26, 791 244, 461		0 52	53.00 54.00
60.00	06000 LABORATORY	8, 049		101, 901		68	60.00
65.00	06500 RESPI RATORY THERAPY	3, 374				18	
66.00	06600 PHYSI CAL THERAPY	6, 338					66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 335				4	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	1,080				40	
70.00	07000 ELECTROENCEPHALOGRAPHY	182		4, 106		2	70.0
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0		19, 082		0	
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS					0	
76.00	03020 ONCOLOGY	6, 999					
76.97		2, 511				0	
~ ~ ~	OUTPATIENT SERVICE COST CENTERS			00.000	570.057	10	
90.00 91.00	09000 CLI NI C 09100 EMERGENCY	11, 516				18	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 003		1,707,704		92.00
	OTHER REIMBURSABLE COST CENTERS		1				
101.00	10100 HOME HEALTH AGENCY	1, 305	0	868	641, 537	21	101.00
113 00	SPECIAL PURPOSE COST CENTERS						113.00
118.00		244, 932	75, 292	2, 425, 425	23, 755, 432	1, 115	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 297 25, 925		2,200			190. 00 192. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	25, 925		23, 464 161			192. 00 192. 0
	2 19202 WEST CLINIC		-	(192.02
	3 19203 DI ABETES CENTER	402		C			192. 03
	19300 NONPALD WORKERS	0	0	0	-		193.00
	I 19301 ADULT/CHI LD CARE 2 19302 PHYSI CI AN OFFI CE BUI LDI NG	4,832			400, 311		193. 0 [°] 193. 0
	19303 OPTI FAST/FOUNDATI ON	0	0		0		193. 0
194.00	07950 PARTNERSHI P HFC	2, 228	0	c c	46, 044	8	194.0
	07951 TRAFALGAR CLINIC	0	0		0		194.0
	2 07952 EDI NBURGH 3 07953 JAI L						194. 0 194. 0
	107954 ATHLETIC TRAINERS	0	0		-		194. 0
200.00	Cross Foot Adjustments						200. 00
201.00		4 700 0		0.740.000	0.000.000	100.000	201.0
202.00	Cost to be allocated (per Wkst. B,	1, 789, 975	86, 509	2, 718, 329	8, 293, 022	499, 964	202.00

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
				To 12/31/2014		pared: 9 pm
	CAP	ITAL RELATED CO	OSTS			
Cost Center Description	BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE	 BENEFITS DEPARTMENT 	COMMUNICATIONS (# NON PT	
				(GROSS SALARI ES)	PHONES)	
	1.00	1.01	2.00	4.00	4.01	
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 401547	1. 123625	1. 10895	6 0. 252757	381.943468	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				21, 299	2, 640	204. 00
205.00 Unit cost multiplier (Wkst. B, Part				0. 000649	2. 016807	205. 00

OST AL	Financial Systems LLOCATION - STATISTICAL BASIS	JOHNSON MEMOR			Peri od:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	par
	Cost Contor Description	DATA	MATERI ALS	ADMI TTI NG		5/21/2015 1:2 Reconciliation	<u>9 p</u>
	Cost Center Description	PROCESSING	MANAGEMENT	(GROSS	ACCOUNTING	Reconciliation	
		(WORK ORDERS)	(SUPPLY USAGE)	CHARGES)	(GROSS		
		4.02	4.03	4.04	CHARGES) 4.05	5A	+
	GENERAL SERVICE COST CENTERS	4.02	1 4.00	4.04	4.05	5/	
	00100 CAP REL COSTS-BLDG & FIXT						1
	00101 CAP REL COSTS-BLDG & FIXT - TOWER						
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						
	00401 COMMUNI CATI ONS						
	00402 DATA PROCESSI NG	2, 648	3				4
	00403 MATERIALS MANAGEMENT	32					4
	00404 ADMITTING 00405 PATIENT ACCOUNTING	139		170, 591, 81			
	00500 ADMI NI STRATI VE & GENERAL	258			0 170, 591, 811 0 0	-9, 583, 877	
	00700 OPERATION OF PLANT	30			0 0	0	
	00800 LAUNDRY & LINEN SERVICE	7			0 0	0	
	00900 HOUSEKEEPI NG	C			0 0	0	
	01000 DI ETARY 01100 CAFETERI A	73			0 0 0 0	0	
	01300 NURSI NG ADMI NI STRATI ON	81				0	
	01400 CENTRAL SERVICES & SUPPLY	C			0 0	0	
	01500 PHARMACY	21			0 0	0	
	01600 MEDI CAL RECORDS & LI BRARY	148	5, 100		0 0	0	10
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	193	172, 357	11, 325, 02	8 11, 325, 028	0	30
	03100 I NTENSI VE CARE UNI T	60				0	
	04100 SUBPROVI DER – I RF	57				0	4
	04300 NURSERY	C	0 0	588, 82	3 588, 823	0	43
	ANCI LLARY SERVI CE COST CENTERS	202	425 502	27 202 46	2 27 202 462	0	
	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	202				0	
	05400 RADI OLOGY-DI AGNOSTI C	139				0	
	06000 LABORATORY	94	1, 085, 921	24, 820, 97	0 24, 820, 970	0	60
	06500 RESPI RATORY THERAPY	83				0	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	30				0	6
	06800 SPEECH PATHOLOGY	6				0	
	06900 ELECTROCARDI OLOGY	74				0	
	07000 ELECTROENCEPHALOGRAPHY	3				0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	C				0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		-			0	
	03020 ONCOLOGY	29				0	
	07697 CARDI AC REHABI LI TATI ON	C				0	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09100 EMERGENCY	104				0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	01	82,700	10, 903, 47	5 10, 905, 475	0	92
	OTHER REIMBURSABLE COST CENTERS						1
	10100 HOME HEALTH AGENCY	44	12, 510	1, 396, 47	6 1, 396, 476	0	10
	SPECIAL PURPOSE COST CENTERS						1
3.00 8.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	2, 337	6, 250, 999	170, 591, 81	1 170, 591, 811	-9, 583, 877	11:
	NONREI MBURSABLE COST CENTERS	2,007	0,200,777	1101011101	1 1/0/0/1/011	7,000,011	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	32			0 0		190
	19200 PHYSI CLANS' PRI VATE OFFI CES	198			0 0		19:
	19201 SOUTH CLINIC 19202 WEST CLINIC) 15) 0		0 0		19:
	19202 DIABETES CENTER	g g	364		0 0		19
	19300 NONPAI D WORKERS	C	0		0 0		19
	19301 ADULT/CHI LD CARE	33	3, 619		0 0		19
	19302 PHYSI CLAN OFFICE BUILDING		0		0 0		19
	19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI P HFC	39	0 0		0 0		19
	07950 PARTNERSHIP HPC 07951 TRAFALGAR CLINIC		i, 320		0 0		19
	07952 EDI NBURGH		o o		0 0		19
4. 03	07953 JAI L	C	0		0 0		19
	07954 ATHLETIC TRAINERS	C	709		0 0	0	19
0.00	Cross Foot Adjustments						20
1.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 786, 414	454, 692	930, 38	1 2, 066, 849		20
<i>,</i> ∠. UU	Part I)	2, 100, 414	404,092	730, 38	2,000,049		
03. 00	Unit cost multiplier (Wkst. B, Part I)	1, 052. 271148	0. 070349				203
03.00 04.00	Cost to be allocated (per Wkst. B,			77, 45	1 197, 534		204

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014		
Cost Center Description	DATA	MATERI ALS	ADMI TTI NG	PATI ENT	Reconciliation	
	PROCESSI NG	MANAGEMENT	(GROSS	ACCOUNTI NG		
	(WORK ORDERS)	(SUPPLY USAGE)	CHARGES)	(GROSS		
				CHARGES)		
	4.02	4.03	4.04	4.05	5A	
205.00 Unit cost multiplier (Wkst. B, Part	436. 545695	0. 006877	0.00045	0. 001158		205.00

OST ALLOCATION - S	stems TATISTICAL BASIS	JOHNSON MEMORI			eri od:	u of Form CMS-2 Worksheet B-1	
				T I	rom 01/01/2014 o 12/31/2014	Date/Time Pre	
Cost Ce	nter Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/21/2015 1:2 DI ETARY	<u>:9</u> p
		& GENERAL	PLANT	LINEN SERVICE	(TOTAL FEET)	(MEALS SERVED)	
		(ACCUM. COST)	(TOTAL FEET)	(POUNDS OF			
		5.00	7.00	LAUNDR) 8.00	9.00	10.00	+
	CE COST CENTERS						
	COSTS-BLDG & FLXT						
	COSTS-BLDG & FIXT - TOWER COSTS-MVBLE EQUIP						
	E BENEFITS DEPARTMENT						
01 00401 COMMUNI							
02 00402 DATA PR 03 00403 MATERIA							
00403 MATERTA	LS MANAGEMENT NG						
00405 PATI ENT							
	TRATIVE & GENERAL	64, 978, 881					
00 00700 OPERATI 00 00800 LAUNDRY	ON OF PLANT & LINEN SERVICE	3, 266, 991 248, 829	222, 778				
0 00900 HOUSEKE		931, 042	2, 404 1, 867		218, 507		
00 01000 DI ETARY		681,065	3, 917		3, 917	9, 275	
00 01100 CAFETER		437, 285	4, 171		4, 171	0	
	ADMI NI STRATI ON SERVI CES & SUPPLY	1, 883, 105 225, 635	9, 867 1, 699		9, 867 1, 699	0	
00 01500 PHARMAC		4, 308, 210	2, 046		2,046	0	
	RECORDS & LI BRARY	1, 075, 728	3, 879	0	3, 879	0	1
	TINE SERVICE COST CENTERS	4 200 244	27 57	1/0 7//	27 577	(005	
00 03000 ADULTS 00 03100 I NTENSI		4, 389, 244 1, 793, 470	27, 577 7, 886		27, 577 7, 886	6, 095 1, 026	
00 04100 SUBPROV		1, 142, 026	6, 763		6, 763	1, 447	
00 04300 NURSERY		253, 365	625	0	625	707	4
	VICE COST CENTERS	4 202 547	45 7/1	04.444	45 7/1		- L
00 05000 OPERATI 00 05300 ANESTHE		4, 322, 547 102, 891	45, 761 394		45, 761 394	0	
	GY-DI AGNOSTI C	4, 627, 024	16, 532		16, 532	0	
00 06000 LABORAT		4, 301, 305	8, 049		8, 049	0	
00 06500 RESPI RA 00 06600 PHYSI CA		1, 459, 813	3, 374		3, 374	0	
	I ONAL THERAPY	1, 077, 722 301, 178	6, 338 1, 335		6, 338 1, 335	0	
00 06800 SPEECH		179, 290	83		83	0	
00 06900 ELECTRO		1, 039, 845	1, 080		1, 080	0	
	ENCEPHALOGRAPHY SUPPLIES CHARGED TO PATIENT	80, 675 2, 137, 811	182 C		182 0	0	
	EV. CHARGED TO PATIENTS	1, 379, 816			0	0	
00 07300 DRUGS C	HARGED TO PATIENTS	223, 265	C	0	0	0	7
00 03020 ONCOLOG		388, 211	6, 999		6, 999	0	
	REHABILITATION RVICE COST CENTERS	151, 757	2, 511	0	2, 511	0	0 7
00 09000 CLINIC		2, 795, 968	11, 516	2, 881	11, 516	0	9
00 09100 EMERGEN		2, 905, 021	9, 934		9, 934	0	
	TI ON BEDS (NON-DI STI NCT PART SABLE COST CENTERS						9
00 10100 HOME HE		1, 060, 850	1, 305	0	1, 305	0	10
	SE COST CENTERS	.,	.,		.,		1.0
3. 00 11300 I NTERES							11:
	LS (SUM OF LINES 1-117) LE COST CENTERS	49, 170, 984	188, 094	541, 691	183, 823	9, 275	111
	LOWER, COFFEE SHOP & CANTEEN	171, 771	1, 297	0	1, 297	0	19
	ANS' PRIVATE OFFICES	13, 738, 035	25, 925		25, 925		19
2. 01 19201 SOUTH C		195	C	-	0		19
2. 02 19202 WEST CL 2. 03 19203 DI ABETE		0 128, 211	402		0 402) 19) 19
. 00 19300 NONPAI D		0	402	0 0	402		19
. 01 19301 ADULT/C		635, 596	4, 832	0	4, 832		19
	AN OFFICE BUILDING	0	C	0	0		19
. 03 19303 OPTI FAS . 00 07950 PARTNER		784, 999 122, 389	2, 228		0 2, 228		19
. 01 07951 TRAFALO		0	2,220	0 0	2,220		19
. 02 07952 EDI NBUR		0	C	0	0	0	19
. 03 07953 JAI L		53, 031	C	0	0		19
04 07954 ATHLETI 0.00 Cross F	C TRAINERS oot Adjustments	173, 670	C	0	0	0	20
	e Cost Centers						20
2.00 Cost to	be allocated (per Wkst. B,	9, 583, 877	3, 748, 846	325, 983	1, 152, 600	873, 123	
Part I)		0 147400	1/ 007704	0 501//0	E 074000		
	st multiplier (Wkst. B, Part I) be allocated (per Wkst. B,	0. 147492 187, 975				94. 137251 86, 885	
Part II		107, 775	201,004	20,000	20,410	00,000	1-0'

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
				To 12/31/2014		
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE	(TOTAL FEET)	(MEALS SERVED)	
	(ACCUM. COST)	(TOTAL FEET)	(POUNDS OF			
			LAUNDR)			
	5.00	7.00	8.00	9.00	10.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 002893	1. 039304	0. 04838	8 0. 116326	9. 367655	205.00

	Financial Systems LOCATION - STATISTICAL BASIS	JOHNSON MEMOR		CCN: 150001 P	In Lieu Period:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	
	Cost Center Description	CAFETERI A (HOURS PAI D)	URSI NG ADMI NI STRATI ON (DI RECT NRSI NG HR)	SUPPLY	PHARMACY (COSTED REQUIS.)	5/21/2015 1:2 MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	9 pm
		11.00	13.00	14.00	15.00	16.00	
1.00 0 1.01 0 2.00 0 4.01 0 4.02 0 4.03 0 4.04 0 4.05 0 5.00 0 7.00 0 8.00 0 10.00 0 11.00 0 13.00 0 15.00 0	GENERAL SERVICE COST CENTERS DO100 CAP REL COSTS-BLDG & FIXT DO101 CAP REL COSTS-BLDG & FIXT - TOWER DO200 CAP REL COSTS-MVBLE EQUIP DO400 EMPLOYEE BENEFITS DEPARTMENT DO401 COMMUNICATIONS D0402 DATA PROCESSING D0403 MATERIALS MANAGEMENT D0404 ADMITTING D0404 ADMITTING D0405 PATIENT ACCOUNTING D0500 ADMINISTRATIVE & GENERAL D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY	795, 102 22, 158 4, 322 13, 087 27, 770	280, 140 0 0	10C C C	100	170, 591, 811	1.00 1.01 2.00 4.01 4.02 4.03 4.04 4.05 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00
1	NPATIENT ROUTINE SERVICE COST CENTERS						
31.00 (41.00 (43.00 (03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04300 NURSERY	98, 963 36, 549 24, 201 6, 098	36, 549 24, 201	0 0 0	0 0	11, 325, 028 1, 899, 932 1, 689, 367 588, 823	31.00 41.00
50.00 C 53.00 C 54.00 C 60.00 C 65.00 C 66.00 C 67.00 C 68.00 C 69.00 C 70.00 C 71.00 C 72.00 C	ANCILLARY SERVICE COST CENTERS 55000 OPERATI NG ROM 55300 ANESTHESI OLOGY 55400 RADI OLOGY-DI AGNOSTI C 56600 LABORATORY 56500 RESPI RATORY THERAPY 56600 PHYSI CAL THERAPY 56600 OCCUPATI ONAL THERAPY 56600 SPEECH PATHOLOGY 56900 ELECTROCARDI OLOGY 56900 ELECTROCARDI OLOGY 57000 ELECTROCARDI OLOGY 57000 ELECTROENCEPHALOGRAPHY 57100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 57200 IMPL. DEV. CHARGED TO PATI ENTS 57300 DRUGS CHARGED TO PATI ENTS	60, 716 C 65, 391 60, 375 29, 112 23, 690 6, 494 3, 555 10, 530 1, 788 C C C				27, 202, 463 2, 500, 035 33, 747, 527 24, 820, 970 5, 501, 585 3, 186, 095 1, 727, 224 548, 280 5, 185, 257 177, 329 5, 992, 038 4, 247, 286 12, 707, 166	53.00 54.00 60.00 65.00 67.00 68.00 69.00 70.00 71.00 72.00
76.00 0	07000 DNCOLOGY 07697 CARDIAC REHABILITATION	7, 414 3, 089	0	C	0	1, 009, 281	76.00
	DUTPATIENT SERVICE COST CENTERS	3,089	0	C	<u> </u>	339, 307] /0.9/
91.00 C 92.00 C	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	26, 241 56, 871		C		7, 834, 869 16, 965, 473	
101.001	DTHER REIMBURSABLE COST CENTERS	22, 431	0	C	0	1, 396, 476	101. 00
113.001 118.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) IONREI MBURSABLE COST CENTERS	610, 845	280, 140	100	100	170, 591, 811	113. 00 118. 00
190. 00 1 192. 00 1 192. 01 1 192. 02 1	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 SOUTH CLINIC 19202 WEST CLINIC	3, 308 134, 835 C	0 0 0	0 0 0 0		0 0 0	190. 00 192. 00 192. 01 192. 02
193.001 193.011 193.021	19203 DI ABETES CENTER 19300 NONPAI D WORKERS 19301 ADULT/CHI LD CARE 19302 PHYSI CI AN OFFI CE BUI LDI NG 19303 OPTI FAST/FOUNDATI ON	2, 771 C 29, 75C C C	0		0	0 0 0	192.03 193.00 193.01 193.02 193.03
194.00 194.01 194.02 194.03	07950 PARTNERSHIP HFC 07951 TRAFALGAR CLINIC 07952 EDINBURGH 07953 JAIL 07954 ATHLETIC TRAINERS Cross Foot Adjustments	7, 378 C C C 6, 215	0 0 0		0 0 0 0	0 0 0 0	194. 00 194. 01 194. 02 194. 03 194. 04 200. 00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	593, 971	2, 395, 487	299, 695	4, 998, 635	1, 340, 870	201.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 747037	8. 551035	2, 996. 950000	49, 986. 350000	0.007860	203. 00

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				rom 01/01/2014 o 12/31/2014	Date/Time Pre 5/21/2015 1:2	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	(HOURS PAID)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
			SUPPLY	REQUIS.)	LI BRARY	
		(DIRECT NRSING	(COSTED		(GROSS	
		HR)	REQUIS.)		CHARGES)	
	11.00	13.00	14.00	15.00	16.00	
204.00 Cost to be allocated (per Wkst. B, Part II)	33, 054	150, 777	49, 595	6 42, 713	105, 372	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 041572	0. 538220	495.950000	427. 130000	0. 000618	205.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	JOHNSON MEMOR		CCN: 150001	Peri od:	u of Form CMS- Worksheet C	2002-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		riovidei	CCN. 150001	From 01/01/2014	Part I	
				To 12/31/2014		
					5/21/2015 1:2	29 pm
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	2.00	2.00	4.00	F 00	-
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	7 220 022		7 220 0	32 0	7 220 022	1 20 00
	7, 328, 932		7, 328, 9		110201102	
	2, 703, 735		2, 703, 7		-, ,	
41.00 04100 SUBPROVI DER - I RF	1, 847, 955		1, 847, 9			
43. 00 04300 NURSERY	432, 430		432, 4	30 0	432, 430	43.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	(704 010		(704 0	10 0 101	(702 110	
	6, 784, 018		6, 784, 0		6, 792, 119	
53. 00 05300 ANESTHESI OLOGY	146, 425		146, 4			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6,008,905		6, 008, 9		6, 008, 905	
60. 00 06000 LABORATORY	5, 353, 812		5, 353, 8		5, 353, 812	
65. 00 06500 RESPIRATORY THERAPY	1, 814, 688				1, 814, 688	
66. 00 06600 PHYSI CAL THERAPY	1, 421, 288		1, 421, 2		1, 421, 288	
67. 00 06700 OCCUPATI ONAL THERAPY	393, 533		393, 5		393, 533	
68. 00 06800 SPEECH PATHOLOGY	214, 534		214, 5		214, 534	
69. 00 06900 ELECTROCARDI OLOGY	1, 268, 444		1, 268, 4		1, 268, 444	
70. 00 07000 ELECTROENCEPHALOGRAPHY	99, 327		99, 3		99, 327	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	2, 799, 913		2, 799, 9		2, 799, 913	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	1, 616, 712		1, 616, 7		1, 616, 712	
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 354, 708		5, 354, 7		5, 354, 708	
76. 00 03020 ONCOLOGY	613, 637		613, 6		613, 637	
76. 97 07697 CARDI AC REHABI LI TATI ON	234, 614		234, 6	14 0	234, 614	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	3, 545, 775		3, 545, 7			
91. 00 09100 EMERGENCY	4, 256, 290		4, 256, 2		1/200/2/0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,006,239		1, 006, 2	39	1, 006, 239	92.00
OTHER REIMBURSABLE COST CENTERS	1					1
101.00 10100 HOME HEALTH AGENCY	1, 273, 894		1, 273, 8	94	1, 273, 894	101.00
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	56, 519, 808					
201.00 Less Observation Beds	1,006,239		1, 006, 2		1, 006, 239	
202.00 Total (see instructions)	55, 513, 569	C	55, 513, 5	69 9, 297	55, 522, 866	202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/21/2015 1:2	pared: 9 pm
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges	· ·			
Cost Center Description	I npati ent	Outpati ent	+ col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 771, 665		9, 771, 6	55		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 899, 932		1, 899, 9	32		31.00
41.00 04100 SUBPROVIDER - IRF	1, 689, 367		1, 689, 3	57		41.00
43. 00 04300 NURSERY	588, 823		588, 8	23		43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	5, 425, 087	21, 777, 376	27, 202, 4	63 0. 249390	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	605, 252	1, 894, 783	2, 500, 0	0. 058569	0.00000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 022, 060	29, 725, 467	33, 747, 5	0. 178055	0.00000	54.00
60. 00 06000 LABORATORY	5, 839, 512	18, 981, 458	24, 820, 9	0. 215697	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 177, 197	2, 324, 388	5, 501, 5	0. 329848	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 157, 305	2, 028, 790	3, 186, 0	0. 446091	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	1, 138, 265	588, 959	1, 727, 2	0. 227841	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	264, 311	283, 969	548, 2	0. 391285	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 398, 606	3, 786, 651	5, 185, 2	57 0. 244625	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	74, 498	102, 831	177, 3	0. 560128	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 019, 771	2, 972, 267	5, 992, 0	38 0. 467272	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 300	4, 245, 986	4, 247, 2	0. 380646	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 233, 894	8, 473, 272	12, 707, 1	0. 421393	0.000000	73.00
76.00 03020 ONCOLOGY	9, 119	1, 000, 162	1, 009, 2	0. 607994	0.000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	968	338, 339	339, 3	0. 691451	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	21, 348	7, 813, 521	7, 834, 8	0. 452563	0.000000	90.00
91.00 09100 EMERGENCY	2, 683, 572	14, 281, 901	16, 965, 4	73 0. 250880	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	486, 244	1,067,119	1, 553, 3	0. 647781	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1, 396, 476	1, 396, 4	76		101.00
SPECIAL PURPOSE COST CENTERS	I					
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	47, 508, 096	123, 083, 715	170, 591, 8	11		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	47, 508, 096	123, 083, 715	170, 591, 8	11		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150001 Porid: From 0/107/2014 To 12/31/2014 Worksheet C Part 1 Cost Center Description PPS Inpatient Ratio Title XVIII Hospital PPS INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 31.00 30.00 31.00 30.00 31.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 30.00 30	Health Fina	ncial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	」of Form CMS-2552-	10
Cost Center Description PPS Inpatient Ratio PPS Inpatient Ratio PPS Inpatient Ratio PPS Inpatient Ratio 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 31.00 31.00 03100 INTENSIVE CARE UNIT 31.00 31.00 41.00 SUBPROVIDER - IRF 31.00 30.00 04300 NURSERY 41.00 ANDIO SUBPROVIDER - IRF 43.00 50.00 05000 APESTRISIOLOGY 0.058569 50.00 05000 ANSTRISIOLOGY 0.249688 50.00 05000 ANSTRISIOLOGY 0.249697 60.00 06000 RESPIRATING ROOM 0.215697 60.00 06000 RESPIRATORY THERAPY 0.227841 61.00 066000 PHYSICAL THERAPY 0.227841 62.00 066000 SEECECH PATHOLOGY 0.2446091 63.00 06300 SEECECH PATHOLOGY 0.244625 64.00 0.00 0.227841 65.00 06400 OPHYSICAL THERAPY 0.244625 66.00 0.244625 69.00 70.00 02000 CLUCURATIONAL THERAPY 0.4217272	COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CCN: 150001	From 01/01/2014	Part I Date/Time Prepared	1:
Ratio 11.00 11.00 30.00 30001 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSI VE CARE UNIT 31.00 41.00 04100 SUBPROVIDER - IRF 41.00 43.00 04300 NURSERY 41.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 50000 OPECATING ROOM 0.249688 51.00 05300 ANESTHESI OLOGY 0.058569 53.00 53.00 53.00 54.00 05400 (ARONTORY 0.215697 60.00 66000 PHASI CAL THERAPY 0.424625 60.00 66000 PHASI CAL THERAPY 0.4246091 67.00 66000 SPECEL PATHOLOCY 0.329848 67.00 66000 SPECH PATHOLOCY 0.3125697 68.00 66000 SPECH PATHOLOCY 0.329848 67.00 66000 SPECH PATHOLOCY 0.3125697 70.00 70000 CLICATIONAL THERAPY 0.446091 70.00 70000 SPECH PATHOLOCY 0.3125697 70.00 70000 CLICATRORAPHY 0.560128 70.00 70000 CLICATROROPATHOLOCY </td <td></td> <td></td> <td></td> <td>Title XVIII</td> <td>Hospi tal</td> <td>PPS</td> <td></td>				Title XVIII	Hospi tal	PPS	
30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 03100 INTENSIVE CARE UNIT 41.00 41. 00 CA300 NURSERY 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0. 249688 50. 00 50. 00 05000 ARSTHESI OLOGY 0.058569 53. 00 51. 00 05400 RADIOLOGY - DI AGNOSTIC 0. 178055 54. 00 60. 00 66000 PLABORT INGY THERAPY 0. 215697 60. 00 60. 00 66000 OCCUPATIONAL THERAPY 0. 446091 66. 00 67. 00 066000 SPECH PATHOLOGY 0. 391285 66. 00 68. 00 66000 SPECH PATHOLOGY 0. 391285 68. 00 69. 00 66000 SPECH PATHOLOGY 0. 391285 68. 00 69. 00 06900 ELECTROCARDIOLOGY 0. 244625 70. 00 70. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 467272 71. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 467273 73. 00 73. 00 07300		Cost Center Description	Ratio				
31. 00 03100 INTENSI VE CARE UNI T 31. 00 41. 00 04100 SUBPROVI DER - IRF 41. 00 ANCILLARY SERVICE COST CENTERS 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 50. 00 05000 (PERATING ROOM 0.249688 50. 00 50.00 (Docom) LABORATIORY 0.058569 51. 00 0.5000 (DARDATORY 0.215697 60. 00 6000 (DABORATORY 0.227841 61. 00 06000 (DECARDATORY 0.227841 62. 00 06000 (DECARDATORY 0.391285 63. 00 06000 (DECETORACADI LICAR) 66. 00 64. 00 06700 (DCCUPATI ONAL THERAPY 0.227841 67. 00 06700 (DCCUPATI ONAL THERAPY 0.227841 67. 00 06000 ELECTROCADDI LICGY 0.391285 68. 00 06800 SPEECH PATHOLOGY 0.391285 69. 00 0100 (DICAL SUPPLIES CHARGED TO PATI ENT 0.460272 71. 00 71. 00 71. 00 71. 00 07100 (MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.36046 72. 00 730. 00 7000 RUSS CHARGED TO PATI ENTS 0.421393 76. 07 07697 (CAR							
41.00 04100 SUBPROVI DER - I RF 41.00 43.00 04300 NURSERY 41.00 ANCI LLARY SERVICE COST CENTERS 43.00 50.00 05000 OPERATI NG ROOM 0.249688 53.00 05300 ANESTHESI OLOGY 0.058569 54.00 05400 (RADI OLOGY-DI AGNOSTI C 0.178055 60.00 06000 LABORATORY 0.215697 60.00 06500 RESPI RATORY THERAPY 0.329848 60.00 06600 PHYSI CAL THERAPY 0.227841 60.00 06600 OPHYSI CAL THERAPY 0.227841 61.00 06600 SPEECH PATHOLOGY 0.391285 62.00 06900 ELECTROCARDI OLOGY 0.391285 63.00 06900 ELECTROCARDI OLOGY 0.244625 70.00 07000 ELECTROCARDI OLOGY 0.391285 63.00 06900 ELECTROCARDI OLOGY 0.244625 70.00 07000 ELECTROCARDI OLOGY 0.380646 71.00 100 ONDIC AL SUPPLIES CHARGED TO PATI ENT 0.4607272 71.00 000 DRUGS CHARGED TO PATI ENTS 0.380646 72.00 07200 DRUGS CHARGED TO PATI ENTS 0.380646 70.00 07100 MEDI CA	30.00 03000) ADULTS & PEDIATRICS				30. (00
43. 00 0300 NURSERY 43. 00 ANCI LLARY SERVICE COST CENTERS 50. 00 Social Cost (Cost Centers) 50. 00 53. 00 05300 0RATI NG ROOM 0. 249688 50. 00 54. 00 05400 0ARSTHESI OLOGY 0. 058569 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 178055 60. 00 60. 00 06500 RESPI RATORY THERAPY 0. 229841 65. 00 66. 00 6600 PKSI CAL THERAPY 0. 244625 68. 00 67. 00 06900 ELECTROENCERPIALOGRY 0. 244625 68. 00 69. 00 06900 ELECTROENCERPIALOGRY 0. 244625 69. 00 60. 00 07000 ELECTROENCERPIALOGRAPHY 0. 560128 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 380646 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 421393 73. 00 76. 07 0.0000 CLIN IC 0. 452563 90. 00 90. 00 OSTOSOLOGY 0. 601451 76. 97 0.00 070000 ELECTROENCE TOR TENE	31.00 03100	INTENSIVE CARE UNIT				31. (0C
ANCL LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0.249688 50.00 53. 00 05300 ANESTHESI OLOGY 0.058569 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.178055 54.00 60. 00 06500 RESPIRATORY THERAPY 0.239848 65.00 66. 00 06600 PHYSI CAL THERAPY 0.426091 66.00 67. 00 06000 LECTROCARDI OLOGY 0.239848 65.00 68. 00 06600 SPEECH PATHOLOGY 0.391285 68.00 69. 00 06900 ELECTROCARDI OLOGY 0.244625 69.00 70. 00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.467272 71.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.421393 73.00 70. 00 73.00 70.00 CHARGED TO PATIENTS 0.421393 73.00 70. 00 70.00 OT200 IMPL. DEV. CHARGED TO PATIENTS 0.421393 73.00 70.00 70.00 0.60799	41.00 04100	SUBPROVIDER - IRF				41. (00
50.00 05000 OPERATI NG ROOM 0.249688 50.00 53.00 05300 ANESTHESI OLOGY 0.058869 53.00 54.00 05400 RADI DLOGY-DI AGNOSTI C 0.178055 54.00 60.00 06000 LABORATORY 0.215697 60.00 65.00 06500 RESPI RATORY THERAPY 0.329848 65.00 66.00 06000 PUSY ICAL THERAPY 0.227841 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.227841 67.00 68.00 06800 SPEECH PATHOLOGY 0.31285 68.00 69.00 60000 LECTROCARDI OLOGY 0.244625 69.00 70.00 7000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.4607272 71.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.380646 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0.691451 76.07 00 09000 CLINIC 0.421393 73.00 76.07 90.00 90.000 90.00 9	43.00 04300	NURSERY				43.0	00
53.00 05300 ANESTHESI OLOGY 0.058569 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.178055 54.00 60.00 LABORATORY 0.215697 60.00 65.00 06500 RESPI RATORY THERAPY 0.329848 65.00 66.00 06700 OCUPATI ONAL THERAPY 0.446091 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.227841 67.00 68.00 06800 SPEECH PATHOLOGY 0.391285 68.00 69.00 0F000 ELECTROCARDI OLOGY 0.227841 69.00 70.00 O7000 ELECTROCARDI OLOGY 0.244625 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.467272 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.421393 73.00 73.00 DRUGS CHARGED TO PATI ENTS 0.421393 73.00 76.00 03020 INCL CREADED (COST CENTERS 90.00 90.00 O9000 CLINI C 0.452563 90.00 91.00 92.00 09200 OLINI C 0.452563 90.00 91.00 09000 CLINI C 0.452563 90.00 91.00 09000 CLI	ANCI L	LARY SERVICE COST CENTERS					
54.00 05400 RADI OLOGY - DI AGNOSTI C 0.178055 54.00 60.00 06000 LABORATORY 0.215697 60.00 65.00 05500 RESPI RATORY THERAPY 0.329848 65.00 66.00 06000 PHYSI CAL THERAPY 0.227841 67.00 68.00 06000 ELECTROCARDI OLOGY 0.244625 68.00 69.00 06000 ELECTROCARDI OLOGY 0.244625 68.00 70.00 07000 ELECTROCARDI OLOGY 0.244625 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.467272 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.380646 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.421393 73.00 74.00 0200 NCOLOGY 0.69794 76.97 074.01 CRIDI AC REHABILI TATI ON 0.697941 76.97 074.02 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.421393 90.00 90.00 OP000 CLINIC 0.452563 90.00 91.000 OP100 EMERGENCY	50.00 05000	OPERATING ROOM	0. 249688			50. (00
60.00 CABORATORY 0.215697 60.00 65.00 O6500 RESPI RATORY THERAPY 0.329848 65.00 66.00 O6600 PHYSI CAL THERAPY 0.446091 66.00 67.00 OCCUPATIONAL THERAPY 0.227841 67.00 68.00 O6600 SPEECH PATHOLOGY 0.391285 68.00 69.00 CEUTROCARDI OLOGY 0.244625 69.00 70.00 OLECTROCARDI ALLOGRAPHY 0.560128 70.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.467272 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 0.380646 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.421393 73.00 74.00 O300 DRUGS CHARGED TO PATIENTS 0.491451 75.00 O7200 INC COST CENTERS 76.00 76.00 O9000 CLI N C 0.452563 90.00 90.00 O9000 CLI N C 0.452563 91.00 90.00 O9000 EMERGENCY 0.250880 91.00 91.00 O9100 EMERGENCY	53.00 05300	ANESTHESI OLOGY	0. 058569			53.0	00
65.00 06500 RESPI RATORY THERAPY 0.329848 65.00 66.00 06600 PHYSI CAL THERAPY 0.446091 66.00 67.00 0CCUPATI ONAL THERAPY 0.327841 68.00 68.00 06800 SPEECH PATHOLOGY 0.391285 68.00 69.00 06900 ELECTROCARDI OLOGY 0.244625 69.00 70.00 O7000 ELECTROCARDI OLOGY 0.244625 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.467272 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.380646 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.421393 73.00 76.07 03202 ONCOLOGY 0.452563 72.00 70.00 DUTPATI ENT SERVICE COST CENTERS 0.250880 91.00 90.00 09000 CLI NIC 0.452563 90.00 91.00 09000 CLI NIC 0.250880 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 91.00 091000 MERERENC	54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 178055			54.0	00
66.00 06600 PHYSI CAL THERAPY 0.446091 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.227841 67.00 68.00 06900 ELECTROCARDI OLOGY 0.391285 68.00 69.00 06900 ELECTROCARDI OLOGY 0.244625 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.560128 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.467272 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.380646 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.461393 73.00 76.00 03020 ONCOLOGY 0.607994 76.00 76.00 09000 CLI NI C 0.452563 90.00 90.00 09000 ELERGENCY 0.250880 91.00 91.00 09100 EMERGENCY 0.250880 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 91.00 92000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 91.1300 <td>60.00 06000</td> <td>LABORATORY</td> <td>0. 215697</td> <td></td> <td></td> <td>60. (</td> <td>00</td>	60.00 06000	LABORATORY	0. 215697			60. (00
67.00 06700 0CCUPATI ONAL THERAPY 0.227841 67.00 68.00 06800 SPEECH PATHOLOGY 0.391285 68.00 69.00 06900 ELECTROCARDI OLOGY 0.244625 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.560128 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.467272 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.380646 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.421393 73.00 76.00 03020 NCOLOGY 0.691451 76.00 000 07697 CARDI AC REHABI LI TATI ON 0.691451 76.00 0100 ENERGENCY 0.452563 90.00 92.00 09200 [OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 011.00 IOTOR HEALTH AGENCY 92.00 92.00 92.00 09200 [OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 011.00 HOME HEALTH AGENCY 101.00 92.00 92.00 DITHER REI MBURSABLE COST CENTERS 101.00 </td <td>65.00 06500</td> <td>RESPI RATORY THERAPY</td> <td>0. 329848</td> <td></td> <td></td> <td>65.0</td> <td>00</td>	65.00 06500	RESPI RATORY THERAPY	0. 329848			65.0	00
68.00 06800 SPEECH PATHOLOGY 0.391285 68.00 69.00 06900 ELECTROCARDI OLOGY 0.244625 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.560128 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.467272 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.380646 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.421393 73.00 76.07 03020 ONCOGY 0.607994 76.00 76.97 07597 CARDI AC REHABI LI TATI ON 0.691451 76.97 0UTPATI ENT SERVICE COST CENTERS 90.00 90.00 91.00 90.00 09000 CLI NI C 0.452563 90.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 91.100 10100 HOME HEALTH AGENCY 101.00 101.00 101.00 11300 INTEREST EXP	66.00 06600	PHYSICAL THERAPY	0. 446091			66.0	00
68.00 06800 SPEECH PATHOLOGY 0.391285 68.00 69.00 06900 ELECTROCARDI OLOGY 0.244625 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.560128 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.467272 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.380646 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.421393 73.00 76.07 03020 ONCOGY 0.607994 76.00 76.97 07597 CARDI AC REHABI LI TATI ON 0.691451 76.97 0UTPATI ENT SERVICE COST CENTERS 90.00 90.00 91.00 90.00 09000 CLI NI C 0.452563 90.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.647781 92.00 91.100 10100 HOME HEALTH AGENCY 101.00 101.00 101.00 11300 INTEREST EXP	67.00 06700	OCCUPATIONAL THERAPY	0. 227841			67.0	00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.560128 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.467272 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.380646 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.421393 73.00 76.00 03020 ONCOLOGY 0.60794 76.00 76.97 OAGPT CARDIAC REHABILITATION 0.691451 76.00 70.00 09000 CLINIC 0.452563 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 07HER REI MBURSABLE COST CENTERS 92.00 07HER REI MBURSABLE COST CENTERS 92.00 113.00 11300 INTERST EXPENSE 101.00 10100 HOME HEALTH AGENCY 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	68.00 06800	SPEECH PATHOLOGY				68.0	00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.467272 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.380646 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.421393 73.00 76.00 03020 ONCOLOGY 0.607994 76.00 76.07 07697 CARDIAC REHABILITATION 0.691451 76.00 00TPATIENT SERVICE COST CENTERS 0.425263 90.00 90.00 90.00 09000 CLINIC 0.452563 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 0100 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 01010 HOME HEALTH AGENCY 0.452563 92.00 01010 HOME KERSENCE 101.00 1010 01010 HOME KERSENCE 101.00 101.00 113.00 INTEREST EXPENSE 113.00 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	69.00 06900	ELECTROCARDI OLOGY	0. 244625			69.0	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.380646 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.421393 73.00 76.00 03020 ONCOLOGY 0.607994 76.00 76.07 OARDIAC REHABILITATION 0.691451 76.97 0UTPATIENT SERVICE COST CENTERS 0.452563 90.00 90.00 09000 EMERGENCY 0.250880 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 01100 HOME HEALTH AGENCY 0.647781 92.00 01100 HOME SECOST CENTERS 101.00 101.00 01100 HOME SECOST CENTERS 113.00 113.00 113.00 113.00 Subtotal (see instructions) 113.00 200.00 201.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	70.00 07000	ELECTROENCEPHALOGRAPHY	0. 560128			70.0	00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.421393 73.00 76.00 03020 ONCOLOGY 0.607994 76.00 76.97 CARDIAC REHABILITATION 0.691451 76.97 0UTPATIENT SERVICE COST CENTERS 0.452563 90.00 90.00 09100 EMERGENCY 0.452563 90.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 0THER REIMBURSABLE COST CENTERS 0.1100 HOME HEALTH AGENCY 92.00 011.00 10100 HOME HEALTH AGENCY 101.00 101.00 10100 HOME HEALTH AGENCY 101.00 00 113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 Less Observation Beds 201.00 201.00	71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 467272			71.0	00
76.00 03020 ONCOLOGY 0.607994 76.00 76.07 07697 CARDIAC REHABILITATION 0.691451 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 9000 CLINIC 0.452563 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 92.00 92.00 0BSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 92.00 0THER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 92.00 SPECIAL PURPOSE COST CENTERS 101.00 10100 INTEREST EXPENSE 113.00 113.00 11300 INTEREST EXPENSE 113.00 200.00 200.00 Subtotal (see instructions) 200.00 201.00	72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 380646			72.0	00
76. 97 07697 CARDI AC REHABILITATION 0. 691451 76. 97 0UTPATI ENT SERVICE COST CENTERS 0000 011 NI C 0. 452563 90. 00 91. 00 09100 EMERGENCY 0. 250880 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 647781 92. 00 0THER REI MBURSABLE COST CENTERS 92. 00 92. 00 10100 HOME HEALTH AGENCY 92. 00 113. 00 11300 INTEREST EXPENSE 101. 00 10100 10100 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 201. 00 201. 00	73.00 07300	DRUGS CHARGED TO PATIENTS	0. 421393			73.0	00
OUTPATI ENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0.452563 90.00 91.00 09100 EMERGENCY 0.250880 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 0THER REIMBURSABLE COST CENTERS 010100 HOME HEALTH AGENCY 101.00 010100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	76.00 03020	ONCOLOGY	0. 607994			76.0	00
90.00 09000 CLINIC 0.452563 90.00 91.00 09100 EMERGENCY 0.250880 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 0THER REIMBURSABLE COST CENTERS 90.00 92.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 101.00 113.00 113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	76.97 0769	CARDIAC REHABILITATION	0. 691451			76.0	97
91.00 09100 EMERGENCY 0.250880 91.00 92.00	OUTPA	ATIENT SERVICE COST CENTERS					
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.647781 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 101.00 113.00 113.00 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	90.00 09000	CLINIC	0. 452563			90. (00
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 113.00 200.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 Less Observation Beds 201.00	91.00 09100	EMERGENCY	0. 250880			91. (00
101.00 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 200.00 200.00 200.00 200.00 201.00	92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 647781			92.0	00
SPECIAL PURPOSE COST CENTERS 113.00 11300 200.00 Subtotal (see instructions) 201.00 Less Observation Beds	OTHER	R REIMBURSABLE COST CENTERS					
113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00						101. (00
200.00 Subtotal (see instructions) 200.00 200.00 201.00 201.00			- I				
201.00 Less Observation Beds 201.00							
202.00 Total (see instructions) 202.00							
	202.00	Total (see instructions)				202. (00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	Sofinoon memoria	AL HOSPITAL	CCN: 150001	Peri od:	u of Form CMS- Worksheet C	2002-10
SOME CHARTER OF RATE OF COSTS TO CHARGES		riovider	CCN. 150001	From 01/01/2014	Part I	
				To 12/31/2014	Date/Time Pre	epared:
					5/21/2015 1:2	9 pm
			le XIX	Hospi tal	Cost	
Cont. Conton Deconintion	Tatal Cast	The second states the second states of the second states tates of the second states of the second states of the se	Tatal Cast	Costs RCE	Tatal Casta	
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	Disallowance	Total Costs	
	Part I, col.	Auj .		DI Sal I Owalice		
	26)					
	1.00	2.00	3.00	4.00	5.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	7, 328, 932		7, 328, 9	32 0	7, 328, 932	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 703, 735		2, 703, 7		2, 703, 735	
41. 00 04100 SUBPROVI DER – I RF	1, 847, 955		1, 847, 9		1, 849, 151	
43. 00 04300 NURSERY	432, 430		432, 4		432, 430	
ANCI LLARY SERVI CE COST CENTERS	102,100		102,1	00	102, 100	10.00
50. 00 05000 OPERATI NG ROOM	6, 784, 018		6, 784, 0	18 8, 101	6, 792, 119	50.00
53. 00 05300 ANESTHESI OLOGY	146, 425		146, 4		146, 425	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6,008,905		6,008,9		6, 008, 905	
60. 00 06000 LABORATORY	5, 353, 812		5, 353, 8		5, 353, 812	
65. 00 06500 RESPI RATORY THERAPY	1, 814, 688				1, 814, 688	
66, 00 06600 PHYSI CAL THERAPY	1, 421, 288		1, 421, 2		1, 421, 288	
67.00 06700 OCCUPATIONAL THERAPY	393, 533	C	393, 5		393, 533	67.00
68.00 06800 SPEECH PATHOLOGY	214, 534	C	214, 5	34 0	214, 534	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 268, 444		1, 268, 4	44 0	1, 268, 444	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	99, 327		99, 3		99, 327	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 799, 913		2, 799, 9	13 0	2, 799, 913	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 616, 712		1, 616, 7	12 0	1, 616, 712	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 354, 708		5, 354, 7	08 0	5, 354, 708	73.00
76.00 03020 ONCOLOGY	613, 637		613, 6	37 0	613, 637	76.00
76. 97 07697 CARDIAC REHABILITATION	234, 614		234, 6	14 0	234, 614	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	3, 545, 775		3, 545, 7	75 0	3, 545, 775	90.00
91.00 09100 EMERGENCY	4, 256, 290		4, 256, 2	90 0	4, 256, 290	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,006,239		1, 006, 2	39	1, 006, 239	92.00
OTHER REIMBURSABLE COST CENTERS						
101.0010100 HOME HEALTH AGENCY	1, 273, 894		1, 273, 8	94	1, 273, 894	101.00
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	56, 519, 808					
201.00 Less Observation Beds	1,006,239		1, 006, 2		1, 006, 239	
202.00 Total (see instructions)	55, 513, 569	C	55, 513, 5	69 9, 297	55, 522, 866	202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150001	Peri od:	Worksheet C	
				From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	nared
				10 12/31/2014	5/21/2015 1:2	29 pm
		Tit	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	9, 771, 665		9, 771, 6			30.00
31.00 03100 I NTENSI VE CARE UNI T	1, 899, 932		1, 899, 9			31.00
41. 00 04100 SUBPROVI DER – I RF	1, 689, 367		1, 689, 3			41.00
43. 00 04300 NURSERY	588, 823		588, 8	23		43.00
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	5, 425, 087	21, 777, 376			0.00000	
53.00 05300 ANESTHESI OLOGY	605, 252	1, 894, 783			0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 022, 060	29, 725, 467			0.00000	
60. 00 06000 LABORATORY	5, 839, 512	18, 981, 458			0.00000	
65. 00 06500 RESPI RATORY THERAPY	3, 177, 197	2, 324, 388			0.00000	
66. 00 06600 PHYSI CAL THERAPY	1, 157, 305	2, 028, 790			0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	1, 138, 265	588, 959			0.00000	
68.00 06800 SPEECH PATHOLOGY	264, 311	283, 969			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	1, 398, 606	3, 786, 651			0.00000	
70.00 07000 ELECTROENCEPHALOGRAPHY	74, 498	102, 831			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 019, 771	2, 972, 267			0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 300	4, 245, 986			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 233, 894	8, 473, 272			0.00000	
76. 00 03020 ONCOLOGY	9, 119	1, 000, 162			0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	968	338, 339	339, 30	0. 691451	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	21, 348	7, 813, 521			0.00000	
91. 00 09100 EMERGENCY	2, 683, 572	14, 281, 901			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	486, 244	1, 067, 119	1, 553, 3	0. 647781	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1, 396, 476	1, 396, 4	76		101.00
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	47, 508, 096	123, 083, 715	170, 591, 8	11		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	47, 508, 096	123, 083, 715	170, 591, 8 ⁻	111		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider COX: 150001 Porid: From 0/10/2014 To 12/31/2014 Worksheet C Part 1 Cost Center Description PPS Inpatient Ratio Title XIX Hospital Cost INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 30.00 30.00 31.00 31.00 0 0 03000 ADULTS & PEDIATRICS 41.00 41.00 41.00 41.00 43.00 0 0 03000 OSUBOR OVER TA INF ROUTINE SERVICE COST CENTERS 50.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00	Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
Cost Center Description PPS Inpatient Ratio Intervention State 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 31.00 31.00 03100 INTENSIVE CARE UNIT 41.00 41.00 41.00 SUBPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03000 INDUSTRY CREATING ROOM 31.00 41.00 SUBPATIENT ROUTINESSIVE CARE UNIT 41.00 43.00 04300 RUBSERY 41.00 ANDIOLASUPERVICE COST CENTERS 50.00 50.00 50.00 05000 APESHESI OLOGY 0.000000 50.00 05600 RESPIRATING ROOM 50.000 60.00 06600 RESPIRATORY THERAPY 0.000000 60.00 06600 RESPIRATONAL THERAPY 0.000000 60.00 06600 PHYSI CAL THERAPY 0.000000 60.00 06600 RESPIRATIONAL THERAPY 0.000000 60.00 06600 PHYSI CAL THERAPY 0.000000 60.00 06600 SUPECH PATHOLOCY 0.000000 60.00 06000 GOUCALDATIONAL THERAPY 0.0000000 70.00 00	COMPUTATION OF RATIO OF COSTS TO CHAR	GES		From 01/01/2014	Part I Date/Time Prepared:
Rait o 11.00 11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSI VE CARE UNIT 41.00 41.00 04100 SUBPROVI DER - I RF 41.00 43.00 04300 AURSERV 41.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATI NOR ROOM 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 54.00 05400 RABIOLOGY - DIAGNOSTI C 0.000000 60.00 06000 LABORATORY 0.000000 60.00 66000 LABORATORY 0.000000 60.00 66000 PHYSI CLA THERAPY 0.000000 60.00 66000 PHYSI CLA THERAPY 0.000000 61.00 66000 PHYSI CLA THERAPY 0.000000 62.00 66000 SPECH PATHOLOGY 0.000000 63.00 66000 SPECH PATHOLOGY 0.000000 64.00 66000 SPECH PATHOLOGY 0.000000 70.00 770.00 71.00 70.00 70.00 71.00 70.00 <td< td=""><td></td><td></td><td>Title XIX</td><td>Hospi tal</td><td>Cost</td></td<>			Title XIX	Hospi tal	Cost
30.00 00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 41.00 41.00 O4100 SUBPROVIDER - IRF 43.00 ANCILLARY SERVICE COST CENTERS	Cost Center Description	Ratio			
31. 00 03100 INTENSI VE CARE UNIT 31. 00 41. 00 04100 SUBPROVIDER - IRF 31. 00 43. 00 04300 NURSERY 43. 00 ANCILLARY SERVICE COST CENTERS 50. 00 50. 00 05000 OPERATING ROM 0. 000000 53. 00 05300 ANESTHESI OLOGY 0. 000000 54. 00 05400 RADIOLOGY - DI AGNOSTI C 0. 000000 60. 00 06000 LABORATORY 0. 000000 60. 00 06000 LABORATORY 0. 000000 61. 00 06000 LABORATORY 0. 000000 62. 00 06400 PHYSI CAL THERAPY 0. 000000 63. 00 06600 PHYSI CAL THERAPY 0. 000000 64. 00 06600 PHYSI CAL THERAPY 0. 000000 65. 00 06600 DELECTROCARDI OLOGY 0. 000000 64. 00 06000 ELECTROCARDI OLOGY 0. 000000 70. 00 07000 ELECTROCARDI OLOGY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 000000 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 74. 00 07100	INPATIENT ROUTINE SERVICE COST	CENTERS			
41.00 04100 SUBPROVI DER - 1 RF 41.00 43.00 04300 NURSERY 43.00 ANCI LLARY SERVICE COST CENTERS 43.00 50.00 05000 OPERATI NC ROOM 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 54.00 05400 RADI OLOGY-DI ARNOSTI C 0.000000 60.00 06400 LABORATORY 0.000000 65.00 65.00 06500 RESPIRATORY THERAPY 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 ORSOO SPEECH PATHOLOGY 0.000000 67.00 67.00 69.00 69.00 CLUCTROENCEPHALOGRAPHY 0.000000 71.00 70.00 07000 ELCTROENCEPHALOGRAPHY 0.000000 72.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 OUDOLOGY 0.000000 73.00 76.97 70.00 01000 OUDOLOGY 0.000000 <td< td=""><td>30. 00 03000 ADULTS & PEDI ATRI CS</td><td></td><td></td><td></td><td>30.00</td></td<>	30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05300 ARESTHESI OLOGY 0.000000 53.00 05300 ARESTHESI OLOGY 0.000000 54.00 05400 RADIOLOGY-DIAGNOSTI C 0.000000 60.00 06500 LABORATORY 0.000000 65.00 06500 CLABORATORY 0.000000 66.00 06600 PHSI CAL THERAPY 0.000000 65.00 67.00 06700 CCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 68.00 69.00 06000 LECTROENCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07200 ILECTROENCEPHALOGRAPHY 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 74.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 74.00 70.00	31.00 03100 INTENSIVE CARE UNIT				31.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 DPERATING 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 ABORATORY 0.000000 65.00 66.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 65.00 66.00 06600 SPECH PATHOLOGY 0.000000 67.00 67.00 0CCUPATI ONAL THERAPY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 71.00 70.00 OT200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 72.00 73.00 7300 PRUGS CHARGED TO PATI ENTS 0.000000 73.00 70.00 70.00 0.000000 72.00 70.00 76.97 0.000	41.00 04100 SUBPROVIDER - IRF				41.00
50.00 05000 OPERATI NG ROM 0.000000 50.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 O5400 RAD LOGY-DI AGNOSTI C 0.000000 60.00 60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06000 PLYSICAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 68.00 68.00 06600 PLYSICAL THERAPY 0.000000 68.00 69.00 OCOPODELECTROCARDI OLOGY 0.000000 68.00 70.00 OT000 ELECTROCARDI OLOGY 0.000000 70.00 71.00 OT000 BEJECH PATHOLOGY 0.000000 71.00 72.00 OT200 INPLESC HARGED TO PATI ENTS 0.000000 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 74.00 OT000 INTERST EXPLOY 0.000000 74.00 75.00 OT300 DRUGS CHARGED TO PATI ENTS </td <td>43.00 04300 NURSERY</td> <td></td> <td></td> <td></td> <td>43.00</td>	43.00 04300 NURSERY				43.00
53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY -DI AGNOSTI C 0.000000 54.00 06.00 LABORATORY 0.000000 66.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 06500 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CUPATI ONAL THERAPY 0.000000 68.00 68.00 06600 SPEECH PATHOLOGY 0.000000 68.00 69.00 CATORO ELECTROCARDI OLOGY 0.000000 69.00 70.00 ELECTROCARDI OLOGY 0.000000 70.00 71.00 OT000 ELECTROCARDI OLOGY 0.000000 71.00 72.00 07200 IMEL CALSCHARGED TO PATI ENT 0.000000 71.00 73.00 ORGOS CHARGED TO PATI ENTS 0.000000 73.00 74.00 07300 RUGS CHARGED TO PATI ENTS 0.000000 73.00 75.00 07200 IMEL COST CENTERS 90.00 90.00 90.00 75.00 09000 CLIN IC 0.0000000 76.00 90.0	ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 60.00 06000 LABORATORY 0.000000 65.00 65.00 06500 RESPI RATORY THERAPY 0.000000 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CUPATI ONAL THERAPY 0.000000 67.00 68.00 SPEECH PATHOLOGY 0.000000 67.00 69.00 O6900 ELECTROCARDI OLOGY 0.000000 69.00 70.00 O7000 ELECTROCARDI OLOGY 0.000000 70.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72.00 O7200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 71.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.00 76.97 ORADI AC REHABI LI TATI ON 0.000000 76.00 90.00 90.00 OP3000 CLI NI C 0.000000 0.000000 90.00 90.00 91.00 O9100 EMEGENCY 0.0000000 90.00 90.00 90.00 <td>50.00 05000 OPERATING ROOM</td> <td>0. 000000</td> <td></td> <td></td> <td>50.00</td>	50.00 05000 OPERATING ROOM	0. 000000			50.00
60.00 06000 LABORATORY 0.000000 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06400 PHYSI CAL THERAPY 0.000000 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 LECTROCARDI OLOGY 0.000000 69.00 70.00 OFO00 ELECTRORACEPHALOGRAPHY 0.000000 70.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 ILECTRORACEPHALOGRAPHY 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.000000 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 O5000 CARGED TO PATI ENTS 0.000000 74.00 75.00 O3020 DRUGS CHARGED TO PATI ENTS 0.000000 76.00 76.97 O7697 CARDI AC REHABI LI TATI ON 0.000000 90.00 91.00 92.00	53.00 05300 ANESTHESI OLOGY	0. 000000			53.00
65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 70.00 O7000 ELECTROCARDI OLOGY 0.000000 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUSS CHARGED TO PATI ENTS 0.000000 73.00 74.00 03020 ONCOLOGY 0.000000 76.07 75.01 OTATI ENT SERVICE COST CENTERS 0.000000 90.00 90.00 09000 CLIN C 0.000000 91.00 91.00 09000 CLIN C 0.000000 91.00 92.00 DSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 91.00 92.00 OBSERVATI ON BEDS (COST CENTERS	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 0CCUPATI 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 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 73.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 74.00 03020 ONCOLOGY 0.000000 73.00 75.00 03020 ONCOLOGY 0.000000 76.00 76.00 03020 ONCOLOGY 0.000000 76.00 76.00 09000 CLI NI C 0.000000 90.00 90.00 09000 ELENT SERVICE COST CENTERS 90.00 91.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 OSERVATION BEDS (NON-DI STINCT PART	60. 00 06000 LABORATORY	0. 000000			60.00
67.00 06700 0CCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.07 07497 CARDIA CEHABILITATION 0.000000 76.00 76.07 07497 CARDIA CEHABILITATION 0.000000 76.97 0017PATIENT SERVICE COST CENTERS 0.000000 90.00 91.00 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 91.00 92.00 07200 JINEREST EXPENSE 101.00 11300 11300 113.00 113.00 SUBTOAL (See instructions) 200.00 201.00 201.00 201.00	65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 70.00 07000 ELECTROCARDI OLOGY 0.000000 70.00 71.00 07100 MEDI CAL SUPLIES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.00 03020 ONCOLOGY 0.000000 73.00 76.97 OT697 CARDI AC REHABI LI TATI ON 0.000000 76.97 0UTPATI ENT SERVICE COST CENTERS 0.000000 90.00 90.00 09000 CLI NI C 0.000000 91.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DI STI NCT PART 0.000000 91.00 92.00 OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 92.00 92.00 OBSERVATION BEDS COST CENTERS 113.00 113.00 113.00 113.00 113.0	66.00 06600 PHYSI CAL THERAPY	0. 000000			66.00
69.00 06900 ELECTROCARDI OLOGY 0.00000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.00 03020 ONCOLOGY 0.000000 76.00 76.00 03020 ONCOLOGY 0.000000 76.00 76.00 03020 ONCOLOGY 0.000000 76.00 70.00 09000 CLI NI C 0.000000 76.97 00100 ERGENCY 0.000000 91.00 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 91.00 91.00 113.00 IMMERGENCY 0.000000 92.00 92.00 011.00 IOTHER REIMBURSABLE COST CENTERS 101.00 113.00 INTEREST EXPENSE 101.00	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.00 03020 ONCOLOGY 0.000000 76.00 76.97 CARDI AC REHABI LI TATI ON 0.000000 76.97 00172.00 09000 CLI NI C 0.000000 76.97 00172.00 09000 CLI NI C 0.000000 90.00 91.00 09000 CLI NI C 0.000000 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92.00 0THER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00	68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 76.00 03020 ONCOLOGY 0.000000 76.00 76.97 CARDI AC REHABI LI TATI ON 0.000000 76.97 0017PATI ENT SERVICE COST CENTERS 90.00 90.00 91.00 90.00 09100 EMERGENCY 0.000000 91.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92.00 01HER REI MBURSABLE COST CENTERS 92.00 92.00 01100 HOME HEALTH AGENCY 0.000000 92.00 01100 INTERST EXPENSE 101.00 101.00 011300 INTERST EXPENSE 113.00 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	69.00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.00 03020 ONCOLOGY 0.000000 76.00 76.97 OAG97 CARDIAC REHABILITATION 0.000000 76.00 00TPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 91.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 01100 HOME HEALTH AGENCY 0.000000 92.00 01100 HOME SABLE COST CENTERS 101.00 101.00 10100 HORES COST CENTERS 101.00 113.00 INTERST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 Less Observation Beds 201.00 201.00	70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 76.00 03020 ONCOLOGY 0.000000 76.00 76.70 076.72 CARDIAC REHABILITATION 0.000000 76.97 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HORESC COST CENTERS 101.00 101.00 10100 HORESC COST CENTERS 101.00 200.00 200.00 200.00 Subtotal (see instructions) 113.00 200.00 201.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENT 0.000000			71.00
76.00 03020 0NC0LOGY 0.000000 76.00 76.97 CARDIAC REHABILITATION 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 09000 CLINIC 0.000000 91.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 92.00 92.00 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	72.00 07200 IMPL. DEV. CHARGED TO PAT	I ENTS 0. 000000			72.00
76.97 O7697 CARDIAC REHABILITATION 0.00000 76.97 0UTPATIENT SERVICE COST CENTERS 0.00000 90.00 90.00 90.00 09000 CLINIC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 92.00 92.00 0100 HOME HEALTH AGENCY 0.000000 92.00 01100 HOME HEALTH AGENCY 0.000000 92.00 101.00 10100 HOME HEALTH AGENCY 101.00 011300 INTEREST EXPENSE 113.00 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 Less Observation Beds 201.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATI ENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0.000000 90.00 90.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 92.00 101.00 10100 HOME HEALTH AGENCY 101.00 101.00 10100 HOME HEALTH AGENCY 101.00 200.00 200.	76.00 03020 ONCOLOGY	0. 000000			76.00
90. 00 09000 CLINIC 0.00000 90. 00 91. 00 09100 EMERGENCY 0.000000 91. 00 92. 00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0.000000 92. 00 0THER REIMBURSABLE COST CENTERS 0.000000 92. 00 92. 00 010100 HOME HEALTH AGENCY 0.000000 92. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 101. 00 113. 00 1NTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76.97
91.00 09100 EMERGENCY 0.000000 91.00 92.00		5			
92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.00000 92.00 0THER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 101.00 113.00 1NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	90. 00 09000 CLI NI C	0. 000000			90.00
OTHER REIMBURSABLE COST CENTERS 101.00 101.00 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91.00 09100 EMERGENCY	0. 000000			91.00
101.00 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 200.00 200.00 200.00 200.00 201.00	92.00 09200 OBSERVATION BEDS (NON-DIS	STINCT PART 0. 000000			92.00
SPECIAL PURPOSE COST CENTERS113.0011300INTEREST EXPENSE113.00200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00		5			
113.00 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					101.00
200.00 Subtotal (see instructions) 200.00 200.00 201.00 201.00					
201.00 Less Observation Beds 201.00					
		is)			
202.00 Total (see instructions) 202.00					
	202.00 Total (see instructions)				202.00

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		pared: 9 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)	2.00	2)	4.00	5.00	
INDATIENT DOUTINE SEDVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 41.00 SUBPROVIDER - IRF 43.00 NURSERY 200.00 Total (lines 30-199) Cost Center Description	672,796 230,414 134,859 17,039 1,055,108 Inpatient Program days	c	672, 75 230, 41 134, 85 17, 03 1, 055, 10	4 1, 026 59 1, 447 59 707	224. 58 93. 20 24. 10	31.00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 41. 00 SUBPROVIDER - IRF 43. 00 NURSERY 200. 00 Total (lines 30-199)	3, 283 267 702 0 4, 252	59, 963 65, 426 0				30. 00 31. 00 41. 00 43. 00 200. 00

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/21/2015 1:2	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	I	I	1			
50. 00 05000 OPERATI NG ROOM	1, 010, 298				79, 749	
53. 00 05300 ANESTHESI OLOGY	38, 599				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	565, 123				34, 677	54.00
60. 00 06000 LABORATORY	300, 530					60.00
65. 00 06500 RESPI RATORY THERAPY	109, 566				25, 904	65.00
66. 00 06600 PHYSI CAL THERAPY	81, 466					
67.00 06700 OCCUPATIONAL THERAPY	19, 077					
68.00 06800 SPEECH PATHOLOGY	5, 678				776	
69. 00 06900 ELECTROCARDI OLOGY	114, 822				21, 473	
70. 00 07000 ELECTROENCEPHALOGRAPHY	8, 186				148	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	111, 370				34, 011	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 463				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	71, 696	12, 707, 166			12, 753	73.00
76. 00 03020 ONCOLOGY	76, 051				134	
76. 97 07697 CARDI AC REHABI LI TATI ON	23, 495	339, 307	0.06924	4 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	194, 324	7, 834, 869				
91.00 09100 EMERGENCY	268, 272				18, 754	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	92, 373	1, 553, 363	0. 05946	06 0	0	
200.00 Total (lines 50-199)	3, 104, 389	155, 245, 548		15, 663, 992	278, 862	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15001 Provider CN: 15001	Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
Cost Center Description Nursing School Allied Health Cost Allied Health Cost Allied Health Medical Education Cost Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of cols. 1 through 3, minus col. 4) 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 31.00 03100 INTENSI VE CARE UNIT 0 0 0 0 0 31.00 31.00 41.00 04100 SUBPROVI DER - IRF 0 0 0 0 0 0 31.00 200.00 Total (lines 30-199) 0	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			From 01/01/2014 To 12/31/2014	Part III Date/Time Pre 5/21/2015 1:2	
Impact Entropy Cost Medical Education Cost Adjustment Amount (see instructions) (sum of cols. 1 through 3, minus col. 4) 1.00 2.00 3.00 4.00 5.00 0.00 0000 ADULTS & PEDI ATRICS 0 0 0 0 0.00 03000 ADULTS & PEDI ATRICS 0 0 0 0 0 0.100 03000 ADULTS & PEDI ATRICS 0 0 0 0 0 0 1.00 04100 SUBPROVIDER - 1RF 0<		-			Hospi tal		
Education Cost Amount (see instructions) 1 through 3, minus col. 4) 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDIATRICS 0	Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 0			Cost	Medi cal	Adjustment	(sum of cols.	
INPATI ENT ROUTINE SERVICE COST CENTERS 0				Education Cos	t Amount (see	1 through 3,	
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRICS 0 0 0 0 0 0 0 0 0 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 31.00 0 0 0 0 31.00 0					instructions)	minus col. 4)	
30. 00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 0 30. 00 31. 00 0 0 0 0 0 0 0 0 31. 00 0		1.00	2.00	3.00	4.00	5.00	
31.00 03100 INTENSIVE CARE UNIT 0	INPATIENT ROUTINE SERVICE COST CENTERS						
31.00 03100 INTENSIVE CARE UNIT 0	30, 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 0 0 0 43.00 200.00 Total (lines 30-199) 0		0	0		0	0	31.00
43.00 04300 NURSERY 0		0			0 0	0	
200.00 Total (lines 30-199) 0 <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td>		0			0	0	
INPATI ENT ROUTI NE SERVICE COST CENTERS Total Pati ent Days Per Di em (col. 5 ÷ col. 6) Inpati ent Program Days Inpati ent Program Pass-Through Cost (col. 7 x col. 8) 30. 00 03000 03000 ADULTS & PEDI ATRI CS 7,065 0.00 3,283 0 30.00 31. 00 03100 INTENSI VE CARE UNI T 1,026 0.00 267 0 31.00 41. 00 04100 SUBPROVI DER - I RF 1,447 0.00 702 0 41.00 43. 00 04300 NURSERY 707 0.00 0 0 43.00		0			0	-	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 7,065 0.00 7,006 8.00 9.00 30.00 03000 ADULTS & PEDI ATRI CS 7,065 0.00 3,283 0 30.00 31.00 31.00 11,026 0.00 267 0 31.00 41.00 04100 SUBPROVI DER - I RF 1,447 0.00 702 0 41.00 43.00 0 0.00 0		Total Patient	Per Diem (col	Innatient	Innatient		200100
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 8.00 9.00 30.00 03000 ADULTS & PEDI ATRI CS 7,065 0.00 3,283 0 30.00 31.00 03100 I INTENSI VE CARE UNI T 1,026 0.00 267 0 31.00 41.00 04100 SUBPROVI DER - I RF 1,447 0.00 702 0 41.00 43.00 04300 NURSERY 707 0.00 0 0 43.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 8.00 9.00 30.00 03000 ADULTS & PEDI ATRI CS 7,065 0.00 3,283 0 30.00 31.00 03100 INTENSI VE CARE UNI T 1,026 0.00 267 0 31.00 41.00 04100 SUBPROVI DER - I RF 1,447 0.00 702 0 41.00 43.00 04300 NURSERY 707 0.00 0 0 43.00		Days					
INPATIENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 30.00 03000 ADULTS & PEDIATRICS 7,065 0.00 3,283 0 30.00 31.00 03100 INTENSIVE CARE UNIT 1,026 0.00 267 0 31.00 41.00 04100 SUBPROVIDER - IRF 1,447 0.00 702 0 41.00 43.00 04300 NURSERY 707 0.00 0 0 43.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 7,065 0.00 3,283 0 30.00 31. 00 03100 INTENSI VE CARE UNI T 1,026 0.00 267 0 31.00 41. 00 04100 SUBPROVI DER - I RF 1,447 0.00 702 0 41.00 43. 00 04300 NURSERY 707 0.00 0 0 43.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 7, 065 0. 00 3, 283 0 30. 00 31. 00 03100 INTENSI VE CARE UNI T 1, 026 0. 00 267 0 31. 00 41. 00 04100 SUBPROVI DER - I RF 1, 447 0. 00 702 0 41. 00 43. 00 04300 NURSERY 707 0. 00 0 0 43. 00		6.00	7.00	8.00		-	
30. 00 03000 ADULTS & PEDIATRICS 7,065 0.00 3,283 0 30. 00 31. 00 03100 INTENSIVE CARE UNIT 1,026 0.00 267 0 31.00 41. 00 04100 SUBPROVIDER - IRF 1,447 0.00 702 0 41.00 43. 00 04300 NURSERY 707 0.00 0 0 43.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	1.00	0.00	7.00		
31.00 03100 INTENSIVE CARE UNIT 1,026 0.00 267 0 31.00 41.00 04100 SUBPROVIDER - IRF 1,447 0.00 702 0 41.00 43.00 04300 NURSERY 707 0.00 0 0 43.00		7 065	0.00	3.28	13 0		30 00
41.00 04100 SUBPROVIDER - IRF 1,447 0.00 702 0 41.00 43.00 04300 NURSERY 707 0.00 0 0 43.00							
43. 00 04300 NURSERY 707 0. 00 0 43. 00							
200.00 10tal (11nes 30-199) 10,245 4,252 0 200.00					-		
	200.00 IOTAL (ILINES 30-199)	10, 245	4	4,25	02 0		200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider	CCN: 150001	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	5/21/2015 1:2	pareu. 9 pm
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				-	0	50.00
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	53.00 54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76.00 03020 ONCOLOGY	0	C)	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C		0 0	0	90.00
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2014	Part IV	norod.
				To 12/31/2014	Date/Time Pre 5/21/2015 1:2	
		Ti tl	e XVIII	Hospi tal	PPS	<u>, bui</u>
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost		
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 OPERATI NG ROOM	0	27, 202, 463				
53. 00 05300 ANESTHESI OLOGY	0	2, 500, 035				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	33, 747, 527				54.00
60. 00 06000 LABORATORY	0	24, 820, 970			3, 186, 693	
65. 00 06500 RESPI RATORY THERAPY	0	5, 501, 585				
66. 00 06600 PHYSI CAL THERAPY	0	3, 186, 095				
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 727, 224				
68.00 06800 SPEECH PATHOLOGY	0	548, 280				
69. 00 06900 ELECTROCARDI OLOGY	0	5, 185, 257				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	177, 329				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 992, 038				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 247, 286				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	12, 707, 166	0. 00000	0 0. 000000	2, 260, 371	73.00
76. 00 03020 ONCOLOGY	0	1, 009, 281				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	339, 307	0.00000	0 0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	7, 834, 869				
91. 00 09100 EMERGENCY	0	16, 965, 473	0.00000			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 553, 363		0 0. 000000		
200.00 Total (lines 50-199)	0	155, 245, 548			15, 663, 992	200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	5 Provi der	CCN: 150001	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014	Part IV	
				To 12/31/2014	Date/Time Pre 5/21/2015 1:2	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through	ר I		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0	4, 725, 030		0		50.00
53. 00 05300 ANESTHESI OLOGY	0	775, 923		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	7, 572, 516		0		54.00
60. 00 06000 LABORATORY	0	1, 567, 044		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	142, 751		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	600		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	372		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 042, 485		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	913, 133		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	954, 153		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 839, 880		0		73.00
76.00 03020 ONCOLOGY	0	137, 832		0		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	107, 310		0		76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	2, 348, 336		0		90.00
91.00 09100 EMERGENCY	0	2, 481, 533		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
200.00 Total (lines 50-199)	0	27, 608, 898		0		200.00

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			Period: From 01/01/2014 To 12/31/2014		
		Titl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		4 705 000			4 470 075	
50. 00 05000 OPERATI NG ROOM	0. 249390			0 0	1, 178, 375	
53. 00 05300 ANESTHESI OLOGY	0. 058569			0 0	45, 445	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 178055			0 0	1, 348, 324	•
60. 00 06000 LABORATORY	0. 215697			0 0	338, 007	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 329848	142, 751		0 0	47, 086	
66. 00 06600 PHYSI CAL THERAPY	0. 446091	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 227841	600		0 0	137	67.00
68.00 06800 SPEECH PATHOLOGY	0. 391285			0 0	146	
69. 00 06900 ELECTROCARDI OLOGY	0. 244625			0 0	499, 643	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 560128			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 467272			0 0	426, 681	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 380646			0 0	363, 195	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 421393			0 2, 479	1, 618, 099	•
76.00 03020 ONCOLOGY	0. 607994			0 0	83, 801	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 691451	107, 310		0 0	74, 200	76.97
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLINIC	0. 452563			6 0	1, 062, 770	•
91.00 09100 EMERGENCY	0. 250880			0 0	622, 567	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 647781			0 0	0	92.00
200.00 Subtotal (see instructions)		27, 608, 898	9	6 2, 479	7, 708, 476	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 +/- line 201)		27, 608, 898	9	6 2, 479	7, 708, 476	202.00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST		CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/21/2015 1:2	
		Title	e XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-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 OCCUPATI 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 PATIENT	0	0				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 045				73.00
76. 00 03020 ONCOLOGY	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS	0					/0. //
90. 00 09000 CLINIC	43	0				90.00
91. 00 09100 EMERGENCY	43	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
200.00 Subtotal (see instructions)	43	1,045				200.00
201.00 Less PBP Clinic Lab. Services-Program	43	1, 045				200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	43	1, 045				202.00
	43	1,045				1202.00

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150001	Period: From 01/01/2014	Worksheet D Part II	
		Component	t CCN: 15T001	To 12/31/2014		pared [.]
		component		10 12/01/2011	5/21/2015 1:2	9 pm
		Ti tl	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	5		(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	1, 010, 298	27, 202, 463	0.0371	40 7, 609	283	50.00
53. 00 05300 ANESTHESI OLOGY	38, 599					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	565, 123					54.00
60. 00 06000 LABORATORY	300, 530					60.00
65. 00 06500 RESPI RATORY THERAPY	109, 566				1, 370	65.00
66. 00 06600 PHYSI CAL THERAPY	81, 466					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	19,077					67.00
68.00 06800 SPEECH PATHOLOGY	5, 678					68.00
69. 00 06900 ELECTROCARDI OLOGY	114, 822				324	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	8, 186				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	111, 370	5, 992, 038	0. 0185	36 32, 546	605	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 463	4, 247, 286	0.0031	70 1, 267	4	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	71, 696	12, 707, 166	0.0056	42 85, 836	484	73.00
76. 00 03020 ONCOLOGY	76, 051	1, 009, 281	0. 0753	52 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	23, 495	339, 307	0. 0692	44 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	194, 324	7, 834, 869	0. 02480	02 0	0	90.00
91. 00 09100 EMERGENCY	268, 272				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	.,,		0 00	0	92.00
200.00 Total (lines 50-199)	3, 012, 016	155, 245, 548		1, 096, 956	17, 753	200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der	CCN: 150001	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15T001	From 01/01/2014 To 12/31/2014		nared
		component		10 12/31/2014	5/21/2015 1:2	
		Ti tl	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Non Physician Anesthetist	Nursing School	Allied Healt		Total Cost (sum of col 1	
	Cost			Medical Education Cost		
	CUST			Education Cost		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00 03020 ONCOLOGY	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
		0	1		0	
90. 00 09000 CLINIC	0	0		0 0	0	101.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	0	0		0 0	0	
200.00 Total (lines 50-199)	0	0			-	92.00 200.00
	I O	0	I	0 0	0	1200. 00

Health Financial System	IS	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	S Provider		Period:	Worksheet D	
THROUGH COSTS			Component		From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	narod
			component		10 12/31/2014	5/21/2015 1:2	
			Ti tl	e XVIII	Subprovider -	PPS	
					I RF		
Cost Cente	r Description	Total	Total Charges			Inpati ent	
			(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.			Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI C							
50.00 05000 OPERATI NG		0				7,609	
53.00 05300 ANESTHESI 0		0	2, 500, 035			4, 020	
54.00 05400 RADI OLOGY-	DI AGNOSTI C	0	33, 747, 527			30, 289	•
60.00 06000 LABORATORY		0	24, 820, 970			116, 777	•
65. 00 06500 RESPI RATOR		0	5, 501, 585			68, 804	•
66. 00 06600 PHYSI CAL T		0	3, 186, 095			319, 129	66.00
67.00 06700 0CCUPATI ON	AL THERAPY	0	1, 727, 224	0.00000	0 0.000000	334, 709	67.00
68.00 06800 SPEECH PAT	HOLOGY	0	548, 280	0.00000	0 0.000000	81, 356	68.00
69.00 06900 ELECTROCAR	DI OLOGY	0	5, 185, 257	0. 00000	0.000000	14, 614	69.00
70.00 07000 ELECTROENC	EPHALOGRAPHY	0	177, 329	0. 00000	0.000000	0	70.00
71.00 07100 MEDICAL SU	PPLIES CHARGED TO PATIENT	0	5, 992, 038	0. 00000	0.000000	32, 546	71.00
	CHARGED TO PATIENTS	0	4, 247, 286	0. 00000	0.000000	1, 267	72.00
73.00 07300 DRUGS CHAR	GED TO PATIENTS	0	12, 707, 166	0. 00000	0.000000	85, 836	73.00
76.00 03020 ONCOLOGY		0	1, 009, 281	0.00000	0.000000	0	76.00
76. 97 07697 CARDI AC RE	HABI LI TATI ON	0	339, 307	0. 00000	0.000000	0	76.97
OUTPATIENT SERVI	CE COST CENTERS						
90.00 09000 CLI NI C		0	7, 834, 869	0.00000	0 0.000000	0	90.00
91.00 09100 EMERGENCY		0	16, 965, 473	0. 00000	0 0.000000	0	91.00
92.00 09200 OBSERVATI 0	N BEDS (NON-DISTINCT PART	0	1, 553, 363	0.00000	0.000000	0	92.00
200.00 Total (lin	es 50-199)	0				1, 096, 956	200 00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	6 Provider	CCN: 150001	Period:	Worksheet D	
THROUGH COSTS		Componen	t CCN: 15T001	From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre	narod
		componen	L CON. 151001	10 12/31/2014	5/21/2015 1:2	9 pm
		Ti tl	e XVIII	Subprovider -	PPS	
				IRF		
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)	10.00	x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM			1	0		1 50 00
	0	C)	0		50.00
53. 00 05300 ANESTHESI OLOGY	0	C)	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0		54.00
60. 00 06000 LABORATORY	0	C)	0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	C)	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C)	0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C)	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C)	0		68.00
69.00 06900 ELECTROCARDI OLOGY	0	C)	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C)	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0		73.00
76.00 03020 ONCOLOGY	0	C)	0		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C)	0		76.97
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		1			
90. 00 09000 CLINIC	0	90)	0		90.00
91.00 09100 EMERGENCY	0	C)	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.00
200.00 Total (lines 50-199)	0	90		0		200.00

Heal th	Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150001 CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pre 5/21/2015 1:2	
			Ti tl	e XVIII	Subprovider -	PPS	<u>, a biii</u>
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS			_			
50.00	05000 OPERATING ROOM	0. 249390	0		0 0	0	50.00
53.00	05300 ANESTHESI OLOGY	0. 058569	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 178055	0	1	0 0	0	54.00
60.00	06000 LABORATORY	0. 215697	0	1	0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 329848	0	1	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 446091	0	1	0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 227841	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 391285	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 244625	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 560128	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 467272	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 380646	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 421393	0		0 223	0	73.00
	03020 ONCOLOGY	0. 607994	0		0 0	0	76.00
	07697 CARDI AC REHABI LI TATI ON	0. 691451	0		0 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1			
	09000 CLINIC	0. 452563	90		0 0	41	90.00
	09100 EMERGENCY	0. 250880			0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 647781			0 0	0	
200.00	Subtotal (see instructions)		90		0 223		200.00
201.00	Less PBP Clinic Lab. Services-Program		,,,		0 0		201.00
201.00	Only Charges				Ŭ Ŭ		
202.00	Net Charges (line 200 +/- line 201)		90		0 223	41	202.00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Componen	CCN: 150001 t CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	5/21/2015 1:29	
		Titl	e XVIII	Subprovider - IRF	PPS	
	Cos	sts				
Cost Center Description	Cost Reimbursed Services	Cost Reimbursed Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVICE COST CENTERS	0.00	7.00		<u> </u>		
50. 00 05000 OPERATI NG ROOM	0	(0			50.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
60. 00 06000 LABORATORY	0	(60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	(D			66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	(D			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	(2			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					70.00 71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	94				73.00
76. 00 03020 ONCOLOGY	0	,-				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0					76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	(90.00
91.00 09100 EMERGENCY	0	(0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	(D			92.00
200.00 Subtotal (see instructions)	0	94	1			200.00
201.00 Less PBP Clinic Lab. Services-Program	0				2	201.00
Only Charges202.00Net Charges (line 200 +/- line 201)	0	94	1		2	202. 00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2014 To 12/31/2014		
		Tit	le XIX	Hospi tal	Cost	
			Charges	-	Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 249390		1, 080, 88		0	
53.00 05300 ANESTHESI OLOGY	0. 058569		108, 06		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 178055	0	1, 328, 92		0	
60. 00 06000 LABORATORY	0. 215697	0	734, 52		0	
65. 00 06500 RESPI RATORY THERAPY	0. 329848	0	92, 93		0	
66. 00 06600 PHYSI CAL THERAPY	0. 446091	0	54, 42		0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 227841	0	68, 71		0	
68.00 06800 SPEECH PATHOLOGY	0. 391285	0	50, 12	6 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 244625	0	77,04	9 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 560128	0	6, 07	3 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 467272	0	412, 68	6 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 380646	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 421393	0	376, 02	5 0	0	73.00
76.00 03020 ONCOLOGY	0. 607994	0	20, 79	5 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 691451	0	3, 48	5 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 452563	0	73, 03	9 0	0	90.00
91.00 09100 EMERGENCY	0. 250880	0	1, 240, 24	5 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 647781	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0	5, 727, 99	8 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 +/- line 201)		o	5, 727, 99	8 0	0	202.00

Heal th Financial Systems	JOHNSON MEMOR		001 150001		u of Form CMS-	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI) VACCINE COST	Provi der	CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pro 5/21/2015 1:2	
		Ti t	le XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)				
I.	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
50.00 O5000 OPERATING ROOM	269, 561	0				50. C
53. 00 05300 ANESTHESI OLOGY	6, 329	0				53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	236, 622	0				54.0
50. 00 06000 LABORATORY	158, 435					60.0
55. 00 06500 RESPI RATORY THERAPY	30, 653					65.0
56. 00 06600 PHYSI CAL THERAPY	24, 280					66.0
67.00 06700 OCCUPATI ONAL THERAPY	15, 656					67.0
58.00 06800 SPEECH PATHOLOGY	19, 614					68.0
59. 00 06900 ELECTROCARDI OLOGY	18, 848					69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 402					70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	192, 837	0				71. (
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	158, 454					73.0
76. 00 03020 ONCOLOGY	12, 643					76.0
76. 97 07697 CARDI AC REHABI LI TATI ON	2,410	0				76. 9
OUTPATIENT SERVICE COST CENTERS	1	r				
90. 00 09000 CLINIC	33, 055		•			90.0
91.00 09100 EMERGENCY	311, 153	0				91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.0
200.00 Subtotal (see instructions)	1, 493, 952	0				200.0
201.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	1, 493, 952	0				202.0

	Financial Systems JOHNSON MEMORIAL F ATION OF INPATIENT OPERATING COST	Provider CCN: 150001	Period: From 01/01/2014 To 12/31/2014	u of Form CMS-2 Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hospi tal	5/21/2015 1:2 PPS	9 pili
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		7,065	1 1.
00	Inpatient days (including private room days, excluding swing-be			7,065	
00	Private room days (excluding swing-bed and observation bed days). If you have only pr	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		6,095	4
00	Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private room	dave) after Decomber	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	l days) al ter beceniber	ST OF THE COST	0	0
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December ?	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)	5		Ũ	
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	g swing-bed and	3, 283	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	room days)	0	10
	through December 31 of the cost reporting period (see instructi				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent		room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	a room dave)	0	13
. 00	after December 31 of the cost reporting period (if calendar yea			0	13
	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 c	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructions)			7, 328, 932	21
. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportir	ng period (line 6	0	23
. 00	x line 18)	21 of the cost report:	ng paried (line	0	24
	Swing-bed cost applicable to NF type services through December 7 x line 19)		0 1 1		
. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	g period (line 8	0	25
	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		7, 328, 932	27
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0 0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)	11110 20)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minu		ctions)	0.00	
. 00 . 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	
. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	7, 328, 932	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
_	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			1, 037. 36 3, 405, 653	
	Medically necessary private room cost applicable to the Program			3, 405, 855 0	
		line 40)		3, 405, 653	

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-	1	
					To 12/31/2014			
		7-+-1		e XVIII	Hospi tal	PPS		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 · col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
. 00	NURSERY (title V & XIX only)	0	0	0.00	0 0	(42.	
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	2, 703, 735	1, 026	2, 635. 22	2 267	703, 604	43	
. 00	CORONARY CARE UNIT	2,700,700	1, 020	2,000.21	207	,,	44	
00	BURN INTENSIVE CARE UNIT						45	
	SURGICAL INTENSIVE CARE UNIT						46	
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47	
	Cost center bescription					1.00	+	
	Program inpatient ancillary service cost (Wks					4, 614, 111	1 48	
00	Total Program inpatient costs (sum of lines 4	11 through 48)(see instructio	ns)		8, 723, 368	3 49	
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing	convious (from	Wkct D cum	of Darte L and	272 402	3 50	
. 00	The second		Services (IIOI	WKSL. D, SUII		372, 603	50	
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, su	um of Parts II	278, 862	2 51	
	and IV)							
. 00 . 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud		lated non chi	cician anacth	tict and	651, 465 8, 071, 903		
. 00	medical education costs (line 49 minus line 5		rateu, non-pny		etist, anu	0, 071, 903	5 33	
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program discharges					(
	Target amount per discharge					0.00		
	Target amount (line 54 x line 55)	na cost and ta	ract amount (1	ino 56 minus l	ino 52)			
	, , , , , , , , , , , , , , , , , , ,							
.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the) 58) 59	
	market basket							
. 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00		
. 00	which operating costs (line 53) are less than							
	amount (line 56), otherwise enter zero (see i				the target			
	Relief payment (see instructions)					(
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			(0 63	
. 00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reportir	na period (See	(64	
	instructions) (title XVIII only)				.9			
. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	0) 65	
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no costs (lino	61 plus lipo 6	5) (+i +l o VVI I I	only) For		66	
. 00	CAH (see instructions)		04 prus rifle d	5)(title xill	oniy). Toi			
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	f the cost rep	orting period	() (67	
	(line 12 x line 19)							
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	ting period	(68	
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (line 67 + line	68)		0	69	
	PART III - SKILLED NURSING FACILITY, OTHER NU							
	Skilled nursing facility/other nursing facili	3					70	
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71	
	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 v li	ne 35)			72	
. 00	Total Program general inpatient routine servi			10 00)			74	
	Capital -related cost allocated to inpatient i	•		orksheet B, Pa	art II, column		75	
00	26, line 45)							
	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line	,					76	
	Inpatient routine service cost (line 74 minus	· ·					78	
	Aggregate charges to beneficiaries for excess		rovi der record	s)			79	
. 00	Total Program routine service costs for compa		ost limitation	(line 78 minu	us line 79)		80	
	Inpatient routine service cost per diem limit		`				81	
	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		· .				82	
	Program inpatient ancillary services (see ins		3)				84	
	Utilization review - physician compensation		ns)				85	
	Total Program inpatient operating costs (sum	of lines 83 th					86	
	PART IV - COMPUTATION OF OBSERVATION BED PASS						1 ~-	
1 00	Total observation bed days (see instructions)					970) 87	
7.00 3.00	Adjusted general inpatient routine cost per o		line 2)			1,037.36		

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lieu of Form CMS-255			
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150001			Worksheet D-1		
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 1:2		
		Titl	e XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	672, 796	7, 328, 932	0. 09180	0 1, 006, 239	92, 373	90.00	
91.00 Nursing School cost	0	7, 328, 932	0.00000	0 1, 006, 239	0	91.00	
92.00 Allied health cost	0	7, 328, 932	0.00000	1, 006, 239	0	92.00	
93.00 All other Medical Education	0	7, 328, 932	0.00000	1, 006, 239	0	93.00	

MPUL	ATION OF INPATIENT OPERATING COST Provider CCN: 150001 Period: From 0 Component CCN: 15T001 To 12	1/01/2014 2/31/2014	Worksheet D-1 Date/Time Pre	
		ovider – RF	5/21/2015 1:2 PPS	9 pr
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)		1, 447	1 1
00	Inpatient days (including private room days, excluding swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)		1, 447	
00	Private room days (excluding swing-bed and observation bed days). If you have only private roo do not complete this line.	oom days,	0	
00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of reporting period	the cost	1, 447 0	
00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of th reporting period (if calendar year, enter 0 on this line)	ne cost	0	6
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of t reporting period		0	
00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-b		0 702	
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days		0	
00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days December 31 of the cost reporting period (if calendar year, enter 0 on this line)	;) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room of through December 31 of the cost reporting period	5 .	-	12
00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room of after December 31 of the cost reporting period (if calendar year, enter 0 on this line).	lays)	0	
	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)		0	
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		-	16
	Medicare rate for swing-bed SNF services applicable to services through December 31 of the correporting period		0.00	
	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost		0.00	
	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost		0.00	
00	reporting period		1, 849, 151	1 21
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting peri 5 x line 17)	od (line	1, 849, 151 0	
00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period x line 18)		0	
00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting perio 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period		0	
00	x line 20) Total swing-bed cost (see instructions)		0	26
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Concernal inpatient routine service obstract (avaluding swing had and observation had observe)		1, 849, 151	
	General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges)		0	
00	Semi -private room charges (excluding swing bed charges)		0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00 0.00	
	Average per diem private room cost differential (line 34 x line 31)		0.00	
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differenti	al (line	0 1, 849, 151	36
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
00	Adjusted general inpatient routine service cost per diem (see instructions)		1, 277. 92	38
	Program general inpatient routine service cost (line 9 x line 38)		897, 100	
. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40
	Total Program general inpatient routine service cost (line 39 + line 40)		897, 100	1 41

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		AL HOSPITAL Provider	CCN: 150001	Peri od:	eu of Form CMS- Worksheet D-1			
			Componen	t CCN: 15T001	From 01/01/2014 To 12/31/2014	Date/Time Pre			
			Ti t	le XVIII	Subprovider -	5/21/2015 1:2 PPS	<u>29 piii</u>		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per sDiem (col. 1	5	Program Cost (col. 3 x col.			
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00			
2.00	NURSERY (title V & XIX only)	0		0. 0.) 42.		
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0		0.	00 0		43.		
. 00	CORONARY CARE UNIT	0		0.	00 0		43.		
. 00	BURN INTENSIVE CARE UNIT						45		
. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.		
. 00	Cost Center Description						47		
. 00	Program inpatient ancillary service cost (Wks	t D 2 col 2	Lipo 200)			1.00 361,301	48		
	Total Program inpatient costs (sum of lines 4			ons)		1, 258, 401			
00	PASS THROUGH COST ADJUSTMENTS	+:+	(6		n of Doute I and	(5.42)			
. 00	Pass through costs applicable to Program inpa	ittent routine	Services (IIO	m wkst. D, Su	II OF PARTS F AND	65, 426	50		
. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	17, 753	3 51		
. 00	and IV) Total Program excludable cost (sum of lines {	50 and 51)				83, 179	52		
8.00	Total Program inpatient operating cost exclud	ling capital re	lated, non-ph	ysician anest	hetist, and	1, 175, 222			
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					1.		
. 00	Program di scharges					0	54		
	Target amount per discharge					0.00			
. 00 . 00									
. 00	Bonus payment (see instructions)								
. 00									
. 00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report, up	dated by the	market basket		0.00	60		
. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the less	ser of 50% of		0			
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		is (lines 54 x	60), or 1% o	f the target				
2. 00	Relief payment (see instructions)	histi detronis)				0	62		
8.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0) 63		
. 00	Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of th	e cost report	ing period (See	0	64		
00	instructions) (title XVIII only)	-		· · · · · · · · · · · · · · · · · · ·					
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s arter Decemb	er 31 of the	cost reportin	g period (See	0	65		
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66		
00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	December 31	of the cost r	eporting period	0	67		
. 00	(line 12 x line 19)		December 31		eporting period		"		
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68		
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (line 67 + lin	e 68)		0	69		
	PART III - SKILLED NURSING FACILITY, OTHER NU						1 70		
0. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	2		• • •			70		
. 00	Program routine service cost (line 9 x line 3	(1)					72		
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi	Ũ	•				73		
. 00	Capital-related cost allocated to inpatient i	•			Part II, column		75		
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76		
. 00	Program capital-related costs (line 9 x line	76)					77		
. 00	Inpatient routine service cost (line 74 minus		rovi dor rocor	de)			78		
. 00 . 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus line 79)		80		
. 00	Inpatient routine service cost per diem limit	ation		-	·		81		
. 00 . 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82		
. 00	Program inpatient ancillary services (see ins						84		
. 00	Utilization review - physician compensation	(see instructio					85		
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)			I	86		
. 00	Total observation bed days (see instructions)	1				0			
	Adjusted general inpatient routine cost per o					0.00			
. UU	Observation bed cost (line 87 x line 88) (see	= instructions)				1 0) 89		

Health Financial Systems	AL HOSPITAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provi de	r CCN: 150001	Period:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014		
		Ti	tle XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cos		Total	Observati on	
		(from line 2	7) column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	134, 859	1, 849, 1	0. 0729	30 0	0	90.00
91.00 Nursing School cost	0	1, 849, 1	0. 0000	0 00	0	91.00
92.00 Allied health cost	0	1, 849, 1	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	1, 849, 1	0.0000	00 0	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150001	Period: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Prep 5/21/2015 1:20	
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days,			7, 065	
00 00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivate room days,	7, 065 0	
00	do not complete this line.	d dave)		6, 095	
00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	6, 095 0	
00	reporting period Total swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	e
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	303	Ģ
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII on	y (including private r	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program				14
	Total nursery days (title V or XIX only)			707	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			35	16
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s through December 31 c	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	7, 328, 932 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3:	1 of the cost reporting	period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)	ling 21 minus ling 2()		0	
	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			7, 328, 932	
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		+!>	0.00	
	Average per diem private room charge differential (line 32 min	, ,	tions)	0.00	
	Average per diem private room cost differential (line 34 x line	e 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an	nd private room cost di	fferential (line	0 7, 328, 932	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 007 04	
00	Adjusted general inpatient routine service cost per diem (see i			1,037.36	
. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			314, 320	40

OMPUT	Financial Systems FATION OF INPATIENT OPERATING COST		Provi der		Peri od:	eu of Form CMS- Worksheet D-1				
					From 01/01/2014 To 12/31/2014					
		- - - -		Ie XIX	Hospi tal	Cost				
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)				
		1.00	2.00	3.00	4.00	5.00				
2.00	NURSERY (title V & XIX only)	432, 430	707	611.6	4 35	21, 407	42.			
> 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	2 702 725	1 024	2, 635. 2	2 50	131, 761	1 42			
3.00 4.00	CORONARY CARE UNIT	2, 703, 735	1, 026	2, 035. 2	2 50	131, /01	43.			
5.00	BURN INTENSIVE CARE UNIT						45.			
	SURGICAL INTENSIVE CARE UNIT						46.			
. 00	OTHER SPECIAL CARE (SPECIFY)						47.			
	Cost Center Description					1.00				
3. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	Line 200)			420, 284	48.			
0.00				ns)		887, 772				
	PASS THROUGH COST ADJUSTMENTS									
0. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50.			
I. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	tiont ancillar	v corvicos (fr	om What D a	um of Parts II	0	51.			
1.00	and IV)		y services (II	UNI WKSL. D, S			/ <u>51</u> .			
2.00	Total Program excludable cost (sum of lines !					0	52.			
3.00	Total Program inpatient operating cost exclud		lated, non-phy	sician anesth	etist, and	0	53.			
	medical education costs (line 49 minus line !	52)					-			
1.00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges					0	54.			
. 00	Target amount per discharge					0.00				
. 00	Target amount (line 54 x line 55)					0	56			
. 00	, , , , , , , , , , , , , , , , , , ,	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)								
. 00	Bonus payment (see instructions)					0				
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	mpounded by the	0.00	59						
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60			
I. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the less	er of 50% of	the amount by	0	61.			
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target					
2.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62.			
3.00		ent (see instru	ctions)			0				
	PROGRAM INPATIENT ROUTINE SWING BED COST					-				
. 00	5	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.			
- 00	instructions)(title XVIII only)	to ofter Decemb	on 21 of the o	oot reporting	noriad (Cas					
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is after Decemb	er si or the c	ost reporting	period (see	0	65.			
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only). For	0	66.			
	CAH (see instructions)				•					
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	porting period	0	67.			
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	rting period	0	68.			
5. 00	(line 13 x line 20)			the cost repo	ring period		/ 00.			
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		0	69.			
	PART III - SKILLED NURSING FACILITY, OTHER NU					[
0. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70.			
2.00	5		The 70 - The	2)			72			
. 00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73			
. 00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)				74			
6. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, P	art II, column		75			
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76			
. 00	Program capital -related costs (line 9 x line						77			
. 00	0						78			
00	Aggregate charges to beneficiaries for excess	• •		· · · · · · · · · · · · · · · · · · ·			79			
. 00	Total Program routine service costs for compa		ost límitation	(line 78 min	us line 79)		80			
00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li)				81			
. 00	Reasonable inpatient routine service cost frim tatron (in						83			
. 00	Program inpatient ancillary services (see ins						84			
. 00	Utilization review - physician compensation	(see instructio					85			
. 00			rough 85)				86.			
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					970	87.			
	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			1, 037. 36				
B. 00										

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lieu of Form CMS-255			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1		
				To 12/31/2014	Date/Time Pre 5/21/2015 1:2		
		Tit	le XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	672, 796	7, 328, 932	0. 09180	1, 006, 239	92, 373	90.00	
91.00 Nursing School cost	0	7, 328, 932	0.00000	1, 006, 239	0	91.00	
92.00 Allied health cost	0	7, 328, 932	0.00000	1, 006, 239	0	92.00	
93.00 All other Medical Education	0	7, 328, 932	0.00000	1, 006, 239	0	93.00	

COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 150001 Component CCN: 15T001 Title XIX Subprovider -	Worksheet D-1 Date/Time Pre 5/21/2015 1:2 Cost	
	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATIENT DAYS	4 447	
	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	1, 447 1, 447	1.00 2.00
3.00	Private room days (excluding private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1, 447	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	C C	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	175	9.00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period	0	12.0
	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.0
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0 707	14.0 15.0
	Nursery days (title V or XIX only)	35	
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0, 00	18.00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
20.00	reporting period	0.00	20.0
	Total general inpatient routine service cost (see instructions)	1, 847, 955	
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)	-	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)	-	
	Total swing-bed cost (see instructions)	0	
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1, 847, 955	27.00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.0
	Semi-private room charges (excluding swing-bed charges)	0	30.0
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000 0. 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 minus line 33)(see instructions)	0.00	34.00
	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 2 x line 25)	0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 1, 847, 955	36.00 37.00
27.00	27 minus line 36)	., 577, 755	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 277 00	30 ~
	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)	1, 277. 09 223, 491	38.0 39.0
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
	Total Program general inpatient routine service cost (line 39 + line 40)	223, 491	1110

UNPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150001	Peri od:	Worksheet D-1	- <u>2552</u> 1		
			Componen	t CCN: 15T001	From 01/01/2014 To 12/31/2014	Date/Time Pre			
			Ti	tle XIX	Subprovider -	5/21/2015 1:2 Cost	29 piii		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days			Program Cost (col. 3 x col.			
		1.00	2.00	col . 2) 3.00	4.00	4) 5.00			
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.	00 00	C) 42.		
. 00	INTENSIVE CARE UNIT	0		0.	00 00	C	43.		
. 00	CORONARY CARE UNI T						44		
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45		
	OTHER SPECIAL CARE (SPECIFY)						47.		
	Cost Center Description					1.00	-		
	Program inpatient ancillary service cost (W					21, 895			
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		245, 386	5 49		
. 00	Pass through costs applicable to Program inp	patient routine	services (fro	m Wkst. D, su	n of Parts I and	0	50		
00	III) Dass through costs applicable to Drogram inc	ationt ancillar	n convigos (f	rom Wkat D	sum of Dorte II				
. 00	Pass through costs applicable to Program inp and IV)		y SELVICES (T	IUNI WKSL. D, S	sum of Pails II	C	51		
. 00	Total Program excludable cost (sum of lines		lated are i		actict and	0			
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		erated, non-ph	ysi ci an anest	netist, and	C) 53		
	Program discharges					C			
. 00 . 00	Target amount per discharge Target amount (line 54 x line 55)					0.00			
	Difference between adjusted inpatient operat	ting cost and ta	arget amount (line 56 minus	line 53)				
. 00									
. 00	0 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket								
. 00	Lesser of lines 53/54 or 55 from prior year					0.00			
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61		
	amount (line 56), otherwise enter zero (see		.5 (TTTC5 54 X	00), 01 1% 0	the target				
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	nont (soo instru	uctions)						
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						03		
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Dece	ember 31 of th	e cost report	ng period (See	0	64		
. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65		
00	instructions)(title XVIII only)	na agata (lina	(4 plue line	(F) (+; + > Y)/					
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (Trne	64 prus rine	b5)(title XVI	TT ONLY). FOI) 66		
. 00	Title V or XIX swing-bed NF inpatient routir	ne costs through	December 31	of the cost r	eporting period	C	67		
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routir	ne costs after D	ecember 31 of	the cost rep	orting period	c	68		
	(line 13 x line 20)				51				
. 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	ity/ICF/MR rout	ine service c	ost (line 37)			70		
. 00 . 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71		
. 00	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73		
. 00	Total Program general inpatient routine serv	•					74		
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (trom	WORKSNEET B,	Part II, column		75		
. 00	Per diem capital-related costs (line 75 ÷ li	,					76		
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,					77		
. 00	Aggregate charges to beneficiaries for excess		orovider recor	ds)			79		
. 00	Total Program routine service costs for comp		cost limitatio	n (line 78 mi	nus line 79)		80		
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81		
. 00	Reasonable inpatient routine service cost (83		
. 00	Program inpatient ancillary services (see in	nstructions)					84		
5.00	Utilization review - physician compensation						85		
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS					1	86		
7.00	Total observation bed days (see instructions					0			
	Adjusted general inpatient routine cost per					0.00	88 (

Health Financial Systems	JOHNSON MEMOR	IAL HOS	PI TAL		In Lieu of Form CMS-255				
COMPUTATION OF INPATIENT OPERATING COST		P	rovi der		Period: From 01/01/2014	Worksheet D-1			
					To 12/31/2014	Date/Time Prep 5/21/2015 1:20	oared: 9 pm		
			Title XIX		Subprovider -	Cost			
Cost Center Description	Cost	Routir	ne Cost	column 1 ÷	Total	Observati on			
		(from I	ine 27)	column 2	Observati on	Bed Pass			
					Bed Cost (from	Through Cost			
					line 89)	(col. 3 x col.			
						4) (see			
						instructions)			
	1.00	2.	00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST								
90.00 Capital-related cost	134, 859	1,	847, 955	0. 07297	7 0	0	90.00		
91.00 Nursing School cost	0	1,	847, 955	0.00000	0 0	0	91.00		
92.00 Allied health cost	0	1,	847, 955	0.0000	0 0	0	92.00		
93.00 All other Medical Education	0	1,	847, 955	0.00000	0 0	0	93.00		

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL				In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 1	50001	Peri od:		Worksheet D-3	
						1/01/2014		
					To 1	2/31/2014		
		Ti tl	e XVII		Hos	pi tal	5/21/2015 1:2 PPS	9 pili
Cost Center Description				of Cos		atient	Inpati ent	
				Charges		rogram	Program Costs	
				J		narges	(col. 1 x col.	
						5	2)	
				1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000 ADULTS & PEDIATRICS						4, 326, 965		30.00
31.00 03100 INTENSIVE CARE UNIT						515, 196		31.00
41.00 04100 SUBPROVIDER - IRF						0		41.00
43.00 04300 NURSERY								43.00
ANCI LLARY SERVICE COST CENTERS			_					
50.00 05000 OPERATING ROOM				0.24968	38	2, 147, 260	536, 145	50.00
53.00 05300 ANESTHESI OLOGY				0.05856	59	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				0.1780	55	2, 070, 791	368, 715	54.00
60. 00 06000 LABORATORY				0.21569	97	3, 186, 693	687, 360	60.00
65. 00 06500 RESPI RATORY THERAPY				0.32984	48	1, 300, 716	429, 039	65.00
66. 00 06600 PHYSI CAL THERAPY				0.4460	91	319, 859	142, 686	66.00
67.00 06700 OCCUPATI ONAL THERAPY				0. 22784	41	293, 283	66, 822	67.00
68.00 06800 SPEECH PATHOLOGY				0.39128	35	74, 916	29, 314	68.00
69. 00 06900 ELECTROCARDI OLOGY				0.24462	25	969, 701	237, 213	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY				0.56012	28	3, 200	1, 792	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0.4672	72	1, 829, 949	855, 084	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS				0.38064	46	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS				0. 42139	93	2, 260, 371	952, 505	73.00
76.00 03020 ONCOLOGY				0.60799	94	1, 783	1, 084	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON				0.6914	51	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLINIC				0.45256	53	19, 453	8, 804	90.00
91.00 09100 EMERGENCY				0.25088	30	1, 186, 017	297, 548	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0.64778	31	0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)					1	5, 663, 992	4, 614, 111	200.00
201.00 Less PBP Clinic Laboratory Services-P	rogram only charges	(line 61)				0		201.00
202.00 Net Charges (line 200 minus line 201)					1	5, 663, 992		202.00

Health Financial Systems JOHNSON MEMORIAL HO	SPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150001	Peri od:	Worksheet D-3	5
	Component	CCN: 15T001	From 01/01/2014 To 12/31/2014	Date/Time Pre	narod
	component		10 12/31/2014	5/21/2015 1:2	
	Ti tl	e XVIII	Subprovider -	PPS	
			I RF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	5	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 INTENSI VE CARE UNI T			0		31.00
41. 00 04100 SUBPROVI DER – I RF			799, 455		41.00
43. 00 04300 NURSERY			,		43.00
ANCI LLARY SERVI CE COST CENTERS		1		1	
50. 00 05000 OPERATI NG ROOM		0.2496	88 7,609	1, 900	50.00
53. 00 05300 ANESTHESI OLOGY		0. 0585	69 4, 020	235	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1780	55 30, 289	5, 393	54.00
60. 00 06000 LABORATORY		0. 2156	97 116, 777	25, 188	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3298	48 68, 804	22, 695	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4460	91 319, 129	142, 361	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 2278	41 334, 709	76, 260	67.00
68.00 06800 SPEECH PATHOLOGY		0. 3912	85 81, 356		
69. 00 06900 ELECTROCARDI OLOGY		0. 2446		3, 575	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 5601			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4672			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3806			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4213			
76. 00 03020 ONCOLOGY		0.6079			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 6914	51 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			[-	
90. 00 09000 CLINIC		0.4525		-	
91.00 09100 EMERGENCY		0.2508		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 6477		0	
200.00 Total (sum of lines 50-94 and 96-98)			1, 096, 956		
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		1 00(05(201.00
202.00 Net Charges (line 200 minus line 201)		I	1, 096, 956		202.00

Health Financial Systems	JOHNSON MEMORIAL H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 150001	Period: From 01/01/2014 To 12/31/2014		pared:
		ті +	le XIX	Hospi tal	Cost	9 pili
Cost Center Description		111	Ratio of Cos		Inpatient	
			To Charges		Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				784, 887		30.00
31. 00 03100 I NTENSI VE CARE UNI T				50, 260		31.00
41.00 04100 SUBPROVIDER – IRF				C		41.00
43. 00 04300 NURSERY				186, 587		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM			0. 2493	90 380, 948	95, 005	50.00
53. 00 05300 ANESTHESI OLOGY			0. 0585	69 52, 886	3, 097	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 1780		23, 511	54.00
60. 00 06000 LABORATORY			0. 2156	97 276, 599	59, 662	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 3298	48 120, 009	39, 585	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 4460	91 9, 226	4, 116	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 2278	41 8, 604	1, 960	67.00
68.00 06800 SPEECH PATHOLOGY			0. 3912	85 1, 971	771	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 2446	25 15, 529	3, 799	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY			0. 5601	28 1, 426	799	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0.4672	72 159, 386	74, 477	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 3806	46 C	0	
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 4213	93 217, 007	91, 445	73.00
76.00 03020 ONCOLOGY			0.6079	94 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0.6914	51 C	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC			0. 4525	63 697	315	90.00
91.00 09100 EMERGENCY			0. 2508	80 86, 662	21, 742	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0, 6477			
200.00 Total (sum of lines 50-94 and 96-98)				1, 462, 994	420, 284	200.00
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)		C	,	201.00
202.00 Net Charges (line 200 minus line 201)	5 - J - J (/		1, 462, 994		202.00

Health Financial Systems JOHNSON	I MEMORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150001	Peri od:	Worksheet D-3	
		001 457004	From 01/01/2014		
	Component	CCN: 15T001	To 12/31/2014	Date/Time Pre 5/21/2015 1:2	
	Ti t	le XIX	Subprovider -	Cost	
			IRF		
Cost Center Description	· · · · · ·	Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31.00 03100 I NTENSI VE CARE UNI T			0		31.00
41.00 O4100 SUBPROVIDER - IRF			58, 044		41.00
43.00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS		0.0400	20 0	0	50.00
50.00 OPERATING ROOM		0. 2493		0	
53. 00 05300 ANESTHESI OLOGY		0.0585		0	
54. 00 O5400 RADI OLOGY-DI AGNOSTI C		0.1780		249	
		0. 2156			
65.00 06500 RESPIRATORY THERAPY		0. 3298		1, 343	
66. 00 06600 PHYSI CAL THERAPY		0. 4460 0. 2278		11, 297	
67.00 06700 OCCUPATIONAL THERAPY				5, 960	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 3912 0. 2446		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2446		0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4672		83	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3806		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4213		1, 514	
76. 00 03020 ONCOLOGY		0.6079		1, 514	
76. 97 07697 CARDI AC REHABI LI TATI ON		0.6914		0	
OUTPATI ENT SERVICE COST CENTERS		0.0714	51 0	0	/0. //
90. 00 09000 CLINIC		0. 4525	63 0	0	90.00
91. 00 09100 EMERGENCY		0. 2508		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.6477		0	
200.00 Total (sum of lines 50-94 and 96-98)			67, 446	21.895	200.00
201.00 Less PBP Clinic Laboratory Services-Program onl	v charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	j		67, 446		202.00
				1	

	Financial Systems JOHNSON MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150001	In Lie Period:	u of Form CMS- Worksheet E	2552-10
				From 01/01/2014 To 12/31/2014	Part A Date/Time Pre 5/21/2015 1:2	
		Ti tl	e XVIII	Hospi tal	PPS	29 pili
			0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				2.00	
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	na prior		0 4, 212, 316		1.00
	to October 1 (see instructions)	0.				
1.02	DRG amounts other than outlier payments for discharges occurrin after October 1 (see instructions)	ng on or		1, 424, 467		1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for	-		0		1.03
1.04	discharges occurring prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	-		0		1.04
	discharges occurring on or after October 1 (see instructions)			50, 700		2 00
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			59, 789 0		2.00
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0		2.02
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	ing		1, 349, 172 83. 34		3.00
	period (see instructions)					
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5.00
(00	cost reporting period ending on or before 12/31/1996. (see instr			0.00		6.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance			0.00		6.00
7.00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified ur	dor 12		0.00		7.00
7.00	CFR §412. $105(f)(1)(iv)(B)(1)$	iuei 42		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified u CFR $\frac{1}{1}$ (1)(iv)(B)(2) If the cost report straddles July			0.00		7.01
	then see instructions.	1, 2011				
8.00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
3. 01	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8.01
5.01	section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.01
3. 02	instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8. 02
	closed teaching hospital under section 5506 of ACA. (see instru	uctions)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	5 (8, 8,01		0.00		9.00
10. 00	FTE count for allopathic and osteopathic programs in the currer	nt year		0.00		10.00
11.00	from your records FTE count for residents in dental and podiatric programs.			0.00		11.00
12.00	Current year allowable FTE (see instructions)			0.00		12.00
13.00 14.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on		0.00 0.00		13.00
45 00	or after September 30, 1997, otherwise enter zero.			0.00		45.00
15.00 16.00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00 0.00		15.00
17.00	Adjusment for residents displaced by program or hospital closur	е		0.00		17.00
18.00 19.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.00 0.000000		18.00
20.00	Prior year resident to bed ratio (see instructions)			0.00000		20.00
21.00 22.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 000000		21.00
22. 01	IME payment adjustment - Managed Care (see instructions)	100 6 1		0		22. 01
23.00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE resider			0.00		23.00
24.00	slots under 42 Sec. 412.105 $(f)(1)(iv)(C)$.	·		0.00		24.00
24.00 25.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	ower of		0.00 0.00		24.00 25.00
04 OO	line 23 or line 24 (see instructions)			0. 000000		24 00
26.00 27.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0.000000		26.00 27.00
28.00 28.01	IME add-on adjustment amount (see instructions)			0		28.00 28.01
29.00	IME add-on adjustment amount - Managed Care (see instructions) 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)	1		0		29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	ient days		4.11		30.00
31 00	(see instructions)	-		14 40		21 00
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			16. 48 20. 59		31.00 32.00
33.00	Allowable disproportionate share percentage (see instructions)			6.20 87_270		33.00
34. UU	Disproportionate share adjustment (see instructions)		I	87, 370		34.00

ALCUL	Financial Systems JOHNSON MEMORIA ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014	Worksheet E Part A	2552-1
			To 12/31/2014	Date/Time Pre	
		Title XVIII	Hospi tal	5/21/2015 1:2 PPS	9 pili
			Prior to	On/After	
	-	0	0ctober 1 1.00	0ctober 1 2.00	
	Uncompensated Care Adjustment	<u> </u>		2100	
5.00	Total uncompensated care amount (see instructions)			7, 647, 644, 855	
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0. 000061598 557, 239	0. 000045337 346, 723	35.0 35.0
5. 02	enter zero on this line) (see instructions)		337,237	340,723	00.0
5. 03	Pro rata share of the hospital uncompensated care payment		416, 784	87, 393	35.0
6. 00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line		504, 177		36.0
	35. 03)				
<u> </u>	Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 through	1		1 40 0
0. 00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and		0		40. C
	685 (see instructions)				
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41. C
1. 01	Total ESRD Medicare covered and paid discharges excluding		0		41. C
0.00	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.0
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.0
4.00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44.0
4.00	divided by line 41 divided by 7 days)		0.000000		44.0
5.00	Average weekly cost for dialysis treatments (see		0.00		45.0
6. 00	instructions) Total additional payment (line 45 times line 44 times line		0		46.0
5.00	41.01)		0		40.0
7.00	Subtotal (see instructions)		6, 288, 119		47.0
8.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.0
9.00	Total payment for inpatient operating costs (see		6, 288, 119		49.0
	instructions)		454.040		
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		454, 863		50.0
1. 00	Exception payment for inpatient program capital (Wkst. L,		0		51.0
2 00	Pt. III, see instructions) Direct graduate medical education payment (from Wkst. E-4,		0		52.0
2.00	line 49 see instructions).		0		52.0
3.00	Nursing and Allied Health Managed Care payment		0		53.0
4.00 5.00	Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		54.0 55.0
5.00	line 69)		0		55.0
6.00	Cost of physicians' services in a teaching hospital (see		0		56.0
7.00	intructions) Routine service other pass through costs (from Wkst. D,		0		57. C
	Pt. III, column 9, lines 30 through 35).				
8.00	Ancillary service other pass through costs from Wkst. D,		0		58.0
9.00	Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58)		6, 742, 982		59.0
0. OO	Primary payer payments		9, 233		60.0
1. 00	Total amount payable for program beneficiaries (line 59 minus line 60)		6, 733, 749		61.0
2. 00	Deductibles billed to program beneficiaries		792, 512		62.0
3.00	Coinsurance billed to program beneficiaries		8, 816		63. (
4.00 5.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		43, 508 28, 280		64. (65. (
6. 00	Allowable bad debts for dual eligible beneficiaries (see		-24, 085		66. (
7 00	instructions)		F 0/0 701		
7.00 8.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		5, 960, 701		67.0 68.0
	for applicable to MS-DRGs (see instructions)				
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96) (For SCH see instructions)		0		69. (
D. 00	96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.0
D. 50	RURAL DEMONSTRATION PROJECT		0		70. !
). 89	Pioneer ACO demonstration payment adjustment amount (see		0		70.8
D. 90	instructions) HSP bonus payment HVBP adjustment amount (see		0		70.
	instructions)		Ŭ Ŭ		
0.91			0		70.
). 92). 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)		-10, 828		70.9
D. 94	HRR adjustment amount (see instructions)		-2, 279		70. 9
0 95	Recovery of accel erated depreciation		0		70.

	Financial Systems JOHNSON MEMORIA				u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001	Peri From	01/01/2014		
			То	12/31/2014	Date/Time Pre	epared:
		Title XVIII	1	Hospi tal	5/21/2015 1:2 PPS	<u>29 pili</u>
		in the with		Prior to	0n/After	
				October 1	October 1	
		0		1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy)		0	0		70.96
	(Enter in column 0 the corresponding federal year for the					
	period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy)		0	0		70.97
	(Enter in column 0 the corresponding federal year for the					
70.00	period ending on or after 10/1)			0		70.00
70. 98 70. 99	Low Volume Payment-3			0		70.98
	HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus			0 5, 947, 594		70.99
71.00	lines 69 & 70)			5, 947, 594		/1.00
71 01	Sequestration adjustment (see instructions)			118, 952		71.01
	Interim payments			5, 794, 175		72.00
	Tentative settlement (for contractor use only)			0, 774, 179		73.00
	Balance due provider (Program) (line 71 minus lines 71.01,			34, 467		74.00
/ 1. 00	72, and 73)			01, 107		/ 1.00
75.00	Protested amounts (nonallowable cost report items) in			38, 611	ĺ	75.00
	accordance with CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see			0		90.00
	instructions)					
	Capital outlier from Wkst. L, Pt. I, line 2			0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0		92.00
93.00	Capital outlier reconciliation adjustment amount (see			0	ĺ	93.00
	instructions)					
94.00	The rate used to calculate the time value of money (see			0.00		94.00
	instructions)					
95.00	Time value of money for operating expenses (see			0		95.00
0/ 00	instructions) Time value of money for capital related expenses (see			0		96.00
96.00	instructions)			0		96.00
			Pr	ior to $10/1$	On/After 10/1	
			<u> </u>	1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0	0	101.00
	HVBP adjustment amount for HSP bonus payment (see instruction	ons)		0	0	102.00
	HRR Adjustment for HSP Bonus Payment					
	HRR adjustment factor (see instructions)			0.0000		103.00
101 00	HRR adjustment amount for HSP bonus payment (see instruction	nc)	1	0		104.00

	Financial Systems DLUME CALCULATION EXHIBIT 4		JOHNSON MEMORI		CCN: 150001	Peri od:	eu of Form CMS-2 Worksheet E	2002
					1	From 01/01/2014 To 12/31/2014		pared
					e XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line 0	<u>E, Part A)</u> 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0		1.
01	payments DRG amounts other than outlier	1. 01	4, 212, 316	0	4, 212, 310	6 0	4, 212, 316	1.
02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	1, 424, 467	0		0 1, 424, 467	1, 424, 467	1.
02	payments for discharges occurring on or after October	1.02	1, 424, 407	Ū		, 1, 121, 107	1, 121, 107	
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0		0 0	0	1.
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0 0	0	1.
00	Outlier payments for discharges (see instructions)	2.00	59, 789	0	59, 789	9 0	59, 789	
01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0		0 0	0	2
00	Operating outlier reconciliation	2. 01	0	0	(0 0	0	3.
00	Managed care simulated payments	3.00	1, 349, 172	0	1, 041, 433	3 307, 739	1, 349, 172	4.
00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0. 000000		5
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0	(o o	0	6
01	instructions) IME payment adjustment for managed care (see	22.01	0	0	(o o	0	6
	instructions) Indirect Medical Education Adju	istment for the	e Add-on for Se	ction 422 of t	he MMA			
00	IME payment adjustment factor	27.00	0. 000000	0. 000000		0. 000000		7
00	(see instructions) IME adjustment (see	28.00	0	0	(o o	0	8
01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	(o o	0	8
00	instructions) Total IME payment (sum of	29.00	0	0	(o o	0	9
01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9
	Disproportionate Share Adjustme	ent	<u> </u>		<u>I</u>		<u> </u>	
00	Allowable disproportionate share percentage (see	33.00	0. 0620	0. 0620	0.0620	0. 0620		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	87, 370	0	65, 29	1 22, 079	87, 370	11
01	Uncompensated care payments Additional payment for high per	36.00	504, 177	0 di scharges	416, 784	4 87, 493	504, 277	11
00	Total ESRD additional payment (see instructions)	46. 00	0	0 o	(0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	6, 288, 119 0	0 0	4, 754, 08((0 1, 534, 039 0 0	6, 288, 119 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	6, 288, 119	0	4, 754, 080	0 1, 534, 039	6, 288, 119	15
00	Payment for inpatient program capital	50.00	454, 863	0	340, 924	4 113, 939	454, 863	16
00	Special add-on payments for new technologies	54.00	0	0	(o o	0	17
01 02	Net organ aquisition cost Capital received from manufacturers for replaced	55.00 68.00	0	0 0	(0	
. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)		0	0	(o o	0	18

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4					Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 1:2	pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	5, 095, 00	4 1, 647, 978	6, 742, 982	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	450, 637	0	336, 69	8 113, 939	450, 637	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0		0 0	0	•
21.00	Capital DRG outlier payments	2.00	4, 226	0	4, 22	6 0	4, 226	21.00
21.01	Model 4 BPCI Capital DRG	2.01	0	0		0 0	0	
	outlier payments		-	-		-	-	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education	6.00	0	0		o o	0	23.00
24.00	adjustment (see instructions) Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.0000	0. 000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		o o	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	454, 863	0	340, 92	4 113, 939	454, 863	26.00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0. 08750	0. 076607		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			445, 81	3	445, 813	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				126, 247	126, 247	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

OSPI 1	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der		Period: From 01/01/2014	Worksheet E Part A Exhibit	t 5
					To 12/31/2014		pared:
			Titl	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
. 00	DRG amounts other than outlier payments	1.00					1.00
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4, 212, 316	4, 212, 31		4, 212, 316	1. 0 [.]
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1, 424, 467		1, 424, 467	1, 424, 467	1.0
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.0
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 0
. 00	Outlier payments for discharges (see instructions)	2.00	59, 789		0 59, 789	59, 789	2.0
. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.0
. 00	Operating outlier reconciliation	2.01	0		0 0	0	3.0
. 00	Managed care simulated payments	3.00	1, 349, 172	1, 041, 43	3 307, 739	1, 349, 172	4.0
. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0 0. 000000		5. C
	(see instructions)						
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22.00 22.01	0		0 0 0 0	0 0	6. (6. (
	Indirect Medical Education Adjustment for the	e Add-on for Se	ection 422 of t	he MMA			
. 00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0 0. 000000		7. C
00	IME adjustment (see instructions)	28.00	0		0 0	0	8. (
01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. (
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9. (
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0 0	0	9. (
	Disproportionate Share Adjustment						
0. 00	Allowable disproportionate share percentage	33.00	0.0620	0.062	0 0.0620		10. (
I. 00	(see instructions) Disproportionate share adjustment (see	34.00	87, 370	65, 29	1 22, 079	87, 370	11. (
I. 01	instructions) Uncompensated care payments	36.00	504, 177	416, 78	4 87, 393	504, 177	11. (
2. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	46. 00	0 O		0 0	0	12. (
3 00	Subtotal (see instructions)	47.00	6, 288, 119	4, 694, 39	1 1, 593, 728	6, 288, 119	13 (
	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	., ., ., ., .,	0 0		
. 00	Total payment for inpatient operating costs (see instructions)	49.00	6, 288, 119	4, 694, 39	1 1, 593, 728	6, 288, 119	15. (
. 00	Payment for inpatient program capital	50.00	454, 863	3, 16	1 451, 702	454, 863	16.0
. 00	Special add-on payments for new technologies	54.00	0		0 0	0	17. (
7.01	Net organ aquisition cost	55.00	0		0 0	0	17.
	Capital received from manufacturers for	68.00	0		0 0	0	17.
7. 02	replaced devices for applicable MS-DRGs						
	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.

Heal th	Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	CCN: 150001	Period: From 01/01/2014 To 12/31/2014		pared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	450, 637		0 450, 637	450, 637	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	4, 226	3, 10	51 1, 065	4, 226	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	454, 863	3, 10	451, 702	454, 863	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00			1.00	2.00	0.00	1.00	27.00
28.00	Low volume adjustment prior to October 1	70, 96	0		0	0	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	1
30,00	HVBP payment adjustment (see instructions)	70, 93	-10, 828	-8,0	-2, 729	-10, 828	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 C	0	1
31.00	HRR adjustment (see instructions)	70, 94	-2, 279	-1, 7	-574	-2,279	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
	· · · · · ·					(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	02.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001	Peri od: From 01/01/2014 To 12/31/2014 Hospi tal	Worksheet E Part B Date/Time Prep 5/21/2015 1:20 PPS	
			nospi tui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			1, 088	1.00
. 00	Medical and other services reimbursed under OPPS (see instruction	ons)		7, 708, 476	2.00
. 00	PPS payments			6, 428, 895	3.00
. 00	Outlier payment (see instructions)			39, 271	4.00
. 00	Enter the hospital specific payment to cost ratio (see instruct)	ions)		0.000	5.00
. 00 . 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	6.00 7.00
. 00	Transitional corridor payment (see instructions)			0.00	8.00
. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	, col. 13, line 200		0	9.00
	Organ acquisitions			0	10.00
1. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 088	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
2.00	Reasonable charges Ancillary service charges			2 575	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col	1. 4)		2, 3, 3	13.00
	Total reasonable charges (sum of lines 12 and 13)			2, 575	
	Customary charges				
	Aggregate amount actually collected from patients liable for pay			0	15.00
6.00	Amounts that would have been realized from patients liable for phad such payment been made in accordance with 42 CFR §413.13(e)		n a chargebasis	0	16.00
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
	Total customary charges (see instructions)			2, 575	18.00
9.00	Excess of customary charges over reasonable cost (complete only	ifline 18 exceeds li	ne 11) (see	1, 487	19.00
	instructions)				
0. 00	Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see i	instructions)		1, 088	21.00
	Interns and residents (see instructions)			1,000	22.00
	Cost of physicians' services in a teaching hospital (see instrue	ctions)		0	23.00
4.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			6, 468, 166	24.00
- 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				05.00
	Deductibles and coinsurance (for CAH, see instructions)	CAH soo instructions)		0 1, 409, 778	25.00 26.00
	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plu			5, 059, 476	
	CAH, see instructions)			010071170	27.00
3. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
	Subtotal (sum of lines 27 through 29)			5, 059, 476	
	Primary payer payments Subtotal (line 30 minus line 31)			2, 018 5, 057, 458	
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)		3,037,430	52.00
3.00	Composite rate ESRD (from Wkst. 1-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			157, 893	
	Adjusted reimbursable bad debts (see instructions)			102, 630	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ctions)		72, 329 5, 160, 088	36.00 37.00
	MSP-LCC reconciliation amount from PS&R			-27	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
9.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39.98
9.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
	Subtotal (see instructions) Sequestration adjustment (see instructions)			5, 160, 115	40. 00 40. 01
	Interim payments			103, 202 5, 132, 929	
	Tentative settlement (for contractors use only)			0, 132, 727	42.00
	Balance due provider/program (see instructions)			-76, 016	
4.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44.00
	\$115.2				
) 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	90.00
	The rate used to calculate the Time Value of Money			-	92.00
3.00	Time Value of Money (see instructions)			0	93.00
4.00	Total (sum of lines 91 and 93)			0	94.0

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Pre 5/21/2015 1:2	
		Title XVIII	Subprovider - IRF	PPS	2 piii
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			94	1.0
00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	i ons)		41	2.0
00	PPS payments			117	3. (
00	Outlier payment (see instructions)			0	4.
00 00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	tions)		0.000	
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9.
. 00	Organ acquisitions			0	
. 00	Total cost (sum of lines 1 and 10) (see instructions)			94	11.
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
. 00	Ancillary service charges			223	12.
. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, c	ol. 4)		0	13.
. 00	Total reasonable charges (sum of lines 12 and 13)			223	14.
00	Customary charges	aumont for convious on	a abarga basi a	0	115
00	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0	
. 00	had such payment been made in accordance with 42 CFR §413.13(e			0	10.
00	Ratio of line 15 to line 16 (not to exceed 1.000000)	, ,		0.000000	17
00	Total customary charges (see instructions)			223	
00	Excess of customary charges over reasonable cost (complete onl instructions)	y if line 18 exceeds li	ne 11) (see	129	19
00	Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds li	ne 18) (see	0	20
00	instructions)			0	20
00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		94	
00	Interns and residents (see instructions)			0	
. 00 . 00	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		0 117	
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			117	24
00	Deductibles and coinsurance (for CAH, see instructions)			0	25
. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		0	
00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	and 23} (for	211	27
00	CAH, see instructions) Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28
00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
00	Subtotal (sum of lines 27 through 29)			211	30
00	Primary payer payments			0	
00	Subtotal (line 30 minus line 31)	F0)		211	32
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33
00	Allowable bad debts (see instructions)			0	
00	Adjusted reimbursable bad debts (see instructions)			0	
00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	
	Subtotal (see instructions)			211	
00 00	MSP-LCC reconciliation amount from PS&R			0	
50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		0	
98	Partial or full credits received from manufacturers for replac		tions)	0	
99	RECOVERY OF ACCELERATED DEPRECIATION	,	-	0	
00	Subtotal (see instructions)			211	
01	Sequestration adjustment (see instructions)			4	
00 00	Interim payments Tentative settlement (for contractors use only)			210	41
00	Balance due provider/program (see instructions)			-3	
00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2				1
00	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
00 00	The rate used to calculate the Time Value of Money			0.00	
00	Time Value of Money (see instructions)				93.
	Total (sum of lines 91 and 93)				94

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150001	Period: From 01/01/2014 To 12/31/2014		pare
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4,00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		5, 794, 1	75 0	5, 132, 929 0	1. 2. 3.
	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					
01 02 03 04	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0 0	3
05				0	0	3
50	Provider to Program					
50 51 52 53	ADJUSTMENTS TO PROGRAM			0 0 0 0	0 0 0 0	3
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 794, 1	75	5, 132, 929	4
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after				1	5
0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	
)3				0	0	
	Provider to Program				1	
50	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	5
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		34, 4	67	0	6
01 02	SETTLEMENT TO PROVIDER		34, 4	0	76, 016	
02	Total Medicare program liability (see instructions)		5, 828, 6	U	5, 056, 913	
			<u> </u>	Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	()	1.00	2.00	8

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150001 t CCN: 15T001	Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovider - IRF	PPS	<u> piii</u>
		Inpatier	nt Part A		тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	Tabel intenin neuments and to previden	1.00	2.00	3.00	4.00	1 00
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		971, 0	0	210 0	1.00 2.00
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	3. 02
03				0	0	3.03
04				0	0	3.04
05				0	0	3.0
	Provider to Program		1			
50	ADJUSTMENTS TO PROGRAM			0	0	3.5
51				0	0	3.5
52				0	0	3.5
3				0	0	3.5
4				0	0	3.5
9	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.9
0	Total interim payments (sum of lines 1, 2, and 3.99)		971, 0	86	210	4.0
0	(transfer to Wkst. E or Wkst. E-3, line and column as		771,0	00	210	4.0
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		1			
0	List separately each tentative settlement payment after					5.C
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
1	TENTATI VE TO PROVI DER			0	0	5.0
2				0	0	5.C
3				0	0	5.C
~	Provider to Program		1	-		
0	TENTATIVE TO PROGRAM			0	0	5.5
1 2				0	0	5.5 5.5
2 9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
1	5. 50-5. 98)			0	0	0.5
0	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
1	SETTLEMENT TO PROVIDER		26, 7	07	0	6. C
2	SETTLEMENT TO PROVIDER		20, /	0	3	6.0
2	Total Medicare program liability (see instructions)		997, 7	93	207	7.0
5	Total meandare program trabitity (see thistractions)		771,1	Contractor	NPR Date	7.0
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	
00	Name of Contractor					8. (

Heal th	Financial Systems JOHN:	ISON MEMORIAL HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150001	Period:	Worksheet E-1	
				From 01/01/2014 To 12/31/2014		arod.
				10 12/31/2014	5/21/2015 1:20	
			Title XVIII	Hospi tal	PPS	, biii
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COS	ST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND	CALCULATI ON				
1.00	Total hospital discharges as defined in AARA §4102	2 from Wkst. S-	3, Pt. I col. 15 line	14	2, 186	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of	f lines 1, 8-12			3, 550	2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00						
5.00	Total hospital charges from Wkst C, Pt. I, col. 8	line 200			170, 591, 811	5.00
6.00	Total hospital charity care charges from Wkst. S-1	10, col. 3 line	20		9, 725, 962	6.00
7.00	3.00Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 24.00Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-125.00Total hospital charges from Wkst C, Pt. I, col. 8 line 2006.00Total hospital charity care charges from Wkst. S-10, col. 3 line 207.00CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I1 ine 168					
8.00	Calculation of the HIT incentive payment (see inst				740, 583	
9.00	Sequestration adjustment amount (see instructions))			14, 812	9.00
10.00	Calculation of the HIT incentive payment after sec	questration (se	e instructions)		725, 771	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instru	uctions)			713, 032	
31.00	Other Adjustment (specify)				0	31.00
32.00	Balance due provider (line 8 (or line 10) minus li	ine 30 and line	31) (see instruction	s)	12, 739	32.00

ALCOL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001	Period:	Worksheet E-3	
		Component CCN: 15T001	From 01/01/2014 To 12/31/2014	Part III	pare
		Title XVIII	Subprovider - IRF	PPS	9 pii
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00	Net Federal PPS Payment (see instructions)			972, 667	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0322	2.
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			52, 329	3.
. 00	Outlier Payments			8, 479	4.
. 00	Unweighted intern and resident FTE count in the most recent to November 15, 2004 (see instructions)	cost reporting period en	ding on or prior	0.00	5.
. 01	Cap increases for the unweighted intern and resident FTE cou	unt for residents that wer	e displaced by	0.00	5.
	program or hospital closure, that would not be counted without				
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instructions)				
. 00	Current year's unweighted I&R FTE count for residents within	n the new program growth p	eriod of a "new	0.00	8.
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education adju	ustment (see instructions)		0.00	9
). 00	Average Daily Census (see instructions)			3.964384	
. 00	Teaching Adjustment Factor (see instructions)			0.00000	
. 00	Teaching Adjustment (see instructions) Total PPS Payment (see instructions)			1 022 475	12
. 00	Nursing and Allied Health Managed Care payments (see instruct	stion)		1, 033, 475 0	13 14
. 00	Organ acquisition (DO NOT USE THIS LINE)			0	14
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	
. 00	Subtotal (see instructions)			1, 033, 475	
. 00	Primary payer payments			0,000,170	18
. 00	Subtotal (line 17 less line 18).			1, 033, 475	
. 00	Deducti bl es			10, 944	
. 00	Subtotal (line 19 minus line 20)			1, 022, 531	
. 00	Coinsurance			4, 864	
. 00	Subtotal (line 21 minus line 22)			1, 017, 667	23
. 00	Allowable bad debts (exclude bad debts for professional serv	/ices) (see instructions)		753	24
. 00	Adjusted reimbursable bad debts (see instructions)			489	25
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		390	26
. 00	Subtotal (sum of lines 23 and 25)			1, 018, 156	27
. 00	Direct graduate medical education payments (from Wkst. E-4,	line 49)		0	28
. 00	Other pass through costs (see instructions)			0	29
. 00	Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	31
. 99	Recovery of Accel erated Depreciation			0	31
2.00	Total amount payable to the provider (see instructions)			1, 018, 156	
2.01	Sequestration adjustment (see instructions)			20, 363	
	Interim payments			971, 086	
1.00	Tentative settlement (for contractor use only)	and 24		0	
5.00	Balance due provider/program line 32 minus lines 32.01, 33 a		chaptor 1	26, 707	
5. 00	Protested amounts (nonallowable cost report items) in accord §115.2	uance with two PUD. 15-2,	спартег I,	0	36
	TO BE COMPLETED BY CONTRACTOR				
D. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			8, 479	50
1.00	Outlier reconciliation adjustment amount (see instructions)			0	51
2.00	The rate used to calculate the Time Value of Money			0.00	

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Pre 5/21/2015 1:2	pare
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI COMPUTATION OF NET COST OF COVERED SERVICES	CES FUR TITLES V UR X	IX SERVICES		-
. 00	Inpatient hospital/SNF/NF services		887, 772		1 1.
. 00	Medical and other services		007,772	1, 493, 952	2.
. 00	Organ acquisition (certified transplant centers only)		0	1, 170, 702	3.
. 00	Subtotal (sum of lines 1, 2 and 3)		887, 772	1, 493, 952	
. 00	Inpatient primary payer payments		0		5.
. 00	Outpatient primary payer payments			0	6.
. 00	Subtotal (line 4 less sum of lines 5 and 6)		887, 772	1, 493, 952	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
. 00	Routi ne servi ce charges		1, 265, 109	F 707 000	8.
. 00	Ancillary service charges		1, 462, 994	5, 727, 998	
0.00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10.
1.00 2.00	Total reasonable charges (sum of lines 8 through 11)		2, 728, 103	5, 727, 998	
2.00	CUSTOMARY CHARGES		2,720,103	5, 727, 990	12.
3. 00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13.
0.00	basi s	or theore on a onal go		0	
4.00	Amounts that would have been realized from patients liable for p	ayment for services o	n 0	0	14.
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	
6.00	Total customary charges (see instructions)		2, 728, 103	5, 727, 998	
7.00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	1, 840, 331	4, 234, 046	17.
	line 4) (see instructions)				
8.00	Excess of reasonable cost over customary charges (complete only	IT line 4 exceeds lin	e 0	0	18.
9.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.
5.00 D.00	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	20.
1.00	Cost of covered services (enter the lesser of line 4 or line 16)		887, 772	1, 493, 952	
1.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co			1, 170, 702	1
2.00	Other than outlier payments		0	0	22.
3.00	Outlier payments		0	0	
4.00	Program capital payments		0		24.
5.00	Capital exception payments (see instructions)		0		25
6.00	Routine and Ancillary service other pass through costs		0	0	26
7.00	Subtotal (sum of lines 22 through 26)		0	0	27.
B. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.
9.00	Titles V or XIX (sum of lines 21 and 27)		887, 772	1, 493, 952	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	1 20
0.00	Excess of reasonable cost (from line 18)		0	1 402 052	
1.00 2.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		887, 772	1, 493, 952 0	
2.00			0	0	
4.00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0	0	35.
5.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	887, 772	1, 493, 952	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	37.
3.00	Subtotal (line 36 \pm line 37)		887, 772	1, 493, 952	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0	-	39.
D. 00	Total amount payable to the provider (sum of lines 38 and 39)		887, 772	1, 493, 952	40
1.00	Interim payments		837, 280	1, 392, 260	41
	Balance due provider/program (line 40 minus line 41)		50, 492	101, 692	42
2.00	barance due provider/program (Trhe 40 minus Trhe 41)		00, 172	101, 072	1

LCUL		Provider CCN: 150001 Component CCN: 15T001	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Pre	
		-		5/21/2015 1:2	9 p
		Title XIX	Subprovider -	Cost	
			Inpatient	Outpatient	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR X	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES		TX SERVICES		1
00	Inpatient hospital/SNF/NF services		245, 386		1 1
00	Medical and other services		210,000	0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		245, 386	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		245, 386	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routine service charges		63, 437		8
00	Ancillary service charges		67, 446	0	
00	Organ acquisition charges, net of revenue		0		10
00	Incentive from target amount computation		120,000	-	1
00	Total reasonable charges (sum of lines 8 through 11)		130, 883	0	1:
00	CUSTOMARY CHARGES	anviore on a change	0		1 1 1
00	Amount actually collected from patients liable for payment for s basis	ervices on a charge	0	0	13
00	Amounts that would have been realized from patients liable for p	avment for services o		0	14
00	a charge basis had such payment been made in accordance with 42	5		0	'
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0,000000	0.000000	1!
	Total customary charges (see instructions)		130, 883	0	
00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	0	0	1
	line 4) (see instructions)				
00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	e 114, 503	0	18
	16) (see instructions)				
00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 16)		130, 883	0	2
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	mpleted for PPS provi			4
	Other than outlier payments		0	0	
00	Outlier payments		0	0	
00	Program capital payments		0		24
00	Capital exception payments (see instructions)		0	0	2!
	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		130, 883	0	
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		130, 883	0	- 2
00	Excess of reasonable cost (from line 18)		114, 503	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		130, 883	0	
	Deductiblies		0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review		0		3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	130, 883	0	30
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
00	Subtotal (line 36 ± line 37)		130, 883	0	38
00	Direct graduate medical education payments (from Wkst. E-4)		0		30
00	Total amount payable to the provider (sum of lines 38 and 39)		130, 883	0	
00	Interim payments		130, 883	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2.	0	0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl		CCN: 150001	Period: From 01/01/2014	Worksheet G	
				To 12/31/2014	Date/Time Pre 5/21/2015 1:2	pare 9 pr
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	2 712 120		0 0	0	1 1
00	Temporary investments	3, 713, 129		0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	15, 230, 423		0 0	0	
00	Other receivable	6, 792, 085		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	-4, 194, 905		0 0	0	6
00	Inventory	1, 460, 066		0 0	0	
00	Prepai d expenses	1, 395, 368		0 0	0	
00	Other current assets Due from other funds	10, 010, 598		0 0	0	
	Total current assets (sum of lines 1-10)	34, 406, 764		0 0	0	
00	FIXED ASSETS	54, 400, 704		<u> </u>	0	1''
00	Land	3, 141, 963		0 0	0	1 12
. 00	Land improvements	1, 603, 865		0 0	0	
00	Accumulated depreciation	-1, 063, 901		0 0	0	14
. 00	Buildings	66, 154, 520		0 0	0	
	Accumulated depreciation	-36, 337, 082		0 0	0	
. 00	Leasehold improvements	0		0	0	
	Accumulated depreciation Fixed equipment			0 0	0	
	Accumulated depreciation	11, 690, 283 -9, 355, 643			0	
	Automobiles and trucks	- 7, 333, 043		0 0	0	
-	Accumul ated depreciation	0		0 0	0	
	Major movable equipment	36, 227, 029		0 0	0	
. 00	Accumulated depreciation	-28, 224, 859		0 0	0	24
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation			0 0	0	
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	2, 584, 230 46, 420, 405		0 0	0	
	OTHER ASSETS	40, 420, 403	I	<u> </u>	0	1 30
	Investments	45, 472, 986		0 0	0	31
. 00	Deposits on leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
	Other assets	71, 375		0 0	0	
. 00	Total other assets (sum of lines 31-34)	45, 544, 361		0 0	0	
. 00	Total assets (sum of lines 11, 30, and 35)	126, 371, 530		0 0	0	36
	CURRENT LIABILITIES Accounts payable	1, 655, 344		0 0	0	37
. 00	Salaries, wages, and fees payable	1,000,044		0 0	0	
	Payrol I taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	71, 097		0 0	0	
	Deferred income	0		0 0	0	41
	Accelerated payments	0				42
	Due to other funds	0		0 0	0	
	Other current liabilities	4, 120, 988		0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	5, 847, 429		0 0	0	45
. 00	Mortgage payable	0		0 0	0	46
	Notes payable	0		0 0	0	
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	0		0 0	0	49
	Total long term liabilities (sum of lines 46 thru 49	0		0 0	0	
. 00	Total liabilites (sum of lines 45 and 50)	5, 847, 429		0 0	0	51
0.0	CAPITAL ACCOUNTS	400 504 453				
. 00	General fund balance	120, 524, 101				52
. 00 . 00	Specific purpose fund Donor created - endowment fund balance - restricted			0		5
. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		5
. 00	Governing body created - endowment fund balance			0		50
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	120, 524, 101		0 0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	126, 371, 530		0 0	0	60

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Li	eu of Form CMS-:	2552-10
STATEM	IENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 150001	Period: From 01/01/2014 To 12/31/2014		pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
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	 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 TRANSFER FROM OTHER FUNDS 5.00 OTHER ADJUSTMENT 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 	1.00 20, 534, 214 9, 016 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 99,426,899 553,972 99,980,871 20,543,230 120,524,101		4.00 0 0 0 0 0 0 0 0 0 0 0 0		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	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		(120, 524, 101				18.00 19.00
		Endowment Fund	PI ant	t Fund			
1.00		6.00	7.00	8.00			1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TRANSFER FROM OTHER FUNDS OTHER ADJUSTMENT	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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0)))	0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	Financial Systems JOHNSON MEMORIAL HO		CCN: 150001	Period:		eu of Form CMS-2552 Worksheet G-2	
STATE	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	PIOVICEI	CCN. 150001		om 01/01/2014	Parts I & II Date/Time Pre	pared:
						5/21/2015 1:2	9 pm
	Cost Center Description		Inpatient 1.00		Outpatient 2.00	<u>Total</u> 3.00	
	PART I - PATIENT REVENUES		1.00		2.00	3.00	
	General Inpatient Routine Services						
1.00	Hospi tal		11, 616, 5	96		11, 616, 596	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF		1, 689, 3	67		1, 689, 367	3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00 10.00	OTHER LONG TERM CARE Total general inpatient care services (sum of lines 1-9)		13, 305, 9	42		13, 305, 963	9.00 10.00
10.00	Intensive Care Type Inpatient Hospital Services		13, 305, 9	03		13, 303, 903	10.00
11.00	INTENSIVE CARE UNIT		2, 197, 6	58		2, 197, 658	11.00
12.00	CORONARY CARE UNIT		2, 1, 1, 1, 0			2,, 0000	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 li	nes	2, 197, 6	58		2, 197, 658	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		15, 503, 6			15, 503, 621	
18.00	Ancillary services		33, 174, 4		99, 296, 045	132, 470, 492	18.00
19.00	Outpatient services			0	21, 791, 432	21, 791, 432	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	0	20.00 21.00
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0	1, 396, 476	0 1, 396, 476	21.00
22.00	AMBULANCE SERVICES				1, 390, 470	1, 390, 470	22.00
24.00	CMHC						23.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPICE						26.00
27.00	OTHER REVENUE			0	9, 036, 873	9, 036, 873	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst.	48, 678, 0	68	131, 520, 826	180, 198, 894	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)		45.4	0.1	76, 221, 831		29.00
30.00	LOSS ON SALE OF ASSET		45, 4				30.00
31.00 32.00				0 0			31.00 32.00
32.00				0			32.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)			Ŭ	45, 431		36.00
37.00	FI SCAL SERVICES EXPENSES		1, 200, 0	000			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				1, 200, 000		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer			75, 067, 262		43.00
	to Wkst. G-3, line 4)		l				

Heal th	Financial Systems	JOHNSON MEMORIAL H	OSPI TAL		In Lie	u of Form CMS-2	552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN:	150001	Peri od:	Worksheet G-3	
					From 01/01/2014	Data /Tima Draw	orod.
					To 12/31/2014	Date/Time Prep 5/21/2015 1:29	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Par	t I, column 3, line :	28)			180, 198, 894	1.00
2.00	Less contractual allowances and discounts or	n patients' accounts				107, 202, 115	2.00
3.00	Net patient revenues (line 1 minus line 2)					72, 996, 779	3.00
4.00	Less total operating expenses (from Wkst. G-)			75, 067, 262	4.00
5.00	Net income from service to patients (line 3	minus line 4)				-2, 070, 483	5.00
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					300, 019	7.00
8.00	Revenues from telephone and other miscellane	eous communication s	ervi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					0	10.00
11.00						0	11.00
12.00	5					0	12.00
13.00						0	13.00
14.00		ests				0	14.00
15.00						0	15.00
16.00	5		n patrents			0	16.00
17.00 18.00	5					0	17.00 18.00
	Tuition (fees, sale of textbooks, uniforms,					0	18.00
20.00						0	20.00
20.00						0	20.00
21.00						0	21.00
23.00						0	22.00
24.00	OTHER OPERATING REVENUE					1, 785, 223	23.00
24.00	OTHER NON-OPERATING REVENUE					26, 310	24.00
24.01						512, 903	24.01
	Total other income (sum of lines 6-24)					2, 624, 455	25.00
	Total (line 5 plus line 25)					553, 972	26.00
	OTHER EXPENSES (SPECIFY)					0	27.00
	Total other expenses (sum of line 27 and sub	oscripts)				0	28.00
	Net income (or loss) for the period (line 26					553, 972	
		,			I	· 1	

	Financial Systems GIS OF PROVIDER-BASED HOME HEALT	TH AGENCY COSTS	JOHNSON MEMORI		CCN: 150001	In Lie Period:	u of Form CMS-2 Worksheet H	2552-10
NALIS	DIS OF PROVIDER-DASED NUME NEALI	H AGENCE COSTS		HHA CCN:		From 01/01/2014	Date/Time Pre 5/21/2015 1:2	
						Home Health Agency I	PPS	F
		Sal ari es	Employee Benefits	Transportati on (see instructi ons)	chased		Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
. 00	Capital Related - Bldg. &			0		0	0	1.00
. 00	Fixtures Capital Related - Movable			0		0	0	2.00
	Equipment							2.00
. 00	Plant Operation & Maintenance	0	0	0		0 0	0	3.00
. 00 . 00	Transportation Administrative and General	0 172, 799	0	0 58, 297		0 0 0 101, 773	0 332, 869	4.00 5.00
. 00	HHA REIMBURSABLE SERVICES	172, 799	0	30, 297		0 101,773	332,009	5.00
. 00	Skilled Nursing Care	294, 864	0	0		0 0	294, 864	6.00
00	Physical Therapy	95, 144				0 0	95, 144	
00	Occupational Therapy	72, 641	0			0 0	72, 641	8.00
00). 00	Speech Pathology Medical Social Services	408				0 0	408 684	
1.00	Home Heal th Aide	4, 997				0 0	4, 997	
2. 00	Supplies (see instructions)	0	0	C)	0 8, 036	8,036	
8.00	Drugs	0	-	C		0 0	0	13.00
1.00		0	0	0		0 0	0	14.00
5. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	C		0 0	0	15.00
5.00	Respiratory Therapy	0	-			0 0	0	16.00
. 00	Private Duty Nursing	0	0	C		0 0	0	17.0
3.00	Clinic	0	0	0		0 0	0	18.00
9.00).00	Health Promotion Activities	0	0	0		0 0	0	19.00 20.00
. 00	Day Care Program Home Delivered Meals Program	0	0				0	20.0
2.00	Homemaker Service	0	0	0		0 0	0	22.00
3. 00	All Others (specify)	0	0	C		0 0	0	23.00
4.00	Total (sum of lines 1-23)	641, 537		58,297 Adjustments		0 109, 809	809, 643	24.00
		Reclassificati on	Reclassified Trial Balance	Aujustments	Net Expenses for Allocatio			
			(col. 6 +		(col. 8 + col			
			col . 7)		9)	_		-
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00			
00	Capital Related - Bldg. &	0	0	C		0		1.00
	Fixtures			-		-		
00	Capital Related - Movable	0	0	0		0		2.00
00	Equipment Plant Operation & Maintenance		_	0		0		3. 0
00	Transportation	0	0			0		4.00
00	Administrative and General	0	332, 869	0	332, 86	9		5.0
	HHA REIMBURSABLE SERVICES					_		
00	Skilled Nursing Care	0						6.00
00 00	Physical Therapy Occupational Therapy	0						7.0 8.0
00	Speech Pathol ogy	0	408					9.0
. 00	Medical Social Services	0	684					10.0
. 00	Home Health Aide	0	4, 997					11.00
. 00			8, 036					12.0
1.00 2.00	Supplies (see instructions)	0		0		0		13.00 14.00
1.00 2.00 3.00	Drugs	0	0	0		0		1 17.00
1.00 2.00 3.00	Drugs DME	0	0	C		0		
. 00 . 00 . 00 . 00	Drugs DME HHA NONREI MBURSABLE SERVI CES Home Di al ysi s Ai de Servi ces	0	0	C		0		
. 00 . 00 . 00 . 00	Drugs DME HHA NONREI MBURSABLE SERVI CES Home Di al ysi s Ai de Servi ces Respi ratory Therapy	0	0 0 0 0	0 0		0		16. 0
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Drugs DME HHA NONREI MBURSABLE SERVI CES Home Di al ysi s Ai de Servi ces Respi ratory Therapy Pri vate Duty Nursi ng	0	0 0 0 0 0	0 0 0		0 0 0		16. 0 17. 0
. 00 2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 8. 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0	0 0 0 0 0 0	0 0 0 0		0 0 0 0		16. 0 17. 0 18. 0
1.00 2.00 3.00 4.00 5.00 5.00 6.00 7.00 3.00 9.00	Drugs DME HHA NONREI MBURSABLE SERVI CES Home Di al ysi s Ai de Servi ces Respi ratory Therapy Pri vate Duty Nursi ng	0	0 0 0 0 0	0 0 0		0 0 0		16.00 17.00 18.00 19.00
. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 7. 00 3. 00 9. 00 9. 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0	0 0 0 0 0 0 0 0 0			0 0 0 0 0		16. 0 17. 0 18. 0 19. 0 20. 0
1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service					0 0 0 0 0 0 0 0 0 0		15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00
1.00 2.00 3.00 4.00 5.00 5.00 5.00 6.00 7.00 3.00 9.00 0.00 1.00 2.00 3.00	Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	0				0 0 0 0 0 0 0 0 0 0 0 0		16.00 17.00 18.00 19.00 20.00 21.00

	Financial Systems		JOHNSON MEMORIA				u of Form CMS-	
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider HHA CCN:	CCN: 150001 157510	Period: From 01/01/2014 To 12/31/2014	Worksheet H-1 Part I Date/Time Pre 5/21/2015 1:2	epared:
						Home Health Agency I	PPS	- 7 pili
			Capital Rela	ated Costs		Agency		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
2.00	Fixtures Capital Related - Movable	0		0			C	2.00
2.00	Equi pment	0		0			0	2.00
3.00 4.00	Plant Operation & Maintenance Transportation	0	0	0		0 0	0	3.00
4.00 5.00	Administrative and General	332, 869	0	0		0 0	332, 869	
(00	HHA REI MBURSABLE SERVI CES	204.044	0	0			204.044	
6.00 7.00	Skilled Nursing Care Physical Therapy	294, 864 95, 144	0	0		0 0 0 0	294, 864 95, 144	
8.00	Occupational Therapy	72, 641	0	0		0 0	72, 641	8.00
9.00 10.00	Speech Pathology Medical Social Services	408 684	0	0		0 0	408 684	
11.00	Home Heal th Ai de	4, 997	Ő	0		0 0	4, 997	
12.00 13.00	Supplies (see instructions) Drugs	8, 036	0	0		0 0	8, 036 0	
14.00	DME	0	0	0		0 0	0	
15 00	HHA NONREI MBURSABLE SERVI CES	0	a					15 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0 0		0 0 0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00 19.00	Clinic Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	1
21.00 22.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	0	0	0		0 0	0	1
	Total (sum of lines 1-23)	809, 643	0	0		0 0	809, 643	3 24.00
		Administrative & General	4A + 5)					
	CENERAL CERVICE COST CENTERS	5.00	6.00		-			
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
0.00	Fixtures							0.00
2.00	Capital Related – Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00 5.00	Transportation Administrative and General	332, 869						4.00
	HHA REIMBURSABLE SERVICES							
6.00 7.00	Skilled Nursing Care Physical Therapy	205, 864 66, 427	500, 728 161, 571					6.00 7.00
8.00	Occupational Therapy	50, 716	123, 357					8.00
9.00 10.00	Speech Pathology Medical Social Services	285 478	693 1, 162					9.00
11.00	Home Heal th Ai de	3, 489	8, 486					11.00
12.00	Supplies (see instructions)	5, 610	13, 646					12.00
13.00 14.00	Drugs DME	0	0					13.00
	HHA NONREI MBURSABLE SERVI CES							
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0					15.00
17.00	Private Duty Nursing	0	Ő					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	Home Delivered Meals Program	0	0					21.00
22 00	Homemaker Service	1 ()	0					22.00
	All Others (specify)	0	O					23.00

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider HHA CCN:	CCN: 150001 157510	Period: From 01/01/2014 To 12/31/2014		pared:
						Home Health Agency I	PPS	
		Capital Re	ated Costs					
		· · · · ·	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	(MILEAGE)	onReconciliation	& General (ACCUM. COST)	_
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS				1			
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	C		0		3.00
4.00	Transportation (see	0	0	C)	0		4.00
	instructions)							
5.00	Administrative and General	0	0	C		0 -332, 869	476, 774	5.00
	HHA REIMBURSABLE SERVICES	-						
6.00	Skilled Nursing Care	0	0	C		0 0	294, 864	
7.00	Physical Therapy	0	0	C		0 0	95, 144	
8.00	Occupational Therapy	0	0	C		0 0	72, 641	
9.00 10.00	Speech Pathology Medical Social Services	0	0			0 0	408 684	
10.00	Home Health Aide	0	0			0 0	4, 997	
12.00	Supplies (see instructions)	0	0				8, 036	
13.00	Drugs		0			0	0,030	1
14.00	DME	0	0	C		0 0	0	
	HHA NONREI MBURSABLE SERVI CES			-				
15.00	Home Dialysis Aide Services	0	0	C)	0 0	0	15.00
16.00	Respiratory Therapy	0	0	C		0 0	0	16.00
17.00	Private Duty Nursing	0	0	C		0 0	0	17.00
18.00	Clinic	0	0	C		0 0	0	
19.00	Health Promotion Activities	0	0	C		0 0	0	
20.00	Day Care Program	0	0	C		0 0	0	
21.00	Home Delivered Meals Program	0	0	C		0 0	0	
22.00	Homemaker Service All Others (specify)	0	0			0 0	0	
23.00 24.00	Total (sum of lines 1-23)					0 -332,869	0 476, 774	
24.00 25.00	Cost To Be Allocated (per					0 -332,869	476,774 332,869	
	Worksheet H-1, Part I)		0 000000		0.0000			
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	JU	0. 698169	26.00

LOCATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider HHA CCN:	CCN: 150001 157510	Period: From 01/01/2014 To 12/31/2014	Worksheet H-2 Part I Date/Time Pre 5/21/2015 1:20	pare
					Home Health Agency I	PPS	
		CAPI	TAL RELATED CO	OSTS			
Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
	0	1.00	1.01	2.00	4.00	4.01	
00 Administrative and General 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Supplies (see instructions) 00 Drugs 00 Home Dialysis Aide Services 00 Home Dialysis Aide Services 00 Respiratory Therapy 00 Private Duty Nursing 00 Clinic 00 Health Promotion Activities 00 Day Care Program 00 Home Delivered Meals Program 00 Homers (specify) 00 All Others (specify) 00 Total (sum of Lines 1-19) (2)	0 500, 728 161, 571 123, 357 693 1, 162 8, 486 13, 646 13, 646 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 354 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			$ \begin{array}{cccccccccccccccccccccccccccccccccccc$		3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19
00 Total (sum of lines 1-19) (2) 00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	DATA PROCESSI NG	8, 354 MATERI ALS MANAGEMENT	ADMI TTI NG	PATI ENT ACCOUNTI NG		ADMI NI STRATI VE & GENERAL	21
	4.02	4.03	4.04	4.05	4A. 05	5.00	
00 Administrative and General 00 Skilled Nursing Care 00 Physical Therapy 00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 Home Health Aide 00 Supplies (see instructions) 00 Drugs 00 DME 00 Meme Dialysis Aide Services 00 Respiratory Therapy 00 Private Duty Nursing 00 Clinic	46, 300 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	880 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7,616 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{ccccc} 0 & 575, 257 \\ 0 & 185, 619 \\ 0 & 141, 718 \\ 0 & 796 \\ 0 & 1, 335 \\ 0 & 9, 749 \\ 0 & 13, 646 \\ 0 & 0 \\ 0 & $	84, 846 27, 377 20, 902 117 1, 438 2, 013 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2 3 4 5 6 7 8 9 10 11 12 13 14
 Heal th Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. 	0 0 0 46, 300	0 0 0 880	0 0 0 7, 616		0 0 0 0 0 0 0 0 0 0 20 1, 060, 850 0. 000000		16 17 18 19

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

	Financial Systems		JOHNSON MEMORI				u of Form CMS-2	
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provi der	CCN: 150001	Period: From 01/01/2014	Worksheet H-2 Part I	
				HHA CCN:	157510		Date/Time Pre 5/21/2015 1:2	pared: 9 pm
						Home Health Agency I	PPS	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERIA	NURSI NG	
		PLANT	LINEN SERVICE				ADMI NI STRATI ON	
1.00		7.00	8.00	9.00	10.00	11.00	13.00	1.00
1.00	Administrative and General	21, 960	0	6, 884		0 16, 757	0	
2.00 3.00	Skilled Nursing Care Physical Therapy	0	0	0		0 0	0	
4.00	Occupational Therapy	0	0	0		0 0	0	
5.00	Speech Pathology	0	0	0		0 0	0	1
6.00	Medical Social Services	0	0	0		0 0	0	6.00
7.00	Home Health Aide	0	0	0		0 0	0	
8.00	Supplies (see instructions)	0	0	0		0 0	0	
9.00	Drugs DME	0	0	0		0 0	0	
10. 00 11. 00	Home Dialysis Aide Services	0	0	0		0 0	0	10.00
12.00	Respiratory Therapy	0	0	0		0 0	0	1
13.00	Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic	0	0	0		0 0	0	14.00
15.00	Health Promotion Activities	0	0	0		0 0	0	
16.00	Day Care Program	0	0	0		0 0	0	
17.00 18.00	Home Delivered Meals Program	0	0	0		0 0	0	1
18.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	
20.00	Total (sum of lines 1-19) (2)	21, 960	0	6, 884		0 16, 757		1
21.00	Unit Cost Multiplier: column	21,700	0	0,001				21.00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	<u>6 decimal places.</u> Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Intern &	Subtotal	
		SERVICES &		RECORDS &	ous to tai	Residents Cost		
		SUPPLY		LI BRARY		& Post		
						Stepdown		
		14.00	15.00	16.00	24.00	Adjustments 25.00	26.00	
1.00	Administrative and General	0	0	10, 976			208, 884	1.00
2.00	Skilled Nursing Care	0	0	0	660, 10	03 0	660, 103	
3.00	Physical Therapy	0	0	0			212, 996	
4.00	Occupational Therapy	0	0	0			162, 620	
5.00 6.00	Speech Pathology Medical Social Services	0	0	0			913 1, 532	1
7.00	Home Heal th Aide	0	0	0			11, 187	
8.00	Supplies (see instructions)	0	0	0			15, 659	
9.00	Drugs	0	0	0		0 0	0	9.00
10.00	DME	0	0	0		0 0	0	
	Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00 14.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
15.00	Health Promotion Activities	0	0	0		0 0	0	
16.00	Day Care Program	0	0	0		0 0	0	
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00	Homemaker Service	0	0	0		0 0	0	
19.00	All Others (specify)	0	0	0	1 070 00	0 0	0	
20. 00 21. 00	Total (sum of lines 1–19) (2) Unit Cost Multiplier: column	0	0	10, 976	1, 273, 89	0	1, 273, 894	20.00
21.00	26, line 1 divided by the sum							21.00
								1
	of column 26, line 20 minus							
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							

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

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	TO HHA COST CEN	TERS	Provi der HHA CCN:	CCN: 150001 157510	Period: From 01/01/2014 To 12/31/2014	Worksheet H-2 Part I Date/Time Pre	pared:
							5/21/2015 1:2	9 pm
						Home Health	PPS	
						Agency I		
	Cost Center Description	Allocated HHA	Total HHA					
		A&G (see Part	Costs					
)						
1.00		27.00	28.00					1 00
1.00	Administrative and General	100.110	700 570					1.00
2.00	Skilled Nursing Care	129, 469	789, 572					2.00
3.00	Physical Therapy	41, 776	254, 772					3.00
4.00	Occupational Therapy	31, 895	194, 515					4.00
5.00	Speech Pathology	179	1, 092					5.00
6.00	Medical Social Services	300	1, 832					6.00
7.00	Home Health Aide	2, 194	13, 381					7.00
8.00	Supplies (see instructions)	3, 071	18, 730					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	208, 884	1, 273, 894					20.00
21.00	Unit Cost Multiplier: column	0. 196133						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 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	n Financial Systems		JOHNSON MEMOR		CON 150001		u of Form CMS-2	
BASI S	ATION OF GENERAL SERVICE COSTS	TU HHA COST CEN	TERS STATISTIC	HHA CCN:		Period: From 01/01/2014 To 12/31/2014		pared:
						Home Health Agency I	PPS	
		CAPI	ITAL RELATED CO	DSTS				
	Cost Center Description	BLDG & FI XT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	COMMUNI CATI ONS (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
1.00		1.00	1.01	2.00	4.00	4.01	4. 02	1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	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) Total (sum of lines 1-19)	1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	868 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	294, 86 95, 14 72, 64 68 4, 99 4, 99 162, 15 0. 25275	4 0 4 0 1 0 8 0 4 0 7 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 20.00 20.00 21.00
		(SUPPLY USAGE)	CHARGES)	(GROSS CHARGES)		(ACCUM. COST)	(TOTAL FEET)	
21.00	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) Total (sum of lines 1-19)	4.03 12,510 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 616			5.00 0 132,730 0 575,257 0 185,619 0 141,718 0 796 0 1,335 0 9,749 0 13,646 0 0 0 <td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00</td>	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 14.00 15.00 14.00 15.00 14.00 20.00 21.00

Heal t	n Financial Systems		JOHNSON MEMOR	IAL H	OSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOC BASI S	ATION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS STATISTIC	AL	Provider HHA CCN:	CCN: 150001 157510	Period: From 01/01/2014 To 12/31/2014	Worksheet H-2 Part II Date/Time Pre 5/21/2015 1:2	pared:
							Home Health Agency I	PPS	<u>, bur</u>
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)		I ETARY _S SERVED)	CAFETERIA (HOURS PAID)	NURSI NG	SUPPLY	
		8.00	9.00		10.00	11.00	13.00	14.00	
$\begin{array}{c} 1, 00\\ 2, 00\\ 3, 00\\ 4, 00\\ 5, 00\\ 6, 00\\ 7, 00\\ 8, 00\\ 9, 00\\ 10, 00\\ 11, 00\\ 12, 00\\ 13, 00\\ 14, 00\\ 15, 00\\ 16, 00\\ 17, 00\\ 18, 00\\ 19, 00\\ 20, 00\\ 21, 00\\ 1, 00\\ 10, 0\\ 10, 0\\ 10, 0\\ 10, 0\\ 10, 0$	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) Total (sum of lines 1-19) Total cost to be allocated		1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			22, 4 22, 4 16, 7	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 31 0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 20.\ 00\\ 20.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$
22.00	Cost Center Description	0. 000000 PHARMACY (COSTED REQUI S.) 15. 00	5. 275096 MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16. 00	_	0.000000	0. 7470	46 0. 000000	0. 000000	-
12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 396, 476 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00

Heal th	n Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST	S			CCN: 150001	Peri od:	Worksheet H-3	
				HHA CCN:	157510	From 01/01/2014 To 12/31/2014		
				Ti tl	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
	cost center bescription	H-2, Part I,	(from Wkst.	Ancillary	Costs (col s.		Per Visit	
		col. 28, line		Costs (from	+ 2)		(col. 3 ÷ col.	
				Part II)			4)	
	PART I - COMPUTATION OF LESSER		1.00		3.00	4.00	5.00	
	BENEFICIARY COST LIMITATION	OF AGGREGATE F	KUGRAM CUST, A	GGREGATE OF T	1E PRUGRAW LII	WITATION COST, O	τ	
	Cost Per Visit Computation						_	
1.00	Skilled Nursing Care	2.00			789, 5			1.00
2.00	Physical Therapy	3.00						
3.00	Occupational Therapy	4.00						3.00
4.00 5.00	Speech Pathology Medical Social Services	5.00) 1, 0 1, 8			4.00 5.00
6.00	Home Heal th Ai de	7.00			13, 3			•
7.00	Total (sum of lines 1-6)		1, 255, 164					7.00
					Program Visi			
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject Deductibles Coinsurance	& Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation	1	1	1	1		1	
8.00	Skilled Nursing Care		18020	(14		8.00
8.01	Skilled Nursing Care Physical Therapy		26900 18020					8.01
9.00 9.01	Physical Therapy		26900			02 99		9.00 9.01
10.00	Occupational Therapy		18020			44		10.00
10.01			26900	0	4	67		10.01
11.00	1 35		18020	0	D	0		11.00
11.01	1 35		26900	(7		11.01
12.00			18020			0 5		12.00
12. 01 13. 00	Medical Social Services Home Health Aide		26900 18020			5 16		12.01 13.00
13.00	Home Heal th Aide		26900			18		13.00
14.00			20,000		2,9			14.00
	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)		
		0	1.00	Part II) 2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput		1.00	2.00	0.00	1.00	0.00	
15.00	Cost of Medical Supplies	8.00		(18, 7	30 0		
16.00	Cost of Drugs	9.00			-	0 0	0.000000	16.00
			Program Visits		Cost of Services			
			Par	tВ	Services	Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	UF AGGREGATE F	YRUGRAM CUST, A	GGREGATE OF I	1E PRUGRAM LI	WITATION COST, O	≺	
1.00	Skilled Nursing Care	0	1, 396			0 400, 373		1.00
2.00	Physical Therapy	0				0 124, 752		2.00
3.00	Occupational Therapy	0				0 99, 400		3.00
4.00	Speech Pathology	0				0 347		4.00
5.00	Medical Social Services	0				0 763		5.00
6.00 7.00	Home Health Aide Total (sum of lines 1–6)	0				0 5, 802 0 631, 437		6.00 7.00
1.00	Total (Sum of TITIES 1-0)	1 0	2,954	I	T	US1,437	I I	1 7.00

	DNMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150001	Period:	Worksheet H-3	3
				HHA CCN:	157510	From 01/01/2014 To 12/31/2014	Part I Date/Time Pre 5/21/2015 1:2	
				Titl	e XVIII	Home Health Agency I	PPS	2.7 pili
	Cost Center Description		7.00		0.00		11.00	
1.1	imitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
	killed Nursing Care							8.0
	Skilled Nursing Care							8.0
	hysical Therapy							9. (
	hysical Therapy							9. (
0.00 0	occupational Therapy							10.0
0. 01 0	occupational Therapy							10.
1.00 S	speech Pathol ogy							11.
1.01 S	speech Pathol ogy							11.
2.00 M	ledical Social Services							12.0
	ledical Social Services							12.0
	lome Health Aide							13.
	lome Health Aide							13.
4.00 T	otal (sum of lines 8-13)							14.
		Prog	ram Covered Cha	rges	Cost of Services			
			Par	+ D		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	-
	cost center bescription	Part A	Deductibles &		Part A	Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	+
Si	upplies and Drugs Cost Computa	ations						
	cost of Medical Supplies	0	-	0				15.
6.00 C	Cost of Drugs		0	0		0) 16.0
	Cost Center Description	Total Program						
		Cost (sum of						
		col s. 9-10)						-
D	ART I - COMPUTATION OF LESSER	12.00)	-
	ENEFICIARY COST LIMITATION	OF AGGREGATE F	KUGRAW CUST, A	GGREGATE OF IN	E PRUGRAW LI	WITATION COST, OF	ί.	
	ost Per Visit Computation							1
	skilled Nursing Care	400, 373						1 1.0
	hysical Therapy	124, 752						2.
	ccupational Therapy	99, 400						3.
	peech Pathology	347						4.
I	ledical Social Services	763						5.
. UU M	lome Health Aide	5, 802						6.
	otal (sum of lines 1-6)	631, 437						7.0
. 00 H	Cost Center Description							
. оо 🛛 н								
. оо 🛛 н		12.00						
. 00 H . 00 T	imitation Cost Computation	12.00						
. 00 H . 00 T	· · · · · · · · · · · · · · · · · · ·	12.00						8.
00 H 00 T Li 00 S 01 S	imitation Cost Computation killed Nursing Care killed Nursing Care	12.00						8.
00 H 00 T Li 00 S 01 S	imitation Cost Computation killed Nursing Care	12.00						8.
00 H 00 T Li 00 S 01 S 00 P	imitation Cost Computation killed Nursing Care killed Nursing Care	12.00						8. 9.
00 H 00 T Li 00 S 01 S 00 P 01 P	imitation Cost Computation killed Nursing Care killed Nursing Care hysical Therapy	12.00						8. 9. 9.
. 00 H . 00 T . 00 S . 01 S . 00 P . 01 P 0. 00 0 0. 01 0	imitation Cost Computation killed Nursing Care killed Nursing Care hysical Therapy hysical Therapy ccupational Therapy ccupational Therapy	12.00						8. 9. 9. 10.
. 00 H . 00 T . 00 S . 01 S . 00 P . 01 P 0. 00 0 0. 01 0 1. 00 S	imitation Cost Computation ikilled Nursing Care ikilled Nursing Care hysical Therapy Physical Therapy Iccupational Therapy	12.00						8. 9. 9. 10. 10. 11.
.00 H .00 T .00 S .01 S .00 P .01 P 0.00 0 0.01 0 1.00 S 1.01 S	imitation Cost Computation ikilled Nursing Care ikilled Nursing Care ihysical Therapy ihysical Therapy iccupational Therapy iccupational Therapy ispeech Pathology ispeech Pathology	12.00						8. 9. 10. 10. 11. 11.
.00 H .00 T .00 S .01 S .00 P .01 P 0.00 0 0.01 0 1.00 S 1.01 S	imitation Cost Computation killed Nursing Care killed Nursing Care hysical Therapy hysical Therapy occupational Therapy occupational Therapy opeech Pathology	12.00						8. 9. 10. 10. 11. 11.
.00 H .00 T .00 S .01 S .01 P .01 P 0.00 0 0.01 0 1.00 S 1.01 S 2.00 M	imitation Cost Computation ikilled Nursing Care ikilled Nursing Care ihysical Therapy ihysical Therapy iccupational Therapy iccupational Therapy ispeech Pathology ispeech Pathology	12.00						8. 9. 10. 10. 11. 11. 12.
. 00 H . 00 T . 00 T . 00 S . 01 S . 00 P . 01 P 0. 00 0 0. 01 0 1. 00 S 1. 01 S 2. 00 M 2. 01 M 3. 00 H	imitation Cost Computation ikilled Nursing Care ikilled Nursing Care Physical Therapy Physical Therapy Iccupational Therapy Iccupational Therapy ispeech Pathology ispeech Pathology Iedical Social Services	12.00						8. 9. 9. 10. 11. 11. 12. 12. 13.
.00 H .00 T .00 S .01 S .00 P .01 P 0.00 0 0.01 0 1.00 S 1.01 S 2.00 M 2.00 H 3.00 H 3.00 H	imitation Cost Computation ikilled Nursing Care ikilled Nursing Care Physical Therapy Physical Therapy Iccupational Therapy Iccupational Therapy Iccupational Therapy Iccupational Services Iedical Social Services	12.00						8. 9. 10. 10. 11. 11. 12. 12.

Health Financial Systems		JOHNSON MEMORI	AL HOSPITA	-	In Li	eu of Form CMS-	2552-10
APPORTIONMENT OF PATIENT SERVICE CO	STS		Provi	ler CCN: 150001	Peri od:	Worksheet H-3	
					From 01/01/2014		
			HHA CO	N: 157510	To 12/31/2014		
						5/21/2015 1:2	9 pm
				itle XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Total HH.	A HHA Share	d Transfer to		
	Part I, col.	Ratio	Charge (fr	om Ancillary	/ Part Las		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)	I		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF CC	ST OF HHA SERVI	CES FURNI SHED B	Y SHARED HO	SPITAL DEPARTM	ENTS		
1.00 Physical Therapy	66.00	0. 446091		0	0 col. 2, line 2	2.00	1.00
2.00 Occupational Therapy	67.00	0. 227841		0	0 col. 2, line 3	3. 00	2.00
3.00 Speech Pathology	68.00	0. 391285		0	Ocol. 2, line 4	1.00	3.00
4.00 Cost of Medical Supplies	71.00	0. 467272		0	0 col. 2, line '	15.00	4.00
5.00 Cost of Drugs	73.00	0. 421393		o	0 col. 2, line 1	16.00	5.00

LCULATION OF	Systems JOHNSON MEMORI HHA REIMBURSEMENT SETTLEMENT		CCN: 150001	Peri od:	worksheet H-4	
		HHA CCN:	157510	From 01/01/2014	Part I-II	par
		Title	e XVIII	Home Health Agency I	PPS	. / p
					t B	
			Part A		Deductibles &	
			1 00	Coinsurance	Coi nsurance	
	COMPUTATION OF THE LESSER OF REASONABLE COST OR CU		1.00	2.00	3.00	
	e Cost of Part A & Part B Services	STOWART CHARGE				1
	e cost of services (see instructions)			0 0	0	1 1
00 Total ch	. ,			0 0		
Customary	r Charges					
	ctually collected from patients liable for payment	for services		0 0	0	3
	rge basis (from your records)					
	nat would have been realized from patients liable f			0 0	0	4
	ces on a charge basis had such payment been made i CFR §413.13(b)	n accordance				
	line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	5
	stomary charges (see instructions)		5.0000	0 0	0.000000	
	f total customary charges over total reasonable cos	t (complete	1	0 0	0	
	ine 6 exceeds line 1)					
	f reasonable cost over customary charges (complete	onlyifline		0 0	0	8
	s line 6)			0 0	0	
00 Primary	payer amounts			Part A	Part B	9
				Servi ces	Servi ces	
PART II -	COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	-
	asonable cost (see instructions)			0	0	10
	S Reimbursement - Full Episodes without Outliers			0	548, 281	
00 Total PP	S Reimbursement - Full Episodes with Outliers			0	0	12
	S Reimbursement - LUPA Episodes			0	1, 799	
	S Reimbursement – PEP Episodes			0	0	
00 Total PP	S Outlier Reimbursement - Full Episodes with Outlie	rs		0	0	
		15		0		
00 Total PP	S Outlier Reimbursement - PEP Episodes			0	0	
00 Total PP 00 Total Otl	S Outlier Reimbursement - PEP Episodes ner Payments			0	0	1
00 Total PP 00 Total Otl 00 DME Paym	S Outlier Reimbursement – PEP Episodes ner Payments ents			000000000000000000000000000000000000000	0	1 1
00TotalPP00TotalOtl00DMEPayme00OxygenPayme	S Outlier Reimbursement - PEP Episodes ner Payments ents ayments				0	1 18 19
00 Total PP 00 Total Ot 00 DME Paymo 00 Oxygen Pa 00 Prosthet	S Outlier Reimbursement - PEP Episodes ner Payments ents ayments c and Orthotic Payments			0 0 0 0 0	0 0 0	1 18 19 20
00Total PP00Total Ot00DME Payme00Oxygen Pa00Prosthet00Part B da	S Outlier Reimbursement - PEP Episodes ner Payments ents ayments				0 0 0	1 18 19 20 21
00Total PP00Total Ott00DME Paym000xygen Pa00Prostheti00Part B de00Subtotal00Excess re	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8)				0 0 0 0 550, 080 0	1 18 19 20 21 22 23
00Total PP00Total Ott00DME Paym00Oxygen P00Prostheti00Part B da00Subtotal00Excess rd00Subtotal	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23)				0 0 0 550, 080 550, 080	17 18 20 21 22 23 24
00 Total PP 00 Total 0tt 00 DME Paym 00 Oxygen P 00 Prostheti 00 Part B dd 00 Subtotal 00 Excess ro 00 Subtotal 00 Coinsurad	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nee billed to program patients (from your records)				0 0 0 550, 080 0 550, 080 0 550, 080	11 18 20 21 22 23 24 25
00 Total PP 00 Total Otl 00 DME Paymo 00 Oxygen P 00 Prostheti 00 Part B dd 00 Subtotal 00 Excess rd 00 Subtotal 00 Coinsural 00 Net cost	S Outlier Reimbursement - PEP Episodes her Payments ents ayments ic and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nee billed to program patients (from your records) (line 24 minus line 25)				0 0 0 550, 080 0 550, 080 0	11 18 20 21 22 23 24 25 26
00 Total PP 00 Total Otl 00 DME Paymm 00 Oxygen P 00 Prostheti 00 Part B d 00 Subtotal 00 Excess r 00 Subtotal 00 Coinsural 00 Net cost 00 Reimburs:	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) hee billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records)	nsurance)			0 0 0 550, 080 0 550, 080 0 550, 080	17 18 20 21 22 23 24 25 26 27
00 Total PP 00 Total 0tl 00 DME Payme 00 Oxygen Pa 00 Prostheti 00 Part B de 00 Subtotal 00 Excess ro 00 Subtotal 00 Coinsuraa 00 Net cost 00 Reimbursa 00 Reimbursa	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nee billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records) able bad debts for dual eligible beneficiaries (see	nsurance)			0 0 0 550, 080 0 550, 080 0 550, 080	17 18 19 20 21 22 23 24 25 26 25 26 25 26
00 Total PP 00 Total 0tl 00 DME Payme 00 Oxygen Pi 00 Prosthet 00 Part B de 00 Subtotal 00 Excess re 00 Subtotal 00 Coinsuraa 00 Net cost 00 Reimburs: 00 Reimburs: 00 Total cost	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nee billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records) able bad debts for dual eligible beneficiaries (see sts - current cost reporting period (line 26 plus l	nsurance)			0 0 0 550, 080 0 550, 080 0 550, 080	17 18 19 20 21 22 23 24 25 26 27 28 26 27 28 26 27 28 29
00Total PP00Total Ott00DME Paym00Oxygen Pa00Prostheti00Part B d00Subtotal00Subtotal00Coinsuran00Net cost00Reimbursa00Total cos00OTHER AD	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nee billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records) able bad debts for dual eligible beneficiaries (see	nsurance) i instructi ons) i ne 27)			0 0 0 550, 080 0 550, 080 0 550, 080 550, 080	17 18 19 20 21 22 22 22 24 25 26 27 28 26 27 28 26 27 28 26 30
00Total PP00Total Ott00DME Paym00Oxygen P00Prostheti00Part B da00Subtotal00Excess ra00Subtotal00Coinsura00Net cost00Reimburs00Reimburs00OTtal cos00OTHER AD50Pioneer	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nee billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records) able bad debts for dual eligible beneficiaries (see sts - current cost reporting period (line 26 plus l JUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	nsurance) i instructi ons) i ne 27)			0 0 0 550, 080 0 550, 080 550, 080 550, 080 0	11 18 19 20 21 22 20 24 25 26 27 28 26 27 28 26 27 28 26 30 30 30
00Total PP00Total Ott00DME Paym00Oxygen Pa00Posthett00Part B dd00Subtotal00Excess r00Subtotal00Coinsuran00Coinsuran00Reimbursa00Reimbursa00Total co00OTHER AD50Pioneer a00Subtotal01Sequestra	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) here billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records) able bad debts for dual eligible beneficiaries (see sts - current cost reporting period (line 26 plus I JUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ACO demonstration payment adjustment (see instructi (see instructions)	nsurance) i instructi ons) i ne 27)			0 0 0 550, 080 0 550, 080 0 550, 080 0 0 550, 080 0 550, 080 11, 002	11 18 20 22 22 22 22 22 22 22 22 22 22 22 22
00Total PP00Total Ott00DME Paym00Oxygen Pa00Postheti00Part B dd00Subtotal00Excess r00Subtotal00Coinsural00Coinsural00Reimbursa00Reimbursa00Total co:00OTHER AD50Pioneer A00Subtotal01Sequestra00Interim	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nee billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records) able bad debts for dual eligible beneficiaries (see sts - current cost reporting period (line 26 plus I JUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ACO demonstration payment adjustment (see instructi (see instructions) ation adjustment (see instructions) payments (see instructions)	nsurance) i instructi ons) i ne 27)			0 0 0 550, 080 0 550, 080 0 550, 080 0 550, 080 0 550, 080 11, 002 539, 078	11 18 19 20 22 22 22 22 22 22 22 22 22 22 22 22
.00Total PP.00Total Ott.00DME Paym.00Oxygen Pa.00Prostheti.00Part B d.00Subtotal.00Subtotal.00Subtotal.00Coinsural.00Reimbursi.00Reimbursi.00Reimbursi.00OTotal cost.00OTHER AD.50Pioneer a.00Subtotal.01Sequestra.00Interim I.00Tentati vol	S Outlier Reimbursement - PEP Episodes her Payments ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nce billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records) able bad debts for dual eligible beneficiaries (see sts - current cost reporting period (line 26 plus I JUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ACO demonstration payment adjustment (see instructi (see instructions) ation adjustment (see instructions) e settlement (for contractor use only)	nsurance) instructions) ine 27) ons)			0 0 0 550, 080 0 550, 080 0 550, 080 0 550, 080 0 550, 080 11, 002 539, 078 0	17 18 19 20 21 22 23 24 25 26 27 28 26 27 28 26 27 28 26 27 30 30 30 31 31 32 33
.00Total PP.00Total Ott.00Total Ott.00DME Paym.00Oxygen Pa.00Prosthett.00Part B d.00Subtotal.00Subtotal.00Coinsurat.00Net cost.00Reimbursa.00Reimbursa.00Total cost.00OTATAL cost.00OTHER AD.50Pioneer a.01Sequestra.00Interim p.00Balance o	S Outlier Reimbursement - PEP Episodes her Payments ents ayments c and Orthotic Payments eductibles billed to Medicare patients (exclude coi (sum of lines 10 thru 20 minus line 21) easonable cost (from line 8) (line 22 minus line 23) nee billed to program patients (from your records) (line 24 minus line 25) able bad debts (from your records) able bad debts for dual eligible beneficiaries (see sts - current cost reporting period (line 26 plus I JUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) ACO demonstration payment adjustment (see instructi (see instructions) ation adjustment (see instructions) payments (see instructions)	nsurance) instructions) ine 27) ons) , and 33)	Dub 15-2		0 0 0 550, 080 0 550, 080 0 550, 080 0 550, 080 0 550, 080 11, 002 539, 078	177 188 199 200 211 222 233 244 255 266 277 288 299 300 311 311 322 333 34

	IS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED M BENEFICIARIES	Provider HHA CCN:	CCN: 150001 157510	F	eriod: rom 01/01/2014 p 12/31/2014	Worksheet H-5 Date/Time Prep 5/21/2015 1:29	bared
					Home Health Agency I	PPS	² piii
		 Inpatien	nt Part A			t B	
		dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00	-	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		539, 078 0	1. (2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3. (
	Program to Provider		1	_		-	_
01 02 03				0000		0 0 0 0	3. 3. 3. 3.
04 05				0		0	з. З.
05	Provider to Program			0		0	э.
50				0		0	3.
50 51				0		0	3.
52				0		0	3.
53				0		0	3
53 54				0		0	3
99 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	3
19				0		0	3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		539, 078	4
	TO BE COMPLETED BY CONTRACTOR						
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5
	Program to Provider						
)1				0		0	5
)2				0		0	5
)3				0		0	5
	Provider to Program						
0		 		0		0	5
1				0		0	5
2				0		0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)						6
01	SETTLEMENT TO PROVIDER			0		0	6
02	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)			0		539, 078	7
					Contractor	NPR Date	
					Number	(Mo/Day/Yr)	

ALCULATI ON	OF CAPITAL PAYMENT	Provider CCN: 150001	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Pre 5/21/2015 1:20	
		Title XVIII	Hospi tal	PPS	7 pm
				1.00	
	I - FULLY PROSPECTIVE METHOD				
	AL FEDERAL AMOUNT				
	al DRG other than outlier			450, 637	1.0
1	4 BPCI Capital DRG other than outlier			0	1.0
	al DRG outlier payments			4, 226	2.0
	4 BPCI Capital DRG outlier payments inpatient days divided by number of days in the cost r	connecting pariod (can incl	ructions)	0 19. 91	2. C 3. C
	r of interns & residents (see instructions)	eporting period (see thst	ructions)	0, 00	4.0
	ect medical education percentage (see instructions)			0.00	4. C
	ect medical education percentage (see first detroits) ect medical education adjustment (multiply line 5 by th	a sum of lines 1 and 1 01)	0.00	6.0
	intage of SSI recipient patient days to Medicare Part A			0.00	7.0
	see instructions)	patrent days (worksheet E		0.00	/.0
	ntage of Medicaid patient days to total days (see instr	ructions)		0.00	8.0
	flines 7 and 8			0.00	9.0
	able disproportionate share percentage (see instruction	is)		0.00	10.0
	oportionate share adjustment (line 10 times the sum of			0	11.0
. 00 Total	prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		454, 863	12. C
DADT				1.00	
	II - PAYMENT UNDER REASONABLE COST			0	1 1.0
	am inpatient routine capital cost (see instructions) am inpatient ancillary capital cost (see instructions)			0	2.0
- 3	inpatient program capital cost (line 1 plus line 2)			0	3.0
	al cost payment factor (see instructions)			0	4.0
	inpatient program capital cost (line 3 x line 4)			0	5.0
oo rotu					0.10
				1.00	
	III - COMPUTATION OF EXCEPTION PAYMENTS				
	am inpatient capital costs (see instructions)			0	1.0
	am inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2.0
5	rogram inpatient capital costs (line 1 minus line 2)			0 0.00	3. C 4. C
00 Net p					4.C
00 Netp 00 Appli	cable exception percentage (see instructions)		I		
00 Net p 00 Appli 00 Capit	al cost for comparison to payments (line 3 x line 4)	nstructions)		0	6 6 7
00 Net p 00 Appli 00 Capit 00 Perce	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i	<i>,</i>	line 6)	0.00	
00 Net p 00 Appli 00 Capit 00 Perce 00 Adjus	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar	<i>,</i>	:line 6)	0. 00 0	7.0
00 Net p 00 Appli 00 Capit 00 Perce 00 Adjus 00 Capit	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7)	y circumstances (line 2 x	tline 6)	0. 00 0 0	6.0 7.0 8.0
DONet pDOAppl iDOCapi tDOPerceDOAdj usDOCapi tDOCurre	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7) nt year capital payments (from Part I, line 12, as appl	ry circumstances (line 2 x icable)	,	0. 00 0	7. C 8. C 9. C
DONet pDOAppl iDOCapi tDOPerceDOAdj usDOCapi tDOCurre. 00Curre	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7)	ry circumstances (line 2 x icable) capital payments (line 8	less line 9)	0.00 0 0 0	7. C 8. C
DONet pDOAppl iDOCapi tDOPerceDOAdj usDOCapi tDOCurreDOCurreDOCarry	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7) nt year capital payments (from Part I, line 12, as appl nt year comparison of capital minimum payment level to	ry circumstances (line 2 x icable) capital payments (line 8	less line 9)	0.00 0 0 0 0	7. C 8. C 9. C 10. C
D0Net pD0AppliD0CapitD0PerceD0AdjusD0CapitD0Curre00Curre00Curre00CarryWorks	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7) nt year capital payments (from Part I, line 12, as appl nt year comparison of capital minimum payment level to over of accumulated capital minimum payment level over	ry circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri	less line 9) or year	0.00 0 0 0 0	7. C 8. C 9. C 10. C
D0 Net p D0 Appli D0 Capit D0 Perce D0 Adjus D0 Capit D0 Capit D0 Capit D0 Capit D0 Curre .00 Carry Works .00	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7) nt year capital payments (from Part I, line 12, as appl nt year comparison of capital minimum payment level to over of accumulated capital minimum payment level over heet L, Part III, line 14)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri payments (line 10 plus lin	less line 9) or year ne 11)	0.00 0 0 0 0 0	7. 0 8. 0 9. 0 10. 0 11. 0
00 Net p 00 Appli 00 Capit 00 Capit 00 Adjus 00 Capit 00 Capit 00 Capit 00 Capit 00 Curre 00 Curre 00 Curre 00 Net c 00 Curre 00 Curre 00 Curre 00 Curre 00 Curre	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7) nt year capital payments (from Part I, line 12, as appl nt year comparison of capital minimum payment level to over of accumulated capital minimum payment level over heet L, Part III, line 14) omparison of capital minimum payment level to capital p	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri payments (line 10 plus lin er the amount on this line	less line 9) or year ne 11) e)	0.00 0 0 0 0 0 0	7. 0 8. 0 9. 0 10. 0 11. 0
00 Net p 00 Appli 00 Capit 00 Capit 00 Adjus 00 Capit 00 Capit 00 Capit 00 Capit 00 Curre 00 Curre	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7) nt year capital payments (from Part I, line 12, as appl nt year comparison of capital minimum payment level to over of accumulated capital minimum payment level over heet L, Part III, line 14) omparison of capital minimum payment level to capital p nt year exception payment (if line 12 is positive, enter over of accumulated capital minimum payment level over	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line or the amount on this line capital payment for the f	less line 9) or year ne 11) e)	0.00 0 0 0 0 0 0 0	7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0
00 Net p 00 Appl i 00 Capi t 00 Perce 00 Adj us 00 Cari t 00 Curre .00 Curre .00 Curre .00 Net c .00 Curre .00 Curre .00 Curre .00 Curre	al cost for comparison to payments (line 3 x line 4) ntage adjustment for extraordinary circumstances (see i tment to capital minimum payment level for extraordinar al minimum payment level (line 5 plus line 7) nt year capital payments (from Part I, line 12, as appl nt year comparison of capital minimum payment level to over of accumulated capital minimum payment level over heet L, Part III, line 14) omparison of capital minimum payment level to capital p nt year exception payment (if line 12 is positive, enter over of accumulated capital minimum payment level over ine 12 is negative, enter the amount on this line)	y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line or the amount on this line capital payment for the f	less line 9) or year ne 11) e)	0.00 0 0 0 0 0 0 0 0 0	7. C 8. C 9. C 10. C 11. C 12. C 13. C 14. C