| Heal th Financi | al Systems | JOHNSON MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2552-10 |
|----------------------------------|--|--------------------------|----------------------|------------------------|--|
| This report is | required by law (42 USC 1395g | 42 CFR 413.20(b)). Fai | lure to report can r | esult in all interim | FORM APPROVED |
| payments made | since the beginning of the cos | t reporting period being | deemed overpayments | (42 USC 1395g). | OMB NO. 0938-0050 EXPIRES 05-31-2019 |
| HOSPITAL AND H AND SETTLEMENT | IOSPITAL HEALTH CARE COMPLEX CO SUMMARY | ST REPORT CERTIFICATION | Provider CCN: 15-000 | From 01/01/2016 | Worksheet S Parts I-III Date/Time Prepared: 1/16/2018 3:01 pm |
| PART I - COST | REPORT STATUS | | | | |
| Provider use only | 1. [X] Electronically filed c 2. [] Manually submitted cos | | | Date: 1/16/20 | 18 Time: 3:01 pm |
| 5 | 3. [1] If this is an amended 4. [F] Medicare Utilization. | report enter the number | | er resubmitted this co | ost report |
| Contractor use only | 5. [5]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopend | . Contractor No. | r this Provider CCN | | |

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHNSON MEMORIAL HOSPITAL (15-0001) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

Officer or Administrator of Provider(s)

Title

| | | | Title | XVIII | | | |
|--------|-------------------------------|---------|----------|---------|------|-----------|--------|
| | Cost Center Description | Title V | Part A | Part B | HIT | Title XIX | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | PART III - SETTLEMENT SUMMARY | | | | | | |
| 1.00 | Hospi tal | 0 | -60, 415 | 79, 366 | 0 | -50, 816 | 1.00 |
| 2.00 | Subprovider - IPF | 0 | 0 | 0 | | 0 | 2.00 |
| 3.00 | Subprovider - IRF | 0 | 0 | -5 | | 9, 568 | 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 | 19 | | 0 | 9.00 |
| 200.00 | Total | 0 | -60, 415 | 79, 380 | 0 | -41, 248 | 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.

Date

| | Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I | DENTIFICATION DA | | | ler CCN | l: 15-00 | | Period: From 01/01/ To 12/31/ | ′2016 ′2016 | Worksho Part I Date/Ti | <u>rm CMS-</u> eet S-2 ime Pre 018 3:0 | pared: |
|---|--|--|--|---|--|--|----------------------------------|---|---------------------|------------------------------|---|---|
| | 1.00 Hospital and Hospital Health Care Co | | 00 | | 3.00 | | | · · · · | 4.00 | | | |
| 1.00 | Street: 1125 WEST JEFFERSON STREET | P0 Box: | | | | | | | | | | 1.00 |
| 2.00 | City: FRANKLIN | State: I | N | Zip Cod | | | | y: JOHNSON | | | | 2.00 |
| | | Component Na | ame | CCN | CBS | | ovi der | Date | | nt Syst | | |
| | | | | Number | Numbe | er | Туре | Certified | I, V | 0, or XVIII | | |
| | | 1.00 | | 2.00 | 3.00 | | 4.00 | 5.00 | 6. 00 | - | 8.00 | |
| | Hospital and Hospital-Based Componen | | | 2.00 | 0.00 | <u> </u> | 1.00 | 0.00 | 0.00 | 17.00 | 1 0.00 | |
| 3.00 | Hospi tal | JOHNSON MEMORIAL | | 150001 | 2690 | 0 | 1 | 07/01/1966 | N | Р | 0 | 3.00 |
| | | HOSPI TAL | | | | | | | | | | |
| 4.00 | Subprovi der – IPF Subprovi der – IRF | | | 157001 | 2400 | | F | 01/01/2005 | N | P | 0 | 4.00 |
| 5.00 | Subprovider - TRF | TODD AIKENS REHAE CENTER | Б | 15T001 | 2690 | | 5 | 01/01/2005 | N | P | | 5.00 |
| 6.00 7.00 8.00 9.00 10.00 11.00 12.00 | Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital-Based SNF Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA | JOHNSON MEMORIAL | HOME | 157510 | 2690 | 00 | | 07/01/1997 | N | Ρ | N | 6.00 7.00 8.00 9.00 10.00 11.00 12.00 |
| 14.00 15.00 16.00 17.00 18.00 | Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FOHC Hospital-Based (CMHC) I Renal Dialysis Other | | | | | | | | | | | 13.00 14.00 15.00 16.00 17.00 18.00 19.00 |
| | | | | | | | | From: | | To | | - |
| | Cost Reporting Period (mm/dd/yyyy) | | | | | | | 1.00 01/01/2 | | 2. 12/31 | | 20.00 |
| 21.00 | Type of Control (see instructions) Inpatient PPS Information | | | | | | | 9 | | | | 21.00 |
| 22.00 | Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en | ance with 42 CFR ity subject to 42 | §412.106 CFR Sec | o? In co tion §47 | olumn 1 | l, ente | er "Y" | e Y | | Ν | l | 22.00 |
| 22.01 | Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions) | es or "N" for no October 1. Enter | for the in colum | portion n 2, "Y' | of the for y | e cost /es or | "N" | Y | | Ŷ | , | 22.01 |
| 22.02 | Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1. | ? (see instructio e cost reporting | ons) Ente period p | er in col prior to | umn 1, Octobe | "Y" f er 1. E | for yes Enter | | | Ν | l | 22.02 |
| 22.03 | 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 o hospital contain at least 100 but no | statistical area no for the portio 2, "Y" for yes or r after October 1 t more than 499 b | as adopte on of the "N" for L. (see i beds (as | ed by CMS cost re no for nstructi counted | 5 in FY eportin the po ons) D | (2015? ng peri ortion Does th | Enter od of the nis | e | | Ν | l | 22. 03 |
| 23.00 | 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per | dicaid days on li f census days, or is cost reporting | nes 24 a 3 if da period 2, enter | nd/or 25 ite of di differer "Y" for | scharg nt from <u>yes or</u> | ge. Is n the m <u>~ "N" f</u> | the nethod <u>for no</u> . | | 2 | N | | 23.00 |
| | | | In-Stat Medicai paid day | d Medi ys elig unp da | ys | Out-d Stat Medica paid d | e aid M ays e | State H Medicaid eligible unpaid | ledi cai IMO day | /s Med | ther di cai d days | |
| | If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out of ctate Medicaid days in col | n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, | | 13 2. 2. | 00 575 72 | 3.00 | 0 | 4.00 0 0 | 5.00 | 72 | <u>6.00</u> C | 24.00 |
| | out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day | umn 4, Medicaid | | | | | | | | | | |

| | Financial Systems JOHNSON AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT | | AL HOSPITAL Provider CC | N: 15-0001 | Period: From 01/ | 01/2016 | wu of For Workshe Part I | eet S-2 | |
|--------------|--|-----------------------------|---|--|-------------------------|-----------|--------------------------------|--------------|----------------|
| | | | | | To 12/ | 31/2016 | Date/Ti 1/16/20 | | |
| | | | | | | | Date of | Geogr | |
| 6. 00 | Enter your standard geographic classification (not wag | ne) sta | atus at the her | inning of | | . 00 | 2. (| 00 | 26.00 |
| | cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wac | rural. je) sta | atus at the end | of the co | | 1 | | | 27.00 |
| E 00 | reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassific | ati on | in column 2. | | D | C | | | 25.0 |
| 5.00 | If this is a sole community hospital (SCH), enter the effect in the cost reporting period. | nuiibei | or periods 30 | n status i | | Ľ | , | | 35.00 |
| | | | | | | nni ng: | Endi | | |
| 6.00 | Enter applicable beginning and ending dates of SCH sta | itus. S | Subscript line | 36 for num | | . 00 | 2.0 | 0 | 36.0 |
| | of periods in excess of one and enter subsequent dates If this is a Medicare dependent hospital (MDH), enter | 5. | · | | | C |) | | 37.0 |
| 7. 01 | is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) | | | | | | | | 37.0 |
| 8. 00 | If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. | | | | | | | | 38.0 |
| | enter subsequent dates. | | | | | ′/N | Y/ | | |
| 9.00 | Does this facility qualify for the inpatient hospital | pavmer | nt adiustment f | or low vol | | . 00 Y | 2. (| | 39.0 |
| | hospitals in accordance with 42 CFR §412.101(b)(2)(ii) or "N" for no. Does the facility meet the mileage requ CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes c | ? Ente uiremer or "N" | er in column 1 nts in accordan for no. (see i | "Y" for ye ce with 42 nstruction | s) | | | | |
| 0. 00 | Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobe no in column 2, for discharges on or after October 1. | er 1. E | Enter "Y" for y | | | N | N | | 40.0 |
| | T | | | | | V 1.0 | XVIII 0 2.00 | XI X 3.00 | |
| | Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment | for c | li sproporti opat | o sharo in | accordance | e N | N | N | 45.0 |
| | with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excep pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. | otion f | °or extraordina | ry circums | tances | N | N | N | 46.0 |
| 7.00 8.00 | Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capit Is the facility electing full federal capital payment? | | | | | N N | N N | N N | 47. 0 48. 0 |
| 5. 00 | Teaching Hospitals Is this a hospital involved in training residents in a | approve | ed GME programs | ? Enter " | Y" for yes | N | | | 56.0 |
| 7.00 | or "N" for no. If line 56 is yes, is this the first cost reporting pe GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes ar "N" for no in column 2. If column 2 is "V | yes or n of th | "N" for no in nis cost report | column 1. ing period | If column ? Enter "` | | | | 57. C |
| | for yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, | if ap | plicable. | | | | | | |
| 3. 00 | If line 56 is yes, did this facility elect cost reimbu defined in CMS Pub. 15–1, chapter 21, §2148? If yes, c | | | ns' servic | es as | N | | | 58. C |
| | Are costs claimed on line 100 of Worksheet A? If yes, | compl | ete Wkst. D-2, | | | N | | | 59. C |
| J. 00 | Are you claiming nursing school and/or allied health c provider-operated criteria under §413.85? Enter "Y" f | | | | | N | | | 60. C |
| | | Y/N | IME | Direct G | | ME | Direc | t GME | |
| | - | 1.00 | 2.00 | 3.00 | Δ | . 00 | 5. (| 00 | |
| | Did your hospital receive FTE slots under ACA | | 2.00 | 0.00 | | 0.00 | | | 61.0 |
| | section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care | | 0.00 | | 0. 00 | | | | 61. C |
| | FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) | | | | | | | | |
| | Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) | | 0. 00 | | 0.00 | | | | 61.0 |
| | Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see | | 0.00 | | 0. 00 | | | | 61.0 |
| 1. 04 | instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the | | 0.00 | | 0. 00 | | | | 61.0 |
| | current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line | | 0.00 | | 0. 00 | | | | 61.0 |

| IOSPI T | AL AND HOSPITAL HEALTH CARE COMPI | LEX IDENTIFICATION DA | ΛTΑ | Provider CC | N: 15-0001 Pe Fr Tc | eriod: fom 01/01/2016 0 12/31/2016 | Worksheet S-2 Part I Date/Time Pre 1/16/2018 3:0 | pared |
|---------|---|--|---|---|---|--|---|-------|
| | | | Y/N | IME | Direct GME | IME | Direct GME | |
| | | | 1.00 | 2.00 | 3. 00 | 4.00 | 5.00 | |
| 1.06 | Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in | that are nonprimary | | 0. 00 | 0.00 | | | 61.0 |
| | | | Pro | ogram Name | Program Code | Unweighted IME FTE Count | Unweighted Direct GME FTE Count | |
| 10 | | | | 1.00 | 2.00 | 3.00 | 4.00 | |
| I. 10 | Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count. | r of FTE residents uctions) Enter in r in column 2, the the IME FTE | | | | 0.00 | 0.00 | 61. |
| 1. 20 | Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou | he number of FTE ram. (see the program name, ode, enter in column and enter in column | | | | 0.00 | 0.00 | 61.2 |
| | | | | | | | 1.00 | |
| | ACA Provisions Affecting the Hea Enter the number of FTE resident | | | | | od for which | 0.00 | 62. |
| | your hospital received HRSA PCRE Enter the number of FTE resident | funding (see instruc | ctions) | | | | | 62. |
| | during in this cost reporting pe Teaching Hospitals that Claim Re | riod of HRSA THC prog | gram. (s | see instruction | | - · | | - |
| 3. 00 | Has your facility trained reside "Y" for yes or "N" for no in col | nts in nonprovider se | ettings | during this co | | eriod? Enter | N | 63.0 |
| | | | | | Unweighted FTEs | Unweighted FTEs in | Ratio (col. 1/ (col. 1 + col. | |
| | | | | | Nonprovi der | Hospi tal | 2)) | |
| | | | | | Si te 1.00 | 2.00 | 3.00 | - |
| | Section 5504 of the ACA Base Yea period that begins on or after J | | | | | | | |
| 4. 00 | Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column | yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in | ty trair n-primar all nor d non-pr n columr | ed residents y care provider imary care 3 the ratio | 0. 00 | 0. 00 | 0. 000000 | 64. |
| | | Program Name | Pro | ogram Code | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 3/ (col. 3 + col. 4)) | |
| - 00 | | 1.00 | | 2.00 | 3.00 | 4.00 | 5.00 | 15 |
| 5. 00 | Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column | | | | 0.00 | 0.00 | 0. 000000 | |

| Health Financial Systems | JOHNSON | MEMORIAL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--|---|--|--|---|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE (| COMPLEX IDENTIFICATION DA | TA Provider CCI | | eriod: com 01/01/2016 o 12/31/2016 | | pared: 1 pm |
| | | | Unweighted FTEs Nonprovider Site | Unweighted FTEs in Hospital | Ratio (col. 1/ (col. 1 + col. 2)) | |
| Section EEOA of the ACA Curr | ont Voor ETE Docidonte in | Nonnrovi dor Sotti nac | 1.00 | 2.00 | 3.00 | |
| Section 5504 of the ACA Curr beginning on or after July 1 | , 2010 | | sEffective fo | or cost reporti | ng periods | |
| 66.00 Enter in column 1 the number FTEs attributable to rotatio Enter in column 2 the number FTEs that trained in your ho | ns occurring in all nonpr of unweighted non-primar | ovider settings. y care resident | 0. 00 | 0. 00 | 0. 000000 | 66.00 |
| (column 1 divided by (column | 1 + column 2)). (see ins Program Name | tructions) Program Code | Unweighted | Unweighted | Ratio (col. 3/ | |
| | | Fi ogi alli Code | FTEs Nonprovi der Si te | FTEs in Hospital | (col. 3 + col. 4)) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | (7.00 |
| 67.00 Enter in column 1, the programe associated with each of your primary care programs i which you trained residents. Enter in column 2, the prograde code. Enter in column 3, the number of unweighted primary care FTE residents attributa to rotations occurring in al non-provider settings. Enter column 4, the number of unweighted primary care resident FTEs that trained i your hospital. Enter in column 3 divided by (column 3 + colum 4)). (see instructions) | n am ble i i n mn | | 0.00 | 0. 00 | 0. 000000 | 67.00 |
| | · · · | | | 1.0 | | |
| Inpatient Psychiatric Facili | ty PPS | | | 1.0 | 0 2.00 3.00 | |
| 70.00 Is this facility an Inpatien | t Psychiatric Facility (I | PF), or does it conta | in an IPF subp | rovider? N | | 70.00 |
| Enter "Y" for yes or "N" fo 71.00 If line 70 yes: Column 1: Di recent cost report filed on 42 CFR 412.424(d)(1)(iii)(c) program in accordance with 4 Column 3: If column 2 is Y, (see instructions) Inpatient Rehabilitation Fac | d the facility have an ap or before November 15, 20) Column 2: Did this faci 2 CFR 412.424 (d)(1)(iii) indicate which program ye ility PPS | 04? Enter "Y" for ye lity train residents (D)? Enter "Y" for ye ar began during this | s or "N" for n in a new teach s or "N" for n cost reporting | io. (see ii ng io. i peri od. | 0 | 71.00 |
| 75.00 Is this facility an Inpatien subprovider? Enter "Y" for | | (IRF), or does it co | ntain an IRF | Y | | 75.00 |
| 76.00 If line 75 yes: Column 1: Di recent cost reporting period no. Column 2: Did this facil CFR 412.424 (d)(1)(iii)(D)? indicate which program year | d the facility have an ap ending on or before Nove ity train residents in a Enter "Y" for yes or "N" | mber 15, 2004? Enter new teaching program for no. Column 3: If | "Y" for yes or in accordance column 2 is Y, | "N" for with 42 | 0 | 76.00 |
| | | | | | 1.00 | |
| Long Term Care Hospital PPS80.00Is this a long term care hos81.00Is this a LTCH co-located wi"Y" for yes and "N" for no. | | | | period? Enter | N N | 80. 00 81. 00 |
| TEFRA Providers 85.00 Is this a new hospital under 86.00 Did this facility establish | a new Other subprovider (| | | | N | 85. 00 86. 00 |
| §413.40(f)(1)(ii)? Enter "Y 87.00 Is this hospital a "subclaus for yes or "N" for no. | | nder section 1886(d)(| 1)(B)(iv)(II)? | | N | 87.00 |
| | | | | V 1.00 | XI X 2.00 | |
| Title V and XIX Services | | | | | | |
| 90.00 Does this facility have titl yes or "N" for no in the app | | hospital services? En | ter "Y" for | N | Y | 90.00 |
| 91.00 Is this hospital reimbursed full or in part? Enter "Y" f | for title V and/or XIX th | | either in | N | N | 91.00 |
| 92.00 Are title XIX NF patients oc | cupying title XVIII SNF b | eds (dual certificati | on)? (see | | N | 92.00 |
| 93.00 Does this facility operate a | n ICF/IID facility for pu | | XIX? Enter | N | N | 93. 00 |
| 94.00 "Y" for yes or "N" for no in poes title V or XIX reduce c applicable column. | | r yes, and "N" for no | in the | Ν | Ν | 94.00 |

| Health Financial Systems JOHNSON MEMORIA | AL HOSPITAL | | L | ר Lieu | u of For | m CMS- | 2552-10 |
|---|--|----------------------------------|------------------------|--------|----------------------|--------|--------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CC | CN: 15-0001 | Period: From 01/01/ | 2014 | Workshe Part I | et S-2 | 2 |
| | | | To 12/31/ | | Date/Ti | | |
| | | | V | | <u>1/16/20</u> XI | | 01 pm |
| | | | 1.00 | | 2. (| | - |
| 95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes | | | 0. 00 N | | 0. (N | | 95.00 96.00 |
| applicable column. 97.00 [ffline 96 is "Y", enter the reduction percentage in the appl | | | 0.00 | | 0. (| | 97.00 |
| Rural Providers | | 1. | | | 0.0 | | |
| 105.00 Does this hospital qualify as a critical access hospital (CAI 106.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions) | | nod of paymen | t N | | | | 105.00 106.00 |
| 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II. | 1. (see instr | ructions) If | t | | | | 107.00 |
| 108.00 Is this a rural hospital qualifying for an exception to the (CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | CRNA fee sched | dule? See 42 | N | | | | 108.00 |
| - | Physi cal 1.00 | Occupationa 2.00 | I Speec 3.00 | | Respir 4. (| | - |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. | N | N | N | | N | | 109.00 |
| | | | | | 1. (| 00 | - |
| 110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for ves or "N" | | on project (4 | 10A Demo)fo | ~ | N | | 110.00 |
| | | | | | | | _ |
| Miscellaneous Cost Reporting Information | | | | 1.00 | 2.00 | 3.00 | |
| 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers | If column 2 i it for long ter | is "E", enter rm care (incl | in column udes | N | | 0 | 115.00 |
| Pub.15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" 1 117.00 Is this facility legally-required to carry malpractice insura | | | "N" for | N Y | | | 116.00 |
| no. 118.00 s the malpractice insurance a claims-made or occurrence poli | | | | 2 | | | 118.00 |
| claim-made. Enter 2 if the policy is occurrence. | | Premi ums | Losse | s | Insur | ance | |
| | | | | - | | | |
| | | 1.00 | 2.00 | | 3. (| 00 | - |
| 118.01 List amounts of malpractice premiums and paid losses: | | 396, 7 | 54 6 | 3, 412 | | (| 0 118. 01 |
| | | | 1.00 | | 2.0 | 00 | - |
| 118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. | | | N | | 2.0 | | 118.02 |
| 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. | column 1, "Y alifies for th | ' for yes or ne Outpatient | | | Ν | | 119. 00 120. 00 |
| 121.00 Did this facility incur and report costs for high cost impla | ntable devices | s charged to | Y | | | | 121.00 |
| patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? I for no in column 1. If column 1 is "Y", enter in column 2 the | | | N | | | | 122.00 |
| where these taxes are included. Transplant Center Information | | | | | | | - |
| 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. | r yes and "N" | for no. If | N | | | | 125.00 |
| 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2. | | fication date | | | | | 126.00 |
| 127.00 If this is a Medicare certified heart transplant center, enter | er the certifi | cation date | | | | | 127.00 |
| in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, entrin in column 1 and termination date, if applicable in column 2. | er the certifi | cation date | | | | | 128.00 |
| in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter | | cation date i | n | | | | 129.00 |
| | | sation date i | | | | | |
| column 1 and termination date, if applicable, in column 2. 130.00 f this is a Medicare certified pancreas transplant center, o | enter the cert | | | | | | 130.00 |
| 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 131.00 If this is a Medicare certified intestinal transplant center, | enter the cert umn 2. , enter the ce | ti fi cati on | | | | | 130. 00 131. 00 |
| 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in colu | enter the cert umn 2. ; enter the ce umn 2. er the certifi | ti fi cati on erti fi cati on | | | | | |

| Health Financial Systems | JOHNSON MEMORIA | AL HOSPITAL | | | In Lie | u of Form CMS-: | 2552-10 |
|---|--------------------------------|----------------|---------------|------------------|-------------------------|-------------------------|------------------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE | X IDENTIFICATION DATA | Provider CC | N: 15-0001 | | | Worksheet S-2 | |
| | | | | | 01/01/2016 12/31/2016 | Part I Date/Time Pre | pared: |
| | | | | | | 1/16/2018 3:0 | |
| | | | | | 1.00 | 2.00 | - |
| 133.00 If this is a Medicare certified ot | her transplant center, ent | er the certifi | cation da | te | 1.00 | 2.00 | 133.00 |
| in column 1 and termination date, | if applicable, in column 2 | | | | | | |
| 134.00 If this is an organ procurement or and termination date, if applicabl | | e OPO number i | n column | 1 | | | 134.00 |
| All Providers | | | | | | | |
| 140.00 Are there any related organization | | | | | N | | 140. 00 |
| chapter 10? Enter "Y" for yes or " | | | | sts | | | |
| are claimed, enter in column 2 the 1.00 | | | .rons) | | 3.00 | | |
| If this facility is part of a chai | n organization, enter on I | ines 141 throu | | e name a | | of the | |
| home office and enter the home off | | ntractor numbe | | | 1 | | 1.11 00 |
| 141.00Name: 142.00Street: | Contractor's Name: PO Box: | | Contra | actor's N | Number: | | 141.00 |
| 143. 00 Ci ty: | State: | | Zip Co | ode: | | | 143.00 |
| | | | · · | | | | |
| 144 00 Are provider based physicians! | to included in Werkeheet A | 2 | | | | 1.00 Y | 144.00 |
| 144.00 Are provider based physicians' cos | its flict uded fit worksheet A | <i>:</i> | | | | T | 144.00 |
| | | | | | 1.00 | 2.00 | |
| 145.00 If costs for renal services are cl | | | | | N | N | 145.00 |
| inpatient services only? Enter "Y" no, does the dialysis facility inc | | | | | | | |
| period? Enter "Y" for yes or "N" | | | reporting | | | | |
| 146.00 Has the cost allocation methodolog | | | | | N | | 146.00 |
| Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c | | 5-2, chapter 4 | 0, §4020) | lf | | | |
| | | | | | | | |
| | | | | | | 1.00 | |
| 147.00 Was there a change in the statisti | | | | | | N | 147.00 |
| 148.00 Was there a change in the order of 149.00 Was there a change to the simplifi | | | | for no | | N N | 148.00 149.00 |
| The share a change to the shaperer | ed eost frindrig method. En | Part A | Part | | Title V | Title XIX | |
| | | 1.00 | 2.00 | | 3.00 | 4.00 | |
| Does this facility contain a provi or charges? Enter "Y" for yes or " | | | | | | | |
| 155. 00 Hospi tal | N TOT HO TOT EACH COmpone | N | N | <u>D. (366 -</u> | <u>42 CIR 3413</u> N | N | 155.00 |
| 156.00 Subprovi der – IPF | | N | N | | Ν | N | 156.00 |
| 157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER | | N | N | | N | N | 157.00 158.00 |
| 159. 00 SNF | | N | N | | Ν | N | 158.00 |
| 160.00 HOME HEALTH AGENCY | | N | N | | N | N | 160.00 |
| 161.00 CMHC | | | N | | N | N | 161.00 |
| | | | | | | 1.00 | - |
| Multicampus | | | | | | 1.00 | |
| 165.00 Is this hospital part of a Multica | mpus hospital that has one | or more campu | ises in di | fferent (| CBSAs? | N | 165.00 |
| Enter "Y" for yes or "N" for no. | Name | County | Stato | Zip Code | e CBSA | FTE/Campus | |
| | 0 | 1. 00 | State 2.00 | 3.00 | 4. 00 | 5.00 | - |
| 166.00 fline 165 is yes, for each | | | | | | | 166.00 |
| 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) | | | | | | | |
| | | | | | | 1.00 | - |
| Health Information Technology (HI |) incentive in the America | n Recovery and | d Reinvest | ment Act | | 1.00 | |
| 167.00 Is this provider a meaningful user | under §1886(n)? Enter "Y | " for yes or " | N" for no | | | Y | 167.00 |
| 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H | | | e 167 is "' | Y"), ente | er the | C | 168.00 |
| 168.01 If this provider is a CAH and is r | | | qualify | for a har | rdshi p | | 168.01 |
| exception under §413.70(a)(6)(ii)? | 'Enter "Y" for yes or "N" | for no. (see i | nstructio | ns) | · | | |
| 169.00 If this provider is a meaningful utransition factor. (see instruction | | is not a CAH (| line 105 | is "N"), | enter the | 9.99 | 169. 00 |
| priansi rioni ractor. (see instructio | 113 <i>)</i> | | | | | I | I |

| Health Financial Systems JO | HNSON MEMORIAL | HOSPI TAL | In Lie | u of Form CMS- | 2552-10 |
|--|------------------------------------|-----------------------|----------------------------|-------------------------|---------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATI | ON DATA | Provider CCN: 15-0001 | Period: From 01/01/2016 | Worksheet S-2 Part I | 2 |
| | | | To 12/31/2016 | | |
| | | | Begi nni ng | Endi ng | |
| | | | 1.00 | 2.00 | |
| 170.00 Enter in columns 1 and 2 the EHR beginning date period respectively (mm/dd/yyyy) | and ending dat | e for the reporting | 01/01/2016 | 12/31/2016 | 170.00 |
| | | | | | |
| | | | 1.00 | 2.00 | |
| 171.00 If line 167 is "Y", does this provider have any section 1876 Medicare cost plans reported on Wks "Y" for yes and "N" for no in column 1. If colum 1876 Medicare days in column 2. (see instruction | st. S-3, Pt. I, mn 1 is yes, en | line 2, col. 6? Enter | n | C | 0171.00 |

| IOSPI T. | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider C | CN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | 1/16/2018 3: | epared: |
|--------------|---|--|-----------------------------------|---|---------------------|----------------|
| | | | | Y/N 1.00 | Date 2.00 | |
| | General Instruction: Enter Y for all YES responses. Enter N | for all NO re | esponses. Ente | | | |
| | mm/dd/yyyy format. | | | | | - |
| | COMPLETED BY ALL HOSPITALS Provider Organization and Operation | | | | | - |
| . 00 | Has the provider changed ownership immediately prior to the | beginning of | the cost | N | | 1.00 |
| | reporting period? If yes, enter the date of the change in co | olumn 2. (see | instructions |) Date | V/I | - |
| | | | 1.00 | 2.00 | 3.00 | - |
| 2. 00 | Has the provider terminated participation in the Medicare Pr yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary. | | N | | | 2.0 |
| 8. 00 | Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions) | ffices, drug er or its f the board | N | | | 3. 00 |
| | | | Y/N | Туре | Date | |
| | Financial Data and Reports | | 1.00 | 2.00 | 3.00 | |
| 1.00 | Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. | or Compiled, | Y | A | | 4.00 |
| 5. 00 | Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reco | | N | | | 5.0 |
| | | | | Y/N 1.00 | Legal Oper. 2.00 | |
| | Approved Educational Activities | | | | | |
| b. 00 | Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program? | lf yes, is th | ne provider is | s N | | 6.00 |
| 7.00 8.00 | Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved a | | d during the | N N | | 7. 0 8. 0 |
| 9. 00 | cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved g | | cal education | Ν | | 9.0 |
| 0. 00 | program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or | | the current | Ν | | 10.0 |
| 1. 00 | cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions. | & R in an App | proved | Ν | | 11.0 |
| | | | | | Y/N 1.00 | |
| | Bad Debts | | | | 1.00 | |
| | Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy. | | | ost reporting | Y N | 12. 0 13. 0 |
| 4.00 | If line 12 is yes, were patient deductibles and/or co-paymen Bed Complement | nts waived? If | fyes, see ins | structions. | N | 14.0 |
| 5.00 | Did total beds available change from the prior cost reportin | | yes, see ins [.] rt A | tructions. Par | N | 15.0 |
| | - | Y/N | Date | Y/N | Date | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| 6. 00 | PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see | Y | 04/03/2017 | Y | 04/03/2017 | 16. 0 |
| 7.00 | instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date | Ν | | Ν | | 17.0 |
| 8. 00 | in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this | Ν | | Ν | | 18. 0 |
| 9. 00 | cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report | Ν | | N | | 19. 0 |

| leal th Financial Systems JOHNSON MEMORI HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | | CN: 1E 0001 | In Li Period: | eu of Form CN | |
|--|-----------------|---------------|----------------------------------|---------------|----------------|
| IUSPITAL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider C | UN: 15-0001 | From 01/01/2010 To 12/31/2010 | | Prepared: |
| | Descr | iption | Y/N | Y/N | |
| | | 0 | 1.00 | 3.00 | |
| 20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: | | | Ν | N | 20. 0 |
| | Y/N | Date | Y/N | Date | |
| 21.00 Was the cost report prepared only using the provider's | 1.00 N | 2.00 | 3.00 N | 4.00 | 21.0 |
| records? If yes, see instructions. | | | N | | 21.0 |
| | | | | 1.00 | |
| COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost | EPT CHILDRENS H | IOSPI TALS) | | | |
| 22.00 Have assets been relifed for Medicare purposes? If yes, see | - instructions | | | | 22.0 |
| 3.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. | | als made du | ring the cost | | 23.0 |
| 24.00 Were new leases and/or amendments to existing leases entere If yes, see instructions | ed into during | this cost re | eporting period? | | 24.0 |
| 5.00 Have there been new capitalized leases entered into during instructions. | the cost repor | ting period | ?lfyes, see | | 25.0 |
| 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the instructions. | ne cost reporti | ng period? I | fyes, see | | 26.0 |
| 17.00 Has the provider's capitalization policy changed during the copy. Interest Expense | e cost reportir | ng period? I1 | fyes, submit | | 27.0 |
| 8.00 Were new Loans, mortgage agreements or letters of credit er period? If yes, see instructions. | ntered into dur | ing the cost | t reporting | | 28.0 |
| 9.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr | | ebt Service I | Reserve Fund) | | 29. C |
| Has existing debt been replaced prior to its scheduled matu instructions. | | debt? If yes | s, see | | 30. C |
| 31.00 Has debt been recalled before scheduled maturity without is instructions. Purchased Services | ssuance of new | debt? If yes | s, see | | 31. 0 |
| Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru | | ed through co | ontractual | | 32.0 |
| 11 line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions. | | ng to competi | tive bidding? If | - | 33.0 |
| Provi der-Based Physi ci ans | | | | 1 | |
| A. 00 Are services furnished at the provider facility under an ar If yes, see instructions. | 0 | · | 1 3 | | 34.0 |
| 85.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in | | nts with the | provi der-based | | 35. C |
| | | | Y/N | Date | |
| | | | 1.00 | 2.00 | |
| Home Office Costs | | | | | _ |
| 36.00 Were home office costs claimed on the cost report?37.00 If line 36 is yes, has a home office cost statement been pr | repared by the | home office | ? | | 36. 0 37. 0 |
| 8.00 If line 36 is yes, was the fiscal year end of the home off | | | f | | 38. 0 |
| the provider? If yes, enter in column 2 the fiscal year end 9.00 If line 36 is yes, did the provider render services to othe | | | 5, | | 39.0 |
| 10.00 If line 36 is yes, did the provider render services to the | home office? | lf yes, see | | | 40. 0 |
| instructions | | - | | | |
| | 1. | 00 | 2 | . 00 | |
| | AUSTIN | | FI SHER | | 41.0 |
| held by the cost report preparer in columns 1, 2, and 3, respectively. 12.00 Enter the employer/company name of the cost report | BLUE & CO | | | | 42.0 |
| preparer. | 3172757438 | | AFI SHER@BLUEA | NDCO COM | 43.0 |
| report preparer in columns 1 and 2, respectively. | | | A I SHENGDEULA | .2.50. 000 | -5.0 |

| Heal th | Financial Systems | JOHNSON MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|----------|--|-----------------|------------------|-------|----------------------------------|---|----------------|
| HOSPI TA | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU | JESTI ONNAI RE | Provider CC | | Period: | Worksheet S-2 | |
| | | | | | From 01/01/2016 To 12/31/2016 | Part II Date/Time Pre 1/16/2018 3:0 | pared: 1 pm |
| | | | | | | | |
| | | | 3. (| 00 | | | |
| | Cost Report Preparer Contact Information | | | | | | |
| 41.00 | Enter the first name, last name and the tit | :le/position S | SENI OR ACCOUNTA | ANT . | | | 41.00 |
| | held by the cost report preparer in columns | 5 1, 2, and 3, | | | | | |
| | respecti vel y. | | | | | | |
| 42.00 | Enter the employer/company name of the cost | report | | | | | 42.00 |
| | preparer. | | | | | | |
| 43.00 | Enter the telephone number and email addres | s of the cost | | | | | 43.00 |
| | report preparer in columns 1 and 2, respect | ti vel y. | | | | | |

| LIGODI T | Financial Systems | JOHNSON MEMORI | | | | | 2552-10 |
|----------|---|---------------------|-------------|-----------------------|----------------------------|-------------------------|---------|
| HOSPII | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | AL DATA | Provider CC | CN: 15-0001 | Period: From 01/01/2016 | Worksheet S-3 Part I | |
| | | | | | To 12/31/2016 | Date/Time Pre | |
| | | | | | | 1/16/2018 3:0 | |
| | | | | | | I/P Days / O/P | |
| | | | | | | <u>Visits / Trips</u> | |
| | Component | Worksheet A | No. of Beds | Bed Days | CAH Hours | Title V | |
| | | Line Number 1.00 | 2.00 | Avai I abl e 3. 00 | 4.00 | 5.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and | 30.00 | 2.00 | 29, 2 | | | 1.00 |
| 1.00 | 8 exclude Swing Bed, Observation Bed and | 30.00 | 00 | 27,2 | 0.00 | | 1.00 |
| | Hospice days) (see instructions for col. 2 | | | | | | |
| | for the portion of LDP room available beds) | | | | | | |
| 2.00 | HMO and other (see instructions) | | | | | | 2.00 |
| 3.00 | HMO IPF Subprovider | | | | | | 3.00 |
| 4.00 | HMO IRF Subprovider | | | | | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | 0 | 5.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | | | | 0 | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation | | 80 | 29, 2 | 0.00 | 0 | 7.00 |
| | beds) (see instructions) | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | 31.00 | 6 | 2, 1 | 96 0.00 | 0 | 8.00 |
| 9.00 | CORONARY CARE UNI T | | | | | | 9.00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | 10.00 |
| 11.00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 11.00 |
| 12.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12.00 |
| 13.00 | NURSERY | 43.00 | | | | 0 | 13.00 |
| 14.00 | Total (see instructions) | | 86 | 31, 4 | 76 0.00 | 0 | 14.00 |
| 15.00 | CAH visits | | | | | 0 | 15.00 |
| 16.00 | SUBPROVIDER - IPF | | | | | | 16.00 |
| 17.00 | SUBPROVIDER – IRF | 41.00 | 11 | 4, 0 | 26 | 0 | 17.00 |
| 18.00 | SUBPROVI DER | | | | | | 18.00 |
| 19.00 | SKILLED NURSING FACILITY | | | | | | 19.00 |
| 20.00 | NURSING FACILITY | | | | | | 20.00 |
| 21.00 | OTHER LONG TERM CARE | | | | | | 21.00 |
| 22.00 | HOME HEALTH AGENCY | 101.00 | | | | 0 | 22.00 |
| 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 23.00 |
| 24.00 | HOSPI CE | | | | | | 24.00 |
| 24.10 | HOSPICE (non-distinct part) | 30.00 | | | | | 24.10 |
| 25.00 | CMHC – CMHC | | | | | | 25.00 |
| 26.00 | RURAL HEALTH CLINIC | | | | | | 26.00 |
| 26.25 | FEDERALLY QUALIFIED HEALTH CENTER | 89.00 | | | | 0 | 26.25 |
| 27.00 | Total (sum of lines 14-26) | | 97 | | | | 27.00 |
| 28.00 | Observation Bed Days | | | | | 0 | 28.00 |
| 29.00 | Ambul ance Trips | | | | | | 29.00 |
| 30.00 | Employee discount days (see instruction) | | | | | | 30.00 |
| 31.00 | Employee discount days - IRF | | | | | | 31.00 |
| 32.00 | Labor & delivery days (see instructions) | | 0 | | 0 | | 32.00 |
| 32.01 | Total ancillary labor & delivery room | | | | | | 32.01 |
| | outpatient days (see instructions) | | | | 1 | 1 | 1 |

| HOSPI T | Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC, | AL DATA | Provider CO | | Period: From 01/01/2016 To 12/31/2016 | | pared: |
|----------------|--|-------------|--------------|-----------------------|---|-------------------------|----------------|
| | | I/P Days | / O/P Visits | / Trips | Full Time | Equi val ents | |
| | Component | Title XVIII | Title XIX | Total All Patients | Total Interns & Residents | Employees On Payroll | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) | 2, 551 | 69 | 5, 43 | 7 | | 1.00 |
| 2.00 | HMO and other (see instructions) | 679 | 1, 406 | | | | 2.00 |
| 3.00 | HMO IPF Subprovider | 0 | 0 | | | | 3.00 |
| 4.00 | HMO IRF Subprovider | 27 | 144 | | | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | 0 | 0 | | 0 | | 5.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | 0 | | 0 | | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation beds) (see instructions) | 2, 551 | 69 | 5, 43 | 7 | | 7.00 |
| 8.00 | INTENSIVE CARE UNIT | 393 | 14 | 1, 05 | 7 | | 8.00 |
| 9.00 | CORONARY CARE UNI T | | | | | | 9.00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | 10.00 |
| 11.00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 11.00 |
| 12.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12.00 |
| 13.00 | NURSERY | | 58 | 74 | 4 | | 13.00 |
| 14.00 | Total (see instructions) | 2, 944 | 141 | 7, 23 | 8 0.00 | 547.98 | 14.00 |
| 15.00 | CAH visits | 0 | 0 | | 0 | | 15.00 |
| 16.00 | SUBPROVIDER - IPF | | | | | | 16.00 |
| 17.00 | SUBPROVIDER - IRF | 649 | 13 | 1, 46 | 1 0.00 | 9.72 | 17.00 |
| 18.00 | SUBPROVI DER | | | | | | 18.00 |
| 19.00 | SKILLED NURSING FACILITY | | | | | | 19.00 |
| 20.00 | NURSING FACILITY | | | | | | 20.00 |
| 21.00 | OTHER LONG TERM CARE | | | | | | 21.00 |
| 22.00 | HOME HEALTH AGENCY | 4, 153 | 157 | 6, 44 | 3 0.00 | 9.59 | 22.00 |
| 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 23.00 |
| 24.00 | HOSPI CE | | | | | | 24.00 |
| 24. 10 | HOSPICE (non-distinct part) | 0 | 0 | | 0 | | 24.10 |
| 25.00 | CMHC - CMHC | | | | | | 25.00 |
| 26.00 | RURAL HEALTH CLINIC | | | | | | 26.00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | | 0 0.00 | | |
| 27.00 | Total (sum of lines 14-26) | | | | 0.00 | 567.29 | |
| 28.00 | Observation Bed Days | | 0 | 1, 24 | 7 | | 28.00 |
| 29.00 | Ambul ance Trips | 0 | | | | | 29.00 |
| 30.00 | Employee discount days (see instruction) | | | | 0 | | 30.00 |
| 31.00 | Employee discount days - IRF | | | | 0 | | 31.00 |
| 32.00 32.01 | Labor & delivery days (see instructions) Total ancillary labor & delivery room | 0 | 89 | 13 | 9 0 | | 32.00 32.01 |
| | outpatient days (see instructions) | | | | | | |
| 33 00 | LTCH non-covered days | 0 | | | | | 33.00 |

| | Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC | <u>JOHNSON MEMORIAL</u> AL DATA | Provi der C | CN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | | pared: |
|----------------|--|------------------------------------|-------------|-------------|---|-----------------------|----------------|
| | | Full Time Equivalents | | Di s | charges | | |
| | Component | Nonpai d Workers | Title V | Title XVIII | Title XIX | Total All Patients | |
| | | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| 1.00 | Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) | | 0 | 78 | 33 29 | 2, 053 | 1.00 |
| 2.00 3.00 | HMO and other (see instructions) HMO IPF Subprovider | | | 17 | 76 516 0 | | 2.00 3.00 |
| 4.00 | HMO IRF Subprovider | | | | 1 | | 4.00 |
| 5.00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | 5.00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | | | | | 6.00 |
| 7.00 | Total Adults and Peds. (exclude observation beds) (see instructions) | | | | | | 7.00 |
| 8.00 | INTENSIVE CARE UNIT | | | | | | 8.00 |
| 9.00 | CORONARY CARE UNIT | | | | | | 9.00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | 10.00 |
| 11.00 | SURGI CAL INTENSI VE CARE UNI T | | | | | | 11.00 |
| 12.00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12.00 |
| 13.00 | NURSERY | 0.00 | 0 | 70 | | 2.052 | 13.00 |
| 14.00 | Total (see instructions) | 0.00 | 0 | 78 | 33 29 | 2, 053 | 14.00 |
| 15.00 16.00 | CAH visits SUBPROVIDER - IPF | | | | | | 15.00 16.00 |
| 17.00 | SUBPROVIDER - IRF | 0. 00 | 0 | l l | 52 9 | 103 | |
| 18.00 | SUBPROVI DER | 0.00 | 0 | | 7 | 103 | 18.00 |
| 19.00 | SKILLED NURSING FACILITY | | | | | | 19.00 |
| 20.00 | NURSING FACILITY | | | | | | 20.00 |
| 21.00 | OTHER LONG TERM CARE | | | | | | 21.00 |
| 22.00 | HOME HEALTH AGENCY | 0.00 | | | | | 22.00 |
| 23.00 | AMBULATORY SURGICAL CENTER (D. P.) | 0100 | | | | | 23.00 |
| 24.00 | HOSPICE | | | | | | 24.00 |
| 24.10 | HOSPICE (non-distinct part) | | | | | | 24.10 |
| 25.00 | CMHC - CMHC | | | | | | 25.00 |
| 26.00 | RURAL HEALTH CLINIC | | | | | | 26.00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0.00 | | | | | 26.25 |
| 27.00 | Total (sum of lines 14-26) | 0.00 | | | | | 27.00 |
| 28.00 | Observation Bed Days | | | | | | 28.00 |
| 29.00 | Ambul ance Trips | | | | | | 29.00 |
| 30.00 | Employee discount days (see instruction) | | | | | | 30.00 |
| 31.00 | Employee discount days - IRF | | | | | | 31.00 |
| 32.00 | Labor & delivery days (see instructions) | | | | | | 32.00 |
| 32.01 | Total ancillary labor & delivery room | | | | | | 32.01 |
| 33. 00 | outpatient days (see instructions) LTCH non-covered days | | | | | | 33.00 |

| PIT | AL WAGE INDEX INFORMATION | | | Provider C | | eriod: rom 01/01/2016 o 12/31/2016 | | pared |
|---------|--|----------------------------|--------------------|---|--|--|---|----------|
| | | Worksheet A Line Number | Amount Reported | Reclassificati on of Salaries (from Worksheet A-6) | Adj usted Sal ari es (col.2 ± col. 3) | | Average Hourly Wage (col. 4 ÷ col. 5) | |
| | PART II - WAGE DATA | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| | SALARI ES | | | | | | | |
| 0 | Total salaries (see instructions) | 200.00 | 38, 906, 469 | 2, 012, 370 | 40, 918, 839 | 1, 328, 596. 00 | 30.80 | 1. |
| 0 | Non-physician anesthetist Part | | C | C | 0 | 0.00 | 0.00 | 2. |
| 0 | A Non-physician anesthetist Part | | C | c | 0 | 0.00 | 0.00 | 3. |
| 0 | B Physician-Part A - | | 184, 531 | C | 184, 531 | 1, 792. 00 | 102. 97 | 4. |
| 1 | Administrative Physicians – Part A – Teaching | | C | 0 | 0 | 0.00 | 0.00 | 4. |
| 0 | Physician and Non | | 899, 024 | - | 899, 024 | | | |
| 0 | Physician-Part B Non-physician-Part B for | | C | 0 | 0 | 0.00 | 0.00 | 6. |
| 0 | hospi tal -based RHC and FQHC services | | | | | | | |
| 0 | Interns & residents (in an approved program) | 21.00 | C | C | 0 | 0.00 | 0.00 | 7. |
| 1 | Contracted interns and residents (in an approved programs) | | C | C | 0 | 0.00 | 0.00 | 7. |
| 0 | Home office and/or related organization personnel | | C | C | 0 | 0.00 | 0.00 | 8. |
| 0 00 | SNF Excluded area salaries (see | 44.00 | C 12, 573, 178 | 0 299, 767 | 0 12, 872, 945 | 0. 00 285, 759. 00 | | |
| | instructions) | | | | | | | |
| 00 | OTHER WAGES & RELATED COSTS Contract labor: Direct Patient | | 1, 190, 875 | C | 1, 190, 875 | 15, 277. 00 | 77.95 | 11. |
| 00 | Care Contract Labor: Top Level management and other | | C | C | 0 | 0.00 | 0.00 | 12. |
| | management and administrative services | | | | | | | |
| 00 | Contract Labor: Physician-Part A - Administrative | | 363, 802 | C | 363, 802 | 4, 113. 00 | 88. 45 | 13. |
| 00 | Home office and/or related orgainzation salaries and | | C | C | 0 | 0.00 | 0.00 | 14 |
| 01 | wage-related costs Home office salaries | | C | c | 0 | 0.00 | 0.00 | 14 |
| 02 | Related organization salaries | | C | - | 0 | 0.00 | | |
| | Home office: Physician Part A - Administrative | | C | | 0 | 0.00 | | |
| 00 | Home office and Contract Physicians Part A - Teaching | | C | C | 0 | 0.00 | 0.00 | 16 |
| ~ ~ | WAGE-RELATED COSTS | | | | | | 1 | |
| 00 | Wage-related costs (core) (see instructions) | | 7, 316, 477 | C | 7, 316, 477 | | | 17 |
| 00 | Wage-related costs (other) (see instructions) | | C | C | 0 | | | 18 |
| 00 | Excluded areas | | 2,031,767 | C | 2, 031, 767 | | | 19 |
| 00 | Non-physician anesthetist Part A | | C | 0 | 0 | | | 20 |
| 00 | Non-physician anesthetist Part B | | C | C | 0 | | | 21 |
| 00 | B Physician Part A - Administrative | | 12, 738 | C | 12, 738 | | | 22 |
| 01 | Physician Part A - Teaching | | C | - | 0 | | | 22 |
| | Physician Part B Wage-related costs (RHC/FQHC) | | 85, 425 | | 85, 425 | | | 23 24 |
| | Interns & residents (in an | | C | d d | 0 | | | 24 |
| 50 | approved program) Home office wage-related | | C | 0 | 0 | | | 25 |
| 51 | Related orgainzation | | C | - | o o | | | 25 |
| 52 | wage-related Home office: Physician Part A - Administrative - | | C | с | о | | | 25 |
| 53 | wage-related Home office & Contract Physicians Part A - Teaching - | | C | c | 0 | | | 25. |
| | wage-related OVERHEAD COSTS - DIRECT SALARIE | S | | | | | | |
| | Employee Benefits Department | 4.00 | 3, 081, 956 | 332, 869 | 3, 414, 825 | 172, 298. 00 | 19. 82 | 26 |

| Heal th | Financial Systems | | JOHNSON MEMOR | I AL HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|-------------|---------------|------------------|---------------|---|-----------------|---------|
| HOSPI T | AL WAGE INDEX INFORMATION | | | Provider C | | Period: From 01/01/2016 Fo 12/31/2016 | | pared: |
| | | Worksheet A | | Reclassi fi cati | | | Average Hourly | |
| | | Line Number | Reported | on of Salaries | | | Wage (col. 4 ÷ | |
| | | | | (from | (col.2 ± col. | | col. 5) | |
| | | | | Worksheet A-6) | , | col. 4 | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| 28.00 | Administrative & General under contract (see inst.) | | 224, 148 | 0 | 224, 14 | 3, 030. 00 | 73. 98 | 28.00 |
| 29.00 | Maintenance & Repairs | 6.00 | 0 | 0 | | 0.00 | 0.00 | 29.00 |
| 30.00 | Operation of Plant | 7.00 | 653, 588 | 31, 979 | 685, 56 | 7 32, 900. 00 | 20. 84 | 30.00 |
| 31.00 | Laundry & Linen Service | 8.00 | 122, 994 | 5, 121 | 128, 11 | 5 8, 935. 00 | 14.34 | 31.00 |
| 32.00 | Housekeepi ng | 9.00 | 650, 679 | 42, 234 | 692, 91 | 3 56, 055. 00 | 12.36 | 32.00 |
| 33.00 | Housekeeping under contract (see instructions) | | 0 | 0 | | 0.00 | 0.00 | 33.00 |
| 34.00 | Dietary | 10.00 | 802, 380 | -478, 688 | 323, 69 | 2 24, 345. 00 | 13.30 | 34.00 |
| 35.00 | Dietary under contract (see instructions) | | 0 | 0 | | 0.00 | 0.00 | 35.00 |
| 36.00 | Cafeteri a | 11.00 | 0 | 527, 173 | 527, 17 | 3 29, 071. 00 | 18. 13 | 36.00 |
| 37.00 | Maintenance of Personnel | 12.00 | 0 | 0 | | 0.00 | 0.00 | 37.00 |
| 38.00 | Nursing Administration | 13.00 | 1, 499, 038 | 112, 896 | 1, 611, 93 | 4 28, 965. 00 | 55.65 | 38.00 |
| 39.00 | Central Services and Supply | 14.00 | 82, 725 | 6, 667 | 89, 39, | 4, 088. 00 | 21.87 | 39.00 |
| 40.00 | Pharmacy | 15.00 | 474, 185 | | 523, 48 | 6 14, 856. 00 | 35.24 | 40.00 |
| 41.00 | Medi cal Records & Medi cal Records Library | 16.00 | 560, 309 | | | 1 32, 241. 00 | 18. 52 | 41.00 |
| 42.00 | Social Service | 17.00 | 0 | 0 | | 0.00 | 0.00 | 42.00 |
| 43.00 | Other General Service | 18.00 | 0 | 0 | | 0.00 | | 43.00 |

| Heal th | Financial Systems | | JOHNSON MEMOR | I AL HOSPI TAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|---------|--|-------------|---------------|-------------------|---------------|---|------------------|---------|
| HOSPI T | AL WAGE INDEX INFORMATION | | | Provider CC | | Period: From 01/01/2016 To 12/31/2016 | | pared: |
| | | Worksheet A | Amount | Recl assi fi cati | Adj usted | Paid Hours | Average Hourly | |
| | | Line Number | | on of Salaries | | | Wage (col. 4 ÷ | |
| | | | | (from | (col.2 ± col. | Salaries in | col. 5) | |
| | | | | Worksheet A-6) | , | 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 | | 38, 231, 593 | 2, 012, 370 | 40, 243, 96 | 3 1, 319, 611. 00 | 30. 50 | 1.00 |
| | instructions) | | | | | | | |
| 2.00 | Excluded area salaries (see instructions) | | 12, 573, 178 | 299, 767 | 12, 872, 94 | 5 285, 759. 00 | 45.05 | 2.00 |
| 3.00 | Subtotal salaries (line 1 | | 25, 658, 415 | 1, 712, 603 | 27, 371, 01 | 8 1, 033, 852. 00 | 26. 47 | 3.00 |
| | minus line 2) | | | | | | | |
| 4.00 | Subtotal other wages & related costs (see inst.) | | 1, 554, 677 | 0 | 1, 554, 67 | 7 19, 390. 00 | 80. 18 | 4.00 |
| 5.00 | Subtotal wage-related costs | | 7, 329, 215 | 0 | 7, 329, 21 | 5 0.00 | 26. 78 | 5.00 |
| 6.00 | (see inst.) Total (sum of lines 3 thru 5) | | 34, 542, 307 | 1, 712, 603 | 36, 254, 91 | 0 1,053,242.00 | 34.42 | 6.00 |
| 7.00 | Total overhead cost (see | | 10, 256, 141 | | | | | |
| 7.00 | instructions) | | 10, 250, 141 | 761,002 | 11, 017, 14 | 3 471, 601. 00 | 23.30 | 7.00 |

| Heal th | Financial Systems | JOHNSON MEMORIA | - HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|----------------|---|---------------------|--------------------------|---|------------------------|---------|
| HOSPI T | AL WAGE RELATED COSTS | | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | | pared: |
| | | | | | Amount | |
| | | | | | Reported | |
| | | | | | 1.00 | |
| | PART IV - WAGE RELATED COSTS | | | | | |
| | Part A - Core List | | | | | |
| | RETIREMENT COST | | | | | |
| 1.00 | 401K Employer Contributions | | | | 958, 631 | 1.00 |
| 2.00 | Tax Sheltered Annuity (TSA) Employer Contri | | | | 0 | 2.00 |
| 3.00 | Nonqualified Defined Benefit Plan Cost (see | , | | | 0 | |
| 4.00 | Qualified Defined Benefit Plan Cost (see in | | | | 44, 568 | 4.00 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External | Organi zati on) | | | | |
| 5.00 | 401K/TSA Plan Administration fees | | | | 0 | |
| 6.00 | Legal /Accounting/Management Fees-Pension P | | | | 0 | 6.00 |
| 7.00 | Employee Managed Care Program Administration | on Fees | | | 0 | 7.00 |
| | HEALTH AND INSURANCE COST | - | | | | |
| 8.00 | Health Insurance (Purchased or Self Funded | | | | 5, 419, 425 | 8.00 |
| 8.01 | Health Insurance (Self Funded without a Th | | | | 0 | |
| 8.02 | Health Insurance (Self Funded with a Third | Party Administrato | or) | | 0 | |
| 8.03 | Health Insurance (Purchased) | | | | 0 | 0.00 |
| 9.00 | Prescription Drug Plan | | | | 0 | |
| 10.00 | Dental, Hearing and Vision Plan | | | | 0 | |
| 11.00 | Life Insurance (If employee is owner or be | | | | 25, 600 | |
| 12.00 | Accident Insurance (If employee is owner of | | | | 0 | |
| 13.00 | Disability Insurance (If employee is owner | | | | 144, 613 | |
| 14.00 | Long-Term Care Insurance (If employee is or | wher or beneficiary | () | | - | 14.00 |
| 15.00 16.00 | 'Workers' Compensation Insurance | | | ad by EACD 10/ | 233, 542 | |
| 16.00 | Retirement Health Care Cost (Only current y Non cumulative portion) | year, not the extra | iordinary accruai requir | ed by FASB 106. | 0 | 16.00 |
| | TAXES | | | | | |
| 17 00 | FICA-Employers Portion Only | | | | 2, 552, 986 | 17 00 |
| 18.00 | Medicare Taxes - Employers Portion Only | | | | 2, 332, 700 | |
| 19.00 | Unemployment Insurance | | | | - | 19.00 |
| | State or Federal Unemployment Taxes | | | | ,, 430 | |
| 20.00 | OTHER | | | | 0 | 20.00 |
| 21.00 | Executive Deferred Compensation (Other Than instructions)) | n Retirement Cost F | Reported on lines 1 thro | ugh 4 above. (see | 0 | 21.00 |
| 22.00 | Day Care Cost and Allowances | | | | 11, 293 | 22.00 |
| 22.00 | Tui ti on Rei mbursement | | | | 48, 314 | |
| | Total Wage Related cost (Sum of lines 1 -23 | 2) | | | 48, 314 9, 446, 408 | |
| 24.00 | Part B - Other than Core Related Cost | 3) | | | 9, 440, 408 | 24.00 |
| 25 00 | OTHER WAGE RELATED COSTS (SPECIFY) | | | | 0 | 25.00 |
| 25.00 | UTIEN WAGE NELATED COSTS (SPECIFT) | | | I | 0 | 25.00 |

| Heal th Financial | Systems | JOHNSON MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|--------------------|-----------------------------------|------------------|-----------------------|-----------------|--------------------------------|----------------|
| HOSPI TAL CONTRACT | T LABOR AND BENEFIT COST | | Provider CCN: 15-0001 | Peri od: | Worksheet S-3 | |
| | | | | From 01/01/2016 | | |
| | | | | To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pared: 1 nm |
| Cost | Center Description | | | Contract Labor | | i piii |
| 0031 | | | | 1.00 | 2.00 | |
| PART V - C | ontract Labor and Benefit Cost | | | | | |
| Hospital a | nd Hospital-Based Component Ident | ti fi cati on: | | | | |
| 1.00 Total faci | lity's contract labor and benefi | t cost | | 0 | 0 | 1.00 |
| 2.00 Hospital | | | | 0 | 0 | 2.00 |
| 3.00 Subprovide | er – IPF | | | | | 3.00 |
| 4.00 Subprovide | er – IRF | | | 0 | 0 | 4.00 |
| 5.00 Subprovi de | er – (Other) | | | 0 | 0 | 5.00 |
| 6.00 Swing Beds | s - SNF | | | 0 | 0 | 6.00 |
| 7.00 Swing Beds | 5 - NF | | | 0 | 0 | 7.00 |
| 8.00 Hospital-E | Based SNF | | | | | 8.00 |
| 9.00 Hospital-E | Based NF | | | | | 9.00 |
| 10.00 Hospital-E | Based OLTC | | | | | 10.00 |
| 11.00 Hospital-E | Based HHA | | | 0 | 0 | 11.00 |
| 12.00 Separately | / Certified ASC | | | | | 12.00 |
| 13.00 Hospital-E | Based Hospi ce | | | | | 13.00 |
| 14.00 Hospital-E | Based Health Clinic RHC | | | | | 14.00 |
| 15.00 Hospital-E | Based Health Clinic FQHC | | | | | 15.00 |
| 16.00 Hospital-E | Based-CMHC | | | | | 16.00 |
| 17.00 Renal Dial | ysi s | | | | | 17.00 |
| 18.00 Other | | | | 0 | 0 | 18.00 |

| | Financial Systems IEALTH AGENCY STATISTICAL DATA | JOHNSON MEMORI | Provi der C | F | In Lie Period: From 01/01/2016 To 12/31/2016 Home Health Agency I | | pared: |
|--|---|-----------------|--------------------------|--|---|--|---|
| | | | I | | | | - |
| 0.00 | County | | | | 1. | 00 | 0.00 |
| 0.00 | looding | Title V | Title XVIII | Title XIX | Other | Total | 0.00 |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 | HOME HEALTH AGENCY STATISTICAL DATA | 0 | C | | 0 | 0 | 1.00 |
| 2.00 | Unduplicated Census Count (see instructions) | 0.00 | | | | | |
| | | | | Number of Emp | loyees (Full Ti | | |
| | | Enter the numb | er of hours in | Staff | Contract | Total | |
| | | your normal | work week | | | | |
| | | (|) | 1.00 | 2.00 | 3.00 | |
| | HOME HEALTH AGENCY - NUMBER OF EMPLOYEES | | | | | | |
| 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 | Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s) Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service Physical Therapy Supervisor Occupational Therapy Supervisor | | 40. OC |) 1.95 0.00 1.57 4.03 0.00 2.37 0.00 1.06 0.00 | 0 0.00 7 0.00 3 0.00 0 0.00 7 0.00 7 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 | 0.00 1.57 4.03 0.00 2.37 0.00 1.06 | 4.00 5.00 6.00 7.00 8.00 9.00 10.00 |
| 12.00 13.00 14.00 15.00 16.00 17.00 18.00 | Speech Pathology Service Speech Pathology Supervisor Medical Social Service Medical Social Service Supervisor Home Health Aide Home Health Aide Supervisor Other (specify) | | | 0.04 0.00 0.01 0.00 0.00 0.00 0.00 | 0 0.00 1 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 | 0. 00 0. 01 0. 00 0. 00 0. 00 | 13.00 14.00 15.00 16.00 17.00 |
| | HOME HEALTH AGENCY CBSA CODES | 1 | | | -1 | 1 | |
| 19.00 | Enter in column 1 the number of CBSAs where you provided services during the cost reporting period. | | | | 3 | | 19.00 |
| 20. 00 | List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code). | | | 18020 26900 | | | 20. 00 |
| 20.01 | | | | 50032 | | | 20.01 |
| | | | bisodes With Outliers | LUPA Epi sodes | PEP Only Episodes | Total (cols. 1-4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 21.00 | PPS ACTIVITY DATA Skilled Nursing Visits | 1,851 | 32 | 27 | 7 26 | 1, 936 | 21.00 |
| 22.00 | Skilled Nursing Visit Charges | 443, 090 | | | | | |
| 23.00 | Physical Therapy Visits | 1, 288 | | | 1 18 | | |
| 24.00 25.00 | Physical Therapy Visit Charges Occupational Therapy Visits | 334, 040 810 | | | 2 4,650 2 10 | | 1 |
| 26.00 | Occupational Therapy Visit Charges | 210, 080 | | | | | |
| 27.00 | Speech Pathology Visits | 11 | 6 | | 0 0 | 17 | 27.00 |
| 28.00 29.00 | Speech Pathology Visit Charges Medical Social Service Visits | 2,860 | 1, 560 | | | 4, 420 | |
| 29.00 30.00 | Medical Social Service Visits | 560 | | | | 560 | |
| 31.00 | Home Health Aide Visits | 0 | 0 |) (| o o | 0 | 31.00 |
| 32.00 | Home Health Aide Visit Charges | 0 | 0 |) (| - | 0 | |
| 33.00 | Total visits (sum of lines 21, 23, 25, 27, 29, and 31) | 3, 962 | 104 | 33 | 3 54 | 4, 153 | 33.00 |
| 34. 00 35. 00 | Other Charges Total Charges (sum of lines 22, 24, 26, 28, | 0 990, 630 | - | | - | 0 1, 038, 460 | |
| 36.00 | 30, 32, and 34) Total Number of Episodes (standard/non outlier) | 225 | | 11 | | | |
| 37.00 38.00 | Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges | 91 | 2 | | 0 0 | | 37.00 38.00 |

| Heal th | Financial Systems JOHNSON MEMORIAL | HOSPI TAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|--------------|--|---------------|----------------|----------------------------------|-----------------------------|--------------|
| | AL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN | | Period: | Worksheet S-1 | |
| | | | | From 01/01/2016 To 12/31/2016 | | |
| | | | | | | |
| | Uncompensated and indigent care cost computation | | | | 1.00 | |
| 1.00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 di | vided by line | e 202 column | 8) | 0. 295219 | 1.00 |
| | Medicaid (see instructions for each line) | riada by rink | 0 202 001 0111 | 3) | 012/021/ | |
| 2.00 | Net revenue from Medicaid | | | | 4, 228, 979 | 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 | | m Medicaid? | | Y | 4.00 |
| 5.00 | If line 4 is no, then enter DSH or supplemental payments from | Medi cai d | | | 0 | 5.00 |
| 6.00 7.00 | Medicaid charges Medicaid cost (line 1 times line 6) | | | | 28, 336, 273 8, 365, 406 | 6.00 7.00 |
| 7.00 8.00 | Difference between net revenue and costs for Medicaid program | (line 7 minus | s sum of lin | es 2 and 5 [,] if | 4, 136, 427 | 8.00 |
| 0.00 | < zero then enter zero) | | 3 3011 01 1111 | | 4, 100, 427 | 0.00 |
| | Children's Health Insurance Program (CHIP) (see instructions f | or each line) |) | | | 1 |
| 9.00 | Net revenue from stand-alone CHIP | | | | 0 | |
| 10.00 | | | | | 0 | |
| 11.00 | | | | | 0 | |
| 12.00 | Difference between net revenue and costs for stand-alone CHIP enter zero) | (line 11 minu | us line 9; i | f < zero then | 0 | 12.00 |
| | Other state or local government indigent care program (see ins | tructions for | r each line) | | | - |
| 13.00 | Net revenue from state or local indigent care program (Not inc | | |) | 0 | 13.00 |
| 14.00 | Charges for patients covered under state or local indigent car | | | | 0 | |
| | 10) | 1 3 (| | | | |
| 15.00 | State or local indigent care program cost (line 1 times line 1 | | | | 0 | 15.00 |
| 16.00 | Difference between net revenue and costs for state or local in | digent care p | program (lin | e 15 minus line | 0 | 16.00 |
| | 13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CH | ID and state | /local india | opt care progra | | |
| | instructions for each line) | IP and State | /iocal indig | ent care progra | IIS (See | |
| 17.00 | Private grants, donations, or endowment income restricted to f | unding chari | ty care | | 0 | 17.00 |
| 18.00 | | | | | 0 | 18.00 |
| 19.00 | | l indigent ca | are programs | (sum of lines | 4, 136, 427 | 19.00 |
| | 8, 12 and 16) | | Uni nsured | Insured | Total (col. 1 | |
| | | | patients | pati ents | + col. 2) | |
| | | | 1.00 | 2.00 | 3.00 | |
| ~~~~~ | Uncompensated Care (see instructions for each line) | · · · · · | 0.00/ 45 | | 0.00/ 450 | 00.00 |
| 20.00 | Charity care charges and uninsured discounts for the entire fa (see instructions) | сппту | 3, 806, 15 | 2 0 | 3, 806, 152 | 20.00 |
| 21.00 | Cost of patients approved for charity care and uninsured disco | unts (see | 1, 123, 64 | 8 0 | 1, 123, 648 | 21 00 |
| 21.00 | instructions) | | 1, 120, 01 | | 1, 120, 010 | 21.00 |
| 22.00 | Payments received from patients for amounts previously written | off as | | 0 0 | 0 | 22.00 |
| | chari ty care | | | | | |
| 23.00 | Cost of charity care (line 21 minus line 22) | | 1, 123, 64 | 8 0 | 1, 123, 648 | 23.00 |
| | | | | | 1.00 | |
| 24.00 | Does the amount in line 20 column 2 include charges for patien | t days beyon | d a length o | f stav limit | N 1.00 | 24.00 |
| 24.00 | imposed on patients covered by Medicaid or other indigent care | | a a rength o | i stay i i mit | | 24.00 |
| 25.00 | If line 24 is yes, enter the charges for patient days beyond t stav limit | | care program | 's length of | 0 | 25.00 |
| 26.00 | Total bad debt expense for the entire hospital complex (see in | structions) | | | 4, 225, 030 | 26.00 |
| 27.00 | | | uctions) | | 172, 106 | |
| | Medicare allowable bad debts for the entire hospital complex (| | | | 264, 779 | |
| 28.00 | | | | | 3, 960, 251 | |
| 29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt ex | pense (see i | nstructions) | | 1, 261, 814 | |
| 30.00 | Cost of uncompensated care (line 23 column 3 plus line 29) | | | | 2, 385, 462 | |
| 31.00 | Total unreimbursed and uncompensated care cost (line 19 plus l | ine 30) | | | 6, 521, 889 | 31.00 |

| | Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | JOHNSON MEMORIA F EXPENSES | L HOSPITAL Provider CO | | eri od: | u of Form CMS-: Worksheet A | 2552-10 |
|----------------|---|-------------------------------|----------------------------|----------------------------|---------------------------------|--|------------------|
| | | | | Fi Te | rom 01/01/2016 o 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | |
| | Cost Center Description | Sal ari es | Other | Total (col. 1 + col. 2) | Reclassificati ons (See A-6) | Reclassified Trial Balance (col. 3 +- col. 4) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 1.00 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT | | 1, 956, 298 | 1, 956, 298 | 0 | 1, 956, 298 | 1.00 |
| 1.00 | 00101 CAP REL COSTS-BLDG & FIXT - TOWER | | 86, 509 | | 0 | 86, 509 | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | 2, 585, 049 | | 0 | 2, 585, 049 | 2.00 |
| 4.00 4.01 | 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS | 312, 899 203, 055 | 10, 974, 959 | | -1, 916, 014 12, 432 | 9, 371, 844 | 4.00 |
| 4.01 | 00402 DATA PROCESSI NG | 749, 896 | 312, 128 779, 130 | | | 527, 615 1, 605, 716 | 4.01 4.02 |
| 4.03 | 00403 MATERIALS MANAGEMENT | 270, 264 | 44, 861 | 315, 125 | 10, 583 | 325, 708 | 4.03 |
| 4.04 | 00404 ADMI TTI NG | 605, 150 | 21, 848 | | | 656, 789 | 4.04 |
| 4.05 | 00405 PATIENT ACCOUNTING | 940, 692 | 657, 528 | | 82, 218 | 1, 680, 438 | 4.05 |
| 5.00 7.00 | 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT | 2, 104, 139 653, 588 | 4, 089, 527 2, 078, 766 | | 95, 754 31, 979 | 6, 289, 420 2, 764, 333 | 5.00 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 122, 994 | 2,078,780 | | | 2, 704, 333 | 8.00 |
| 9.00 | 00900 HOUSEKEEPING | 650, 679 | 117, 059 | | | 809, 972 | 9.00 |
| 10.00 | 01000 DI ETARY | 802, 380 | 364, 836 | | | 448, 826 | |
| 11.00 | | 0 | 0 | 0 | 766, 875 | 766, 875 | 11.00 |
| 13.00 14.00 | 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY | 1, 499, 038 82, 725 | 205, 063 98, 805 | | 114, 784 6, 667 | 1, 818, 885 188, 197 | 13.00 14.00 |
| 15.00 | 01500 PHARMACY | 474, 185 | 2, 883, 485 | | | 3, 406, 971 | 1 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 560, 309 | 269, 755 | | | 866, 926 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | 4,049,423 | 1, 161, 736 | | | 5, 151, 435 | |
| 31.00 41.00 | 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF | 1, 249, 456 733, 427 | 218, 631 139, 034 | | 31, 776 -64, 142 | 1, 499, 863 808, 319 | 31.00 41.00 |
| 43.00 | 04300 NURSERY | 0 | 0 | | 278, 012 | 278, 012 | 43.00 |
| | ANCI LLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 1, 954, 775 | 631, 190 | | | 2, 776, 759 | |
| 53.00 54.00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | 0 2, 075, 349 | 35, 136 839, 621 | | | 60, 136 3, 054, 856 | |
| 60.00 | 06000 LABORATORY | 1, 520, 292 | 2, 030, 626 | | | 3, 625, 896 | |
| 65.00 | 06500 RESPIRATORY THERAPY | 947, 223 | 188, 740 | | | 1, 180, 611 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 759, 155 | 38, 557 | | 155, 944 | 953, 656 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 232, 634 | 1, 275 | | 14, 883 | 248, 792 | 67.00 |
| 68.00 69.00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 134, 116 467, 220 | 107 226, 404 | | 12, 788 31, 344 | 147, 011 724, 968 | 68.00 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 407, 220 | 7, 138 | | | 58, 102 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 3, 454, 553 | | | 1, 899, 820 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | - | 1, 554, 733 | 1, 554, 733 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 125 (50 | 0 | 0 | 0 | 0 | 73.00 |
| 76.00 76.97 | 03020 ONCOLOGY 07697 CARDI AC REHABI LI TATI ON | 135, 650 124, 091 | 76, 643 41, 913 | | 3, 856 5, 217 | 216, 149 171, 221 | 76.00 76.97 |
| 70.77 | OUTPATIENT SERVICE COST CENTERS | 124,071 | 41, 713 | 100,004 | 5,217 | 171,221 | /0. // |
| 90.00 | 09000 CLI NI C | 717, 696 | 2, 105, 162 | | | 2, 844, 851 | 1 |
| 91.00 | 09100 EMERGENCY | 1, 886, 320 | 317, 313 | 2, 203, 633 | 86, 700 | 2, 290, 333 | |
| 92.00 | 09200 0BSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 680, 123 | 158, 922 | 839, 045 | 38, 244 | 877, 289 | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | · · · | | | · · · | | |
| | 11300 INTEREST EXPENSE | | 15, 650 | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS | 27, 746, 841 | 39, 287, 353 | 67, 034, 194 | -237, 850 | 66, 796, 344 | 118.00 |
| 190 00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 84, 104 | 30, 485 | 114, 589 | 0 | 114, 589 | 190 00 |
| | 19200 PHYSI CI ANS' PRI VATE OFFI CES | 10, 239, 825 | 3, 825, 975 | | | 14, 379, 587 | |
| | 19201 SOUTH CLINIC | 0 | 0 | | 0 | 0 | 192.01 |
| | 19202 WEST CLINIC | 0 | 0 | 0 | 0 | | 192.02 |
| | 3 19203 DI ABETES CENTER 19300 NONPAI D WORKERS | 83, 465 | 6, 390 | 89, 855 | 5, 173 | | 192.03 193.00 |
| | 19301 ADULT/CHI LD CARE | 517, 221 | 74, 240 | 591, 461 | -95, 437 | 496, 024 | |
| | 19302 PHYSICIAN OFFICE BUILDING | 0 | 0 | 0 | 0 | | 193.02 |
| 193.03 | 19303 OPTI FAST/FOUNDATI ON | 0 | 752, 872 | 752, 872 | 0 | 752, 872 | |
| | 07950 PARTNERSHIP HFC | 27, 708 | 4, 690 | | 0 | | 194.00 |
| | 07951 TRAFALGAR CLINIC 07952 EDINBURGH | 0 | 0 | 0 | 0 | | 194.01 194.02 |
| | 307952 EDI NBURGH | 0 | 48, 000 | - | 0 | 48,000 | |
| 194.04 | 07954 ATHLETI C TRAI NERS | 207, 305 | 37, 109 | 244, 414 | 14, 327 | 258, 741 | 194.04 |
| 200.00 | TOTAL (SUM OF LINES 118-199) | 38, 906, 469 | 44, 067, 114 | 82, 973, 583 | 0 | 82, 973, 583 | 200. 00 |
| | | | | | | | |

| Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (| JOHNSON MEMORIA | | | of Form CMS-2552-10 |
|---|--------------------|---|---|---|
| RECLASSIFICATION AND ADJUSTMENTS OF INTAL BALANCE (| DI EAFENJEJ | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet A Date/Time Prepared: 1/16/2018 3:01 pm |
| Cost Center Description | | Net Expenses for Allocation 7.00 | | |
| GENERAL SERVICE COST CENTERS | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT | 83, 386 | 2,039,684 | | 1.00 |
| 1. 01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2. 00 00200 CAP REL COSTS-MVBLE EQUIP | 0 | 86, 509 2, 585, 049 | | 1.01 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | -109, 313 | 9, 262, 531 | | 4.00 |
| 4. 01 00401 COMMUNI CATI ONS | -30, 660 | 496, 955 | | 4.01 |
| 4. 02 00402 DATA PROCESSI NG | 0 | 1, 605, 716 | | 4.02 |
| 4. 03 00403 MATERIALS MANAGEMENT | 0 | 325, 708 | | 4.03 |
| 4. 04 00404 ADMITTING 4. 05 00405 PATIENT ACCOUNTING | 0 -8, 880 | 656, 789 1, 671, 558 | | 4.04 |
| 5. 00 00500 ADMINI STRATI VE & GENERAL | -2, 564, 606 | 3, 724, 814 | | 5.00 |
| 2.00 00700 OPERATION OF PLANT | -34, 628 | 2, 729, 705 | | 7.00 |
| 3. 00 00800 LAUNDRY & LINEN SERVICE | 0 | 201, 511 | | 8.00 |
| 9. 00 00900 HOUSEKEEPING | 0 | 809, 972 | | 9.00 |
| IO. 00 01000 DI ETARY I 1. 00 01100 CAFETERI A | - 48 - 311, 963 | 448, 778 454, 912 | | 10.00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | -15, 990 | 1, 802, 895 | | 13.00 |
| 4.00 01400 CENTRAL SERVICES & SUPPLY | 0 | 188, 197 | | 14.00 |
| 15. 00 01500 PHARMACY | - 788 | 3, 406, 183 | | 15.00 |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS | -26, 456 | 840, 470 | | 16.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | -1, 395, 109 | 3, 756, 326 | | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | 0 | 1, 499, 863 | | 31.00 |
| 41.00 04100 SUBPROVIDER - IRF | 0 | 808, 319 | | 41.00 |
| 43. 00 04300 NURSERY | 0 | 278, 012 | | 43.00 |
| ANCI LLARY SERVICE COST CENTERS | 0 | 2, 776, 759 | | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 60, 136 | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | -137 | 3, 054, 719 | | 54.00 |
| 0.00 06000 LABORATORY | 0 | 3, 625, 896 | | 60.00 |
| 55. 00 06500 RESPI RATORY THERAPY | 0 | 1, 180, 611 | | 65.00 |
| 06.00 06600 PHYSICAL THERAPY 07.00 06700 0CCUPATI 0NAL THERAPY | 0 | 953, 656 248, 792 | | 66.00 67.00 |
| 58.00 06800 SPEECH PATHOLOGY | 0 | 147, 011 | | 68.00 |
| 9. 00 06900 ELECTROCARDI OLOGY | -57, 391 | 667, 577 | | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 58, 102 | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 1, 899, 820 | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 1, 554, 733 0 | | 72.00 73.00 |
| 76. 00 03020 ONCOLOGY | -61, 250 | 154, 899 | | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 171, 221 | | 76. 97 |
| OUTPATIENT SERVICE COST CENTERS | 105 001 | 2 (40 050 | | |
| 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY | -195,001 | 2, 649, 850 2, 290, 333 | | 90.00 91.00 |
| 22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 2, 270, 333 | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 877, 289 | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | -15, 650 | 0 | | 113.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | -4, 744, 484 | 62, 051, 860 | | 118.00 |
| NONREI MBURSABLE COST CENTERS | | · · · · | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 114, 589 | | 190.00 |
| 92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 92. 01 19201 SOUTH CLINIC | 0 | 14, 379, 587 | | 192.00 |
| 92. 02 19201 SOUTH CLINIC 92. 02 19202 WEST CLINIC | | 0 | | 192. 01 192. 02 |
| 92. 03 19203 DI ABETES CENTER | 0 | 95, 028 | | 192.02 |
| 93. 00 19300 NONPAI D WORKERS | 0 | 0 | | 193.00 |
| 93. 01 19301 ADULT/CHI LD CARE | 0 | 496, 024 | | 193.01 |
| 93. 02 19302 PHYSI CI AN OFFI CE BUILDING 93. 03 19303 OPTI FAST/FOUNDATI ON | 0 | 0 752, 872 | | 193. 02 193. 03 |
| 94. 00 07950 PARTNERSHIP HFC | 0 | 32, 398 | | 193.03 |
| 94. 01 07951 TRAFALGAR CLINIC | 0 | 0 | | 194. 01 |
| 94. 02 07952 EDI NBURGH | 0 | 0 | | 194. 02 |
| 94. 03 07953 JAI L | 0 | 48,000 | | 194.03 |
| 194. 04 07954 ATHLETI C TRAI NERS | 0 | 258, 741 | | 194.04 |
| 200.00 TOTAL (SUM OF LINES 118-199) | -4, 744, 484 | 78, 229, 099 | | 200.00 |

| CLASSI FI CATI ON | S | | | Provider CCN: 15 | | Worksheet A-6 |
|------------------------------|-----------------------------------|-----------------|---------------------------------|-----------------------------|----------------------------|------------------------|
| | | | | | From 01/01/2 To 12/31/2 | 2016 Date/Time Prepare |
| | | Increases | | | | 1/16/2018 3:01 pm |
| | Cost Center | Line # | Salary | Other | | |
| A - NURSE | 2.00 RY RECLASS | 3.00 | 4.00 | 5.00 | | |
| DO NURSERY | | 43.00 | 226, 326 | 5 <u>1,6</u> 86 | | 1. |
| 0 | | | 226, 326 | 51, 686 | | |
| | NTABLE RECLASS | 72.00 | 0 | 1, 554, 733 | | 1. |
| PATI ENT | . CHARGED TO | 72.00 | Ű | 1, 334, 733 | | 1. |
| 0 | | | o | 1, 554, 733 | | |
| | ERIA RECLASS | 11 00 | E 27 172 | 220 702 | | 1 |
| DO CAFETERI A | <u> </u> | <u>11.00</u> | <u>527, 173</u> 527, 173 | <u>239, 702</u> 239, 702 | | 1. |
| D - DAY C | ARE RECLASS | | 02,7170 | 2077702 | | |
| DO <u>EMPLOYEE</u> | BENEFITS DEPARTMENT | 4.00 | 104, 134 | 1 <u>4, 9</u> 47 | | 1. |
| 0 | | | 104, 134 | 14, 947 | | |
| | CLAN RECLASS PEDIATRICS | 30.00 | 68, 781 | 0 | | 1. |
| O OPERATING | | 50.00 | 90, 750 | 0 | | 2. |
| 00 ANESTHESI | | 53.00 | 25,000 | 0 | | 3. |
| TOTALS | | | 184, 531 | ō | | |
| G - STD R DATA PROC | | 4, 02 | 0 | 2, 212 | | 1. |
| | CCOUNTI NG | 4.02 | 0 | 2, 212 7, 233 | | 2. |
| | ATIVE & GENERAL | 5.00 | 0 | 1, 166 | | 3. |
| O NURSING A | DMI NI STRATI ON | 13.00 | 0 | 1, 888 | | 4. |
| | S' PRIVATE OFFICES | 1 <u>92.</u> 00 | 0 | <u>36, 692</u> | | 5. |
| TOTALS | YEE WELLNESS RECLASS | | 0 | 49, 191 | | |
| | BENEFITS DEPARTMENT | 4.00 | 0 | 66, 984 | | 1. |
| TOTALS | | | 0 | 66, 984 | | |
| I - PTO R | | 4.00 | 04.444 | 0 | | |
| 0 EMPLOYEE 0 COMMUNICA | BENEFITS DEPARTMENT | 4.00 4.01 | 26, 466 12, 432 | 0 | | 1. |
| 0 DATA PROC | | 4.02 | 76, 690 | 0 | | 3. |
| | MANAGEMENT | 4.03 | 10, 583 | 0 | | 4. |
| O ADMITTING | | 4.04 | 29, 791 | 0 | | 5. |
| | CCOUNTING ATIVE & GENERAL | 4.05 | 82, 218 | 0 | | 6 |
| | OF PLANT | 5.00 7.00 | 162, 738 31, 979 | 0 | | 8 |
| | LINEN SERVICE | 8.00 | 5, 121 | 0 | | 9 |
| 00 HOUSEKEEF | | 9.00 | 42, 234 | 0 | | 10 |
| 00 DI ETARY | | 10.00 | 48, 485 | 0 | | 11. |
| | DMINISTRATION ERVICES & SUPPLY | 13.00 | 114, 784 | 0 | | 12. |
| 00 PHARMACY | ERVICES & SUPPLI | 14.00 15.00 | 6, 667 49, 301 | 0 | | 14. |
| | ECORDS & LI BRARY | 16.00 | 36, 862 | 0 | | 15. |
| 00 ADULTS & | PEDI ATRI CS | 30.00 | 149, 507 | 0 | | 16 |
| | CARE UNI T | 31.00 | 31, 776 | 0 | | 17 |
| 00 SUBPROVID | | 41.00 50.00 | 45, 418 100, 044 | 0 | | 18 |
| | -DI AGNOSTI C | 54.00 | 139, 886 | 0 | | 20 |
| 00 LABORATOR | Y | 60.00 | 74, 978 | Ö | | 21 |
| | RY THERAPY | 65.00 | 44, 648 | 0 | | 22 |
| 00 PHYSICAL | | 66.00 | 46, 384 | 0 | | 23 |
| 00 OCCUPATIO 00 SPEECH PA | NAL THERAPY | 67.00 68.00 | 14, 883 12, 788 | 0 | | 24 |
| 00 ELECTROCA | | 69.00 | 31, 344 | 0 | | 25. |
| | CEPHALOGRAPHY | 70.00 | 3, 066 | 0 | | 27 |
| 00 ONCOLOGY | | 76.00 | 3, 856 | 0 | | 28. |
| | EHABI LI TATI ON | 76.97 | 5, 217 | 0 | | 29 |
| 00 CLINIC 00 EMERGENCY | , | 90.00 91.00 | 21, 993 86, 700 | 0 | | 30 |
| | TH AGENCY | 101.00 | 38, 244 | 0 | | 32 |
| | S' PRIVATE OFFICES | 192.00 | 498, 318 | 0 | | 33. |
| 00 DI ABETES | | 192.03 | 5, 173 | 0 | | 34. |
| 00 ADULT/CHI | | 193.01 | 23, 644 | 0 | | 35. |
| 00 ATHLETIC TOTALS | | <u>194.04</u> | 1 <u>4, 3</u> 27 2, 128, 545 | <u>0</u> | | 36. |
| | A RECLASS | | 2, 120, 343 | U | | |
| 0 PHYSICAL | | 66.00 | 0 | 109, 560 | | 1. |
| TOTALS | | | 0 | 109, 560 | | |
|) 00 Grand Tot | al: Increases | | 3, 170, 709 | 2, 086, 803 | | 500. |

| LASS | Financial Systems SIFICATIONS | | JOHNSON MEMORIA | | CCN: 15-0001 | Peri od: | u of Form CMS-2552 Worksheet A-6 |
|----------|--|-----------------|-------------------|------------------|------------------------|----------------------------------|--|
| | | | | | | From 01/01/2016 To 12/31/2016 | Date/Time Prepare 1/16/2018 3:01 pr |
| | | Decreases | | | | | 171072018 S. 01 pi |
| | Cost Center 6.00 | Line # | Salary 8.00 | 0ther 9.00 | Wkst. A-7 Ref 10.00 | ; | |
| | A - NURSERY RECLASS | 7.00 | 8.00 | 9.00 | 10.00 | | |
| | ADULTS & PEDIATRICS | | 226, 326 | 51,686 | | 0 | 1 |
| | | | 226, 326 | 51, 686 | | | |
| | B - IMPLANTABLE RECLASS MEDICAL SUPPLIES CHARGED TO | 71.00 | 0 | 1, 554, 733 | 2 | 0 | 1 |
| | PATI ENTS | /1.00 | 0 | 1, 554, 755 | , | 0 | |
| | 0 | | 0 | 1, 554, 733 | 3 | | |
|) | C – CAFETERIA RECLASS DI ETARY | 10.00 | 527, 173 | 239, 702 | | 0 | 1 |
| J | | | <u>527, 173</u> | 239,702 | | | |
| | D - DAY CARE RECLASS | | | , | - | | |
| 0 | ADULT/CHILD_CARE | 1 <u>93.</u> 01 | <u>104, 1</u> 34 | 1 <u>4, 9</u> 47 | | 0 | 1 |
| | 0 F - PHYSICIAN RECLASS | | 104, 134 | 14, 947 | 7 | | |
| | PHYSICIAN RECLASS | 192.00 | 184, 531 | (| | 0 | 1 |
| 0 | | 0.00 | 0 | C | | 0 | 2 |
|) | | 0.00 | 0 | 0 | | 0 | 3 |
| | TOTALS G - STD RECLASS | | 184, 531 | (|) | | |
| | G - STD RECLASS | 4.02 | 2, 212 | (| | 0 | 1 |
|) | PATIENT ACCOUNTING | 4.05 | 7, 233 | C | | 0 | 2 |
|) | ADMI NI STRATI VE & GENERAL | 5.00 | 1, 166 | 0 | | 0 | 3 |
| | NURSING ADMINISTRATION PHYSICIANS' PRIVATE OFFICES | 13.00 192.00 | 1, 888 36, 692 | 0 | | 0 | 2 |
| | TOTALS | | 49, 191 | (| | Ĭ | |
| | H - EMPLOYEE WELLNESS RECLASS | | | | | | |
|) | ADMI NI STRATI VE & GENERAL | 5.00 | 66, 984 | 0 |) | <u>0</u> | 1 |
| | TOTALS | | 66, 984 | (| | | |
|) | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 2, 128, 545 | 5 | 0 | 1 |
|) | | 0.00 | 0 | C | | 0 | 2 |
|)) | | 0.00 0.00 | 0 | 0 | | 0 | 3 |
|) | | 0.00 | 0 | (| | 0 | 5 |
|) | | 0.00 | 0 | C | | 0 | 6 |
| 0 | | 0.00 | 0 | 0 | | 0 | 7 |
| 0 0 | | 0.00 0.00 | 0 | 0 | | 0 | 8 |
| 00 | | 0.00 | 0 | (| | 0 | 10 |
| 00 | | 0.00 | 0 | C | | 0 | 11 |
| 00 | | 0.00 | 0 | 0 | | 0 | 12 |
| 00 00 | | 0.00 0.00 | 0 | (| | 0 | 13 |
| 00 | | 0.00 | 0 | C | | 0 | 15 |
| 00 | | 0.00 | 0 | (| | 0 | 16 |
| 00 00 | | 0.00 0.00 | 0 | (| | 0 | 17 |
| 00 | | 0.00 | 0 | (| | 0 | 19 |
| 00 | | 0.00 | 0 | C | | 0 | 20 |
| 00 | | 0.00 | 0 | 0 | | 0 | 21 |
| 00 00 | | 0.00 0.00 | 0 | (| | 0 | 22 |
| 00 | | 0.00 | 0 | (| | 0 | 24 |
| 00 | | 0.00 | 0 | C | | 0 | 25 |
| 00 | | 0.00 | 0 | (| | 0 | 26 |
| 00 00 | | 0.00 0.00 | 0 | 0 | | 0 | 27 |
| 00 | | 0.00 | 0 | (| | 0 | 29 |
| 00 | | 0.00 | 0 | C | | 0 | 30 |
| 00 | | 0.00 | 0 | (| | 0 | 31 |
| 00 00 | | 0.00 0.00 | 0 | (| | 0 | 32 |
| 00 | | 0.00 | 0 | (| | 0 | 34 |
| 00 | | 0.00 | 0 | (| | 0 | 35 |
| 00 | | 0.00 | 0 | 120 545 | | <u>o</u> | 36 |
| | J - PART A RECLASS | | 0 | 2, 128, 545 | | | |
|) | SUBPROVIDER - IRF | 41.00 | ol | 109, 560 |) | 0 | 1 |
| | TOTALS | | | 109, 560 | | 7 | · · · |

| Health Financial Systems | JOHNSON MEMORI | | | | eu of Form CMS-2 | |
|---|------------------|----------------|-------------|----------------------------|-------------------------|-------|
| RECONCILIATION OF CAPITAL COSTS CENTERS | | Provider CC | CN: 15-0001 | Period: From 01/01/2016 | Worksheet A-7 Part I | |
| | | | | To 12/31/2016 | | nared |
| | | | | | 1/16/2018 3:0 | 1 pm |
| | | Acqui si ti or | | S | | |
| | Begi nni ng | Purchases | Donati on | Total | Disposals and | |
| | Bal ances | | | | Retirements | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | BALANCES | | | | | |
| 1.00 Land | 4, 743, 329 | 0 | | 0 0 | 0 0 | 1.00 |
| 2.00 Land Improvements | 1, 463, 185 | 1, 283, 021 | | 0 1, 283, 021 | 0 | 2.00 |
| 3.00 Buildings and Fixtures | 0 | 0 | | 0 0 | 0 0 | 3.00 |
| 4.00 Building Improvements | 66, 944, 131 | 2, 028, 514 | | 0 2, 028, 514 | t 0 | 4.00 |
| 5.00 Fixed Equipment | 12, 824, 093 | 106, 346 | | 0 106, 346 | 0 | 5.00 |
| 6.00 Movable Equipment | 37, 840, 030 | 12, 639, 983 | | 0 12, 639, 983 | 3 0 | 6.00 |
| 7.00 HIT designated Assets | 0 | 0 | | 0 (| 0 0 | 7.00 |
| 8.00 Subtotal (sum of lines 1-7) | 123, 814, 768 | 16, 057, 864 | | 0 16, 057, 864 | l 0 | 8.00 |
| 9.00 Reconciling Items | 0 | 0 | | 0 (| 0 0 | 9.00 |
| 10.00 Total (line 8 minus line 9) | 123, 814, 768 | 16, 057, 864 | | 0 16, 057, 864 | 0 | 10.00 |
| | Endi ng Bal ance | Fully | | | | |
| | - | Depreci ated | | | | |
| | | Assets | | | | |
| | 6.00 | 7.00 | | | | |
| PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | | | | | | |
| 1.00 Land | 4, 743, 329 | 0 | | | | 1.00 |
| 2.00 Land Improvements | 2, 746, 206 | 0 | | | | 2.00 |
| 3.00 Buildings and Fixtures | 0 | 0 | | | | 3.00 |
| 4.00 Building Improvements | 68, 972, 645 | 0 | | | | 4.00 |
| 5.00 Fixed Equipment | 12, 930, 439 | 0 | | | | 5.00 |
| 6.00 Movable Equipment | 50, 480, 013 | 0 | | | | 6.00 |
| 7.00 HIT designated Assets | 0 | 0 | | | | 7.00 |
| 8.00 Subtotal (sum of lines 1-7) | 139, 872, 632 | 0 | | | | 8.00 |
| 9.00 Reconciling Items | 0 | 0 | | | | 9.00 |
| 10.00 Total (line 8 minus line 9) | 139, 872, 632 | 0 | | | | 10.00 |

| Heal th | Financial Systems | JOHNSON MEMORI | AL_HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|-------------------|----------------|---------------|---------------------------------|--------------------------------|----------------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provider CO | CN: 15-0001 | Period: From 01/01/2016 | | |
| | | | | | To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pared: 1 pm |
| | | | SL | JMMARY OF CAF | PITAL | | |
| | Cost Center Description | Depreciation | Lease | Interest | Insurance (see instructions) | | |
| | | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WORK | | N 2, LINES 1 a | nd 2 | 1 | I | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 1, 956, 298 | 0 | | 0 0 | 0 | 1.00 |
| 1.01 | CAP REL COSTS-BLDG & FIXT - TOWER | 86, 509 | 0 | | 0 0 | 0 | 1.01 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 2, 585, 049 | 0 | | 0 0 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 4, 627, 856 | | | 0 0 | 0 | 3.00 |
| | | SUMMARY OF | | | | | |
| | Cost Center Description | Other ' | Total (1) (sum | | | | |
| | | Capi tal -Rel ate | of cols. 9 | | | | |
| | | d Costs (see | through 14) | | | | |
| | | instructions) | | | | | |
| | | 14.00 | 15.00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WORK | SHEET A, COLUM | | 1 | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | 1, 956, 298 | | | | 1.00 |
| 1.01 | CAP REL COSTS-BLDG & FIXT - TOWER | 0 | 86, 509 | | | | 1.01 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 2, 585, 049 | | | | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | 4, 627, 856 | | | | 3.00 |

| Heal th | Financial Systems | JOHNSON MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|----------------|---------------------------------------|---|-----------------------------|----------------------------------|---------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provider C | F | | Date/Time Prep 1/16/2018 3:01 | |
| | | COME | PUTATION OF RA | TIOS | ALLOCATION OF | OTHER CAPITAL | |
| | Cost Center Description | Gross Assets | Capi tal i zed Leases | Gross Assets for Ratio (col. 1 - col. 2) | Ratio (see instructions) | Insurance | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS C | | | | | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 89, 392, 619 | 0 | 89, 392, 619 | | | 1.00 |
| 1.01 | CAP REL COSTS-BLDG & FIXT - TOWER | 0 | 0 | 0 | 0. 000000 | | 1.01 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 50, 480, 013 | C | 50, 480, 013 | 0. 360900 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 139, 872, 632 | C | 139, 872, 632 | 1. 000000 | 0 | 3.00 |
| | | | FION OF OTHER (| - | | F CAPI TAL | |
| | 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 | NEW CAP REL COSTS-BLDG & FIXT | 0 | C | 0 | 2, 039, 684 | 0 | 1.00 |
| 1.01 | CAP REL COSTS-BLDG & FIXT - TOWER | 0 | 0 | 0 | 86, 509 | 0 | 1.01 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | C | 0 | 2, 585, 049 | 0 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | C | 0 | 4, 711, 242 | 0 | 3.00 |
| | | | SI | JMMARY OF CAPI | ΓAL | | |
| | Cost Center Description | Interest | Insurance (see | Taxes (see | Other | Total (2) (sum | |
| | | | instructions) | instructions) | Capi tal -Rel ate | of cols. 9 | |
| | | | | | d Costs (see | through 14) | |
| | | | | | instructions) | | |
| | | 11.00 | 12.00 | 13.00 | 14.00 | 15.00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS C | | | 1 | 1 | | |
| 1.00 | NEW CAP REL COSTS-BLDG & FIXT | 0 | 0 | 0 | 0 0 | 2, 039, 684 | 1.00 |
| 1.01 | CAP REL COSTS-BLDG & FIXT - TOWER | 0 | 0 | 0 | 0 0 | 86, 509 | 1.01 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | C | 0 | 0 0 | 2, 585, 049 | 2.00 |
| 3.00 | Total (sum of lines 1-2) | 0 | C | 0 0 | 0 0 | 4, 711, 242 | 3.00 |
| | | | | | | | |

| | Financial Systems MENTS TO EXPENSES | | JOHNSON MEMORIAL | Provider CCN: 15-0001 | Peri od: | u of Form CMS-2 Worksheet A-8 | |
|--------------|---|----------------|-------------------|---|----------------------------------|----------------------------------|----------|
| 55051 | | | | | From 01/01/2016 To 12/31/2016 | | pare |
| | | | Tc | Expense Classification o D/From Which the Amount i | | | |
| | Cost Center Description | Basis/Code (2) | Amount | Cost Center | | Wkst. A-7 Ref. | |
| 00 | Investment income - NEW CAP | 1.00 | 2.00 0.NE | 3.00 W CAP REL COSTS-BLDG & | 4.00 | 5.00 | 1. |
| | REL COSTS-BLDG & FIXT (chapter | | | XT | | | |
| 01 | 2) Investment income - CAP REL COSTS-BLDG & FIXT - TOWER | | | P REL COSTS-BLDG & FIXT WER | - 1.01 | 0 | 1 |
| 00 | (chapter 2) Investment income - CAP REL | | ADO | P REL COSTS-MVBLE EQUIP | 2.00 | 0 | 2 |
| 00 | COSTS-MVBLE EQUIP (chapter 2) Investment income - other | | О | | 0.00 | 0 | 3 |
| 00 | (chapter 2) Trade, guantity, and time | | 0 | | 0.00 | 0 | 4 |
| 00 | di scounts (chapter 8) Refunds and rebates of | | 0 | | 0.00 | | |
| | expenses (chapter 8) | | 0 | | | | |
| 00 | Rental of provider space by suppliers (chapter 8) | | 0 | | 0.00 | 0 | 6 |
| 00 | Telephone services (pay stations excluded) (chapter 21) | | 0 | | 0.00 | 0 | 7 |
| 00 | Television and radio service (chapter 21) | | 0 | | 0.00 | 0 | 8 |
| 00 . 00 | Parking Lot (chapter 21) Provider-based physician adjustment | A-8-2 | 0 -1, 513, 750 | | 0.00 | 0 | |
| 00 | Sale of scrap, waste, etc. | | О | | 0.00 | 0 | 11 |
| 00 | (chapter 23) Related organization transactions (chapter 10) | A-8-1 | 0 | | | 0 | 12 |
| . 00 . 00 | Laundry and linen service Cafeteria-employees and guests | | 0 | | 0.00 0.00 | | |
| | Rental of quarters to employee | | 0 | | 0.00 | | |
| 00 | and others Sale of medical and surgical supplies to other than | | 0 | | 0.00 | 0 | 16 |
| 00 | patients Sale of drugs to other than | | О | | 0.00 | 0 | 17 |
| 00 | patients Sale of medical records and | | о | | 0.00 | 0 | 18 |
| 00 | abstracts Nursing school (tuition, fees, | | 0 | | 0.00 | 0 | 19 |
| | books, etc.) | | ő | | | | |
| 00 | Vending machines Income from imposition of interest, finance or penalty | | 0 0 | | 0.00 0.00 | | |
| . 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 | ORE | SPIRATORY THERAPY | 65.00 | | 23 |
| 00 | limitation (chapter 14) Adjustment for physical therapy costs in excess of | A-8-3 | OPH | IYSI CAL THERAPY | 66.00 | | 24 |
| 00 | limitation (chapter 14) Utilization review - physicians' compensation | | 0 * * | * Cost Center Deleted ** | * 114.00 | | 25 |
| 00 | (chapter 21) Depreciation - NEW CAP REL | | | W CAP REL COSTS-BLDG & | 1.00 | 0 | 26 |
| 01 | COSTS-BLDG & FIXT Depreciation - CAP REL | | | XT .P REL COSTS-BLDG & FIXT | - 1.01 | 0 | 26 |
| 00 | COSTS-BLDG & FIXT - TOWER Depreciation - CAP REL | | тс | WER P REL COSTS-MVBLE EQUIP | 2.00 | | 27 |
| | COSTS-MVBLE EQUIP | | | | | | |
| | Non-physician Anesthetist Physicians' assistant | | 0 | * Cost Center Deleted ** | 0.00 | 0 | 28 29 |
| . 00 | Adjustment for occupational therapy costs in excess of limitation (chapter 14) | A-8-3 | 000 | CUPATI ONAL THERAPY | 67.00 | | 30 |
| . 99 | Hospice (non-distinct) (see instructions) | | OAD | ULTS & PEDIATRICS | 30.00 | | 30 |

| 55051 | MENTS TO EXPENSES | | | | Peri od: | Worksheet A-8 | ; |
|---------------|--|-----------------|----------------|--|----------------------------------|----------------|------|
| | | | | | From 01/01/2016 To 12/31/2016 | | nare |
| | | | | | | 1/16/2018 3:0 | |
| | | | | Expense Classification on To/From Which the Amount is | | | |
| | | | | 10/From which the Amount is | to be Adjusted | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | | Amount | Cost Center | | Wkst. A-7 Ref. | - |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | - |
| 1.00 | Adjustment for speech pathology costs in excess of | A-8-3 | 0 | SPEECH PATHOLOGY | 68.00 | | 31 |
| | limitation (chapter 14) | | | | | | |
| > 00 | CAH HIT Adjustment for | | 0 | | 0.00 | 0 | 32 |
| . 00 | Depreciation and Interest | | 0 | | 0.00 | Ű | |
| 3.00 | JMH PAIN CARE CENTER REVENUE | В | -194, 082 | CLINIC | 90.00 | 0 | 33 |
| | OPERATI | | | | | | |
| 4.00 | JMH NUTRIENT SERVICES | В | 6 | DI ETARY | 10.00 | 0 | 34 |
| | DI SCOUNTS OPER | | | | | | |
| 5.00 | JMH PURCHASE DI SCOUNTS | В | -8, 694 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 35 |
| | OPERATING FUN | В | 107 | RADI OLOGY-DI AGNOSTI C | F4 00 | | 3 |
| 5.00 7.00 | JMH SALE OF FILM JMH CAFETERIA REVENUE | В | - | CAFETERI A | 54.00 11.00 | | |
| 1.00 | OPERATING FUND | D | -311, 903 | CAFETERIA | 11.00 | 0 | |
| 8.00 | JMH CATERING REVENUE OPERATING | В | -54 | DI ETARY | 10.00 | 0 | 38 |
| | FUND | 5 | 01 | | 10100 | , j | |
| 9.00 | JMH MI SCELLANEOUS PHARMACY | В | -788 | PHARMACY | 15.00 | 0 | 39 |
| | REVENUE O | | | | | | |
|). 00 | JMH RENT OF SPACE | В | -4, 500 | OPERATION OF PLANT | 7.00 | 0 | 40 |
| 1.00 | JMH MEDICAL RECORD FEES | В | | MEDICAL RECORDS & LIBRARY | 16.00 | | |
| 2.00 | JMH GENERAL ACCOUNT REVENUE | В | -6, 662 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 42 |
| | OPERATIN | _ | | | | - | |
| 3.00 | JMH RETURNED CHECK FEES | В | -375 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 43 |
| 5. 01 | OPERATING FU BILLING SERVICES | В | 0 000 | PATI ENT ACCOUNTI NG | 4.05 | 0 | 45 |
| | MI SC REV | B | | ADMI NI STRATI VE & GENERAL | 5.00 | | |
| 5.02 | JMH PHJC PROGRAMS OTHER | B | | ADMI NI STRATI VE & GENERAL | 5.00 | | |
| | EXPENSE | 5 | 0,001 | | 0.00 | | `` |
| 5.04 | 1933 AHA LIFE | А | 84, 563 | NEW CAP REL COSTS-BLDG & | 1.00 | 9 | 45 |
| | | | | FLXT | | | |
| | MEDICAL STAFF OTHER EXPENSES | A | | ADMINISTRATIVE & GENERAL | 5.00 | | |
| | CABLE SERVICES | A | | OPERATION OF PLANT | 7.00 | | |
| 5.07 | TELEPHONE SERVICES | A | | NEW CAP REL COSTS-BLDG & | 1.00 | 9 | 4 |
| F 00 | | ٨ | | | F 00 | 0 | |
| | TELEPHONE SERVICES COMMUNICATIONS | A | | ADMINISTRATIVE & GENERAL COMMUNICATIONS | 5.00 4.01 | 0 | |
| 5. 10 | ADVERTISING EXP - A&G | A | | ADMI NI STRATI VE & GENERAL | 5.00 | - | |
| 5.11 | ADVERTISING EXP - NURSING | A | | NURSING ADMINISTRATION | 13.00 | | |
| 5. 11 | ADMI N | ~ | 10, 770 | | 10.00 | Ű | |
| 5.13 | ADVERTISING EXP - WOUND CARE | А | -919 | CLINIC | 90.00 | 0 | 45 |
| | DAYCARE | В | | EMPLOYEE BENEFITS DEPARTMEN | | | |
| 5.15 | LOBBYING EXPENSE - AHA | А | -4, 901 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | 4! |
| <u>5</u> . 16 | LOBBYING EXPENSE - IHHA | А | -1, 628 | ADMI NI STRATI VE & GENERAL | 5.00 | 0 | |
| | PROF – BUI LDI NG | A | | OPERATION OF PLANT | 7.00 | | |
| | PROF – BUILDING | A | | EMPLOYEE BENEFITS DEPARTMEN | | | |
| | INTEREST INCOME | В | | INTEREST EXPENSE | 113.00 | | |
| | HAF EXPENSE | A | | ADMI NI STRATI VE & GENERAL | 5.00 | | |
| | DAYCARE DISCOUNT | A | | EMPLOYEE BENEFITS DEPARTMEN | T 4.00 | 0 | |
| J. UU | TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, | | -4, 744, 484 | | | 1 | 50 |
| | column 6, line 200.) | | | | | 1 | |
| 1) 00 | scription - all chapter referen | cas in this cal | ump pertain ta | L CMS Pub 15-1 | 1 | L | 1 |
| - | scription - all chapter referen sis for adjustment (see instruc | | | J UNIJ PUD. 13-1. | | | |
| | osts - if cost, including appli- | | can be determ | ni ned. | | | |
| | mount Received - if cost cannot | | | | | | |
| | | | | oscripts thereof. | | | |

| Heal th | Financial Syste | ems | JOHNSON MEMOR | REAL HOSPETAL | | In Lie | eu of Form CMS- | 2552-10 |
|---------|-----------------|-----------------------|----------------------------|----------------|--------------------|----------------------------------|------------------|---------|
| | R BASED PHYSIC | | | | | Period: | Worksheet A-8 | |
| | | | | | | From 01/01/2016 To 12/31/2016 | | |
| | Wkst. A Line # | | Total | Professi onal | Provi der | | Physi ci an/Prov | |
| | | Identifier | Remuneration | Component | Component | | ider Component | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | Hours 7.00 | |
| 1.00 | | ADULTS & PEDIATRICS | 1, 395, 109 | | | | 7.00 | 1.00 |
| 2.00 | | LABORATORY | 110,004 | 1, 373, 107 | | - | - | |
| 3.00 | | ELECTROCARDI OLOGY | 57, 391 | 57, 391 | (| | 1, 3/3 | 3.00 |
| 4.00 | | ONCOLOGY | 61, 250 | | | | 0 | 4.00 |
| 5.00 | 0.00 | | 0 | 0 | | | 0 | 5.00 |
| 6.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 10.00 |
| 200.00 | | | 1, 623, 754 | | | | | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | Cost of | Provi der | Physician Cost | |
| | | Identifier | Limit | Unadjusted RCE | | | of Malpractice | |
| | | | | Limit | Continuing | Share of col. | Insurance | |
| | 1.00 | 2.00 | 8.00 | 9.00 | Education 12.00 | 12 13.00 | 14.00 | |
| 1.00 | | ADULTS & PEDIATRICS | 0.00 | | | 0 0 | 0 | 1.00 |
| 2.00 | | LABORATORY | 160, 150 | | | | 0 | 2.00 |
| 3.00 | | ELECTROCARDI OLOGY | 0 | | | | 0 | 3.00 |
| 4.00 | | ONCOLOGY | 0 | 0 | (| | 0 | 4.00 |
| 5.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 5.00 |
| 6.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | (| 0 0 | 0 | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | (| | 0 | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | (| ° | 0 | 10.00 |
| 200.00 | | | 160, 150 | | | 0 0 | 0 | 200.00 |
| | Wkst. A Line # | Cost Center/Physician | Provi der | Adjusted RCE | RCE | Adjustment | | |
| | | l denti fi er | Component Share of col. | Limit | Di sal I owance | | | |
| | | | 14 | | | | | |
| | 1.00 | 2.00 | 15.00 | 16.00 | 17.00 | 18.00 | | |
| 1.00 | | ADULTS & PEDIATRICS | 0 | | | | | 1.00 |
| 2.00 | | LABORATORY | 0 | 160, 150 | (| | | 2.00 |
| 3.00 | 69.00 | ELECTROCARDI OLOGY | 0 | 0 | (| 57, 391 | | 3.00 |
| 4.00 | 76.00 | ONCOLOGY | 0 | 0 | (| 61, 250 | | 4.00 |
| 5.00 | 0.00 | | 0 | 0 | (| 0 0 | | 5.00 |
| 6.00 | 0.00 | | 0 | 0 | (| 0 0 | | 6.00 |
| 7.00 | 0.00 | | 0 | 0 | (| | | 7.00 |
| 8.00 | 0.00 | | 0 | 0 | (| ° | | 8.00 |
| 9.00 | 0.00 | | 0 | 0 | (| | | 9.00 |
| 10.00 | 0.00 | | 0 | 0 | (| - | | 10.00 |
| 200.00 | | | 0 | 160, 150 | (| 1, 513, 750 | | 200.00 |
| | | | | | | | | |

| | Financial Systems LLOCATION - GENERAL SERVICE COSTS | JOHNSON MEMORI | AL HOSPITAL Provider C | CN: 15-0001 P | eri od: | u of Form CMS-2 Worksheet B | 2552-10 |
|------------------|---|--|---------------------------|------------------------|--------------------------------|--|------------------|
| | | | | T | rom 01/01/2016 o 12/31/2016 | Part I Date/Time Pre 1/16/2018 3:0 | |
| | | | CAP | ITAL RELATED CO | ISTS | 171072010 3.0 | |
| | Cost Center Description | Net Expenses for Cost Allocation | NEW BLDG & FIXT | BLDG & FIXT - TOWER | MVBLE EQUIP | EMPLOYEE BENEFI TS DEPARTMENT | |
| | | (from Wkst A col. 7) | | | | | |
| | GENERAL SERVICE COST CENTERS | 0 | 1.00 | 1.01 | 2.00 | 4.00 | |
| 1.00 | 00100 NEW CAP REL COSTS-BLDG & FIXT | 2, 039, 684 | 2, 039, 684 | | | | 1.00 |
| 1.01 2.00 | 00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-MVBLE EQUIP | 86, 509 2, 585, 049 | 0 | 86, 509 | 2, 585, 049 | | 1.01 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | 9, 262, 531 | 21, 767 | | 1, 151 | 9, 285, 449 | 4.00 |
| 4.01 4.02 | 00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG | 496, 955 1, 605, 716 | 2, 867 45, 664 | | 0 1, 211, 900 | 49, 435 189, 120 | |
| 4.03 | 00403 MATERIALS MANAGEMENT | 325, 708 | 27, 909 | 0 | 5, 741 | 64, 429 | 4.03 |
| 4.04 4.05 | 00404 ADMI TTI NG 00405 PATI ENT ACCOUNTI NG | 656, 789 1, 671, 558 | 16, 333 48, 509 | | 0 10, 134 | 145, 662 233, 006 | |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | 3, 724, 814 | 69, 488 | 0 | 25, 435 | 504, 410 | 5.00 |
| 7.00 8.00 | 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE | 2, 729, 705 201, 511 | 182, 073 17, 536 | | 39, 014 4, 296 | 157, 276 29, 391 | 7.00 |
| 9.00 | 00900 HOUSEKEEPING | 809, 972 | 13, 619 | | 4, 290 3, 865 | 158, 961 | 9.00 |
| 10. 00 11. 00 | 01000 DI ETARY 01100 CAFETERI A | 448, 778 454, 912 | 28, 573 30, 426 | | 17, 992 0 | 74, 258 120, 939 | |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 1, 802, 895 | 50, 420 71, 976 | | 28, 359 | 369, 794 | |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 188, 197 | 12, 394 | | 28, 604 | 20, 507 | 1 |
| 15. 00 16. 00 | 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY | 3, 406, 183 840, 470 | 14, 925 28, 296 | | 4, 835 6, 986 | 120, 093 136, 997 | 15.00 16.00 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | 2 754 224 | 201 1/2 | 10 5// | 112,020 | 007 104 | |
| 30. 00 31. 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 3, 756, 326 1, 499, 863 | 201, 163 57, 525 | | 112, 938 30, 856 | 927, 134 293, 927 | 1 |
| 41.00 | 04100 SUBPROVIDER - IRF | 808, 319 | 49, 333 | | 17, 003 | 178, 675 | |
| 43.00 | 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 278, 012 | 4, 559 | 0 | 0 | 51, 921 | 43.00 |
| 50.00 | 05000 OPERATI NG ROOM | 2, 776, 759 | 333, 810 | | 386, 374 | 492, 215 | |
| 53.00 54.00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | 60, 136 3, 054, 719 | 2, 874 120, 594 | | 12, 303 297, 737 | 5, 735 508, 197 | 53.00 54.00 |
| 60.00 | 06000 LABORATORY | 3, 625, 896 | 58, 714 | 6, 924 | 122, 412 | 365, 971 | 60.00 |
| 65.00 66.00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 1, 180, 611 953, 656 | 24, 612 46, 233 | | 13, 422 8, 754 | 227, 545 184, 799 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 248, 792 | 9, 738 | 0 | 2, 069 | 56, 783 | 67.00 |
| 68. 00 69. 00 | 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY | 147, 011 667, 577 | 605 7, 878 | | 324 29, 422 | 33, 701 114, 376 | 68.00 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 58, 102 | 1, 328 | 204 | 1, 603 | 11, 692 | 70.00 |
| 71.00 72.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 899, 820 1, 554, 733 | 0 0 | | 12, 162 0 | 0 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 | 73.00 |
| | 03020 ONCOLOGY 07697 CARDI AC REHABI LI TATI ON | 154, 899 171, 221 | 51, 055 18, 317 | | 1, 875 8, 953 | 32, 004 29, 665 | 1 |
| | OUTPATIENT SERVICE COST CENTERS | 1/1,221 | 10, 317 | | 0, 700 | 27,005 | /0. // |
| | 09000 CLINIC 09100 EMERGENCY | 2, 649, 850 2, 290, 333 | 84, 004 72, 464 | | | 169, 692 452, 631 | 1 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 2, 290, 333 | 72,404 | 10, 800 | 20, 955 | 452, 031 | 91.00 |
| 101 00 | OTHER REIMBURSABLE COST CENTERS | 877, 289 | 9, 519 | 0 | 56 | 164, 801 | 101 00 |
| 101.00 | SPECIAL PURPOSE COST CENTERS | 0/1,209 | 9, 519 | <u> </u> | 50 | 104, 801 | |
| | 11300 INTEREST EXPENSE | (2.051.0(0 | 1 707 700 | 84.400 | 2 407 040 | ((75 74) | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS | 62, 051, 860 | 1, 786, 680 | 84,600 | 2, 487, 848 | 6, 675, 742 | 118.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 114, 589 | 9, 461 | | 3, 868 | | 190.00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES 19201 SOUTH CLI NI C | 14, 379, 587 0 | 189, 112 0 | 0 | 92, 862 0 | 2, 412, 688 0 | 192.00 192.01 |
| 192.02 | 19202 WEST CLINIC | 0 | 0 | 0 | 0 | 0 | 192.02 |
| | 19203 DI ABETES CENTER 19300 NONPAI D WORKERS | 95, 028 | 2, 932 | 452 | 471 | | 192.03 193.00 |
| 193.01 | 19301 ADULT/CHI LD CARE | 496, 024 | 35, 247 | 0 | 0 | 100, 190 | 193.01 |
| | 19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION | 0 752, 872 | 0 | 0 | 0 | | 193.02 193.03 |
| 194.00 | 07950 PARTNERSHI P HFC | 32, 398 | 16, 252 | 0 | 0 | 6, 356 | 194.00 |
| | 07951 TRAFALGAR CLINIC 07952 EDINBURGH | 0 | 0 | 0 | 0 | | 194.01 194.02 |
| 194.03 | 07953 JAI L | 48, 000 | 0 | 0 | 0 | 0 | 194.03 |
| 194.04 | 07954 ATHLETIC TRAINERS Cross Foot Adjustments | 258, 741 | 0 | 0 | 0 | 50, 845 | 194.04 200.00 |
| | | | | | | | |
| 200.00 201.00 | | | 0 | 0 | 0 | 0 9, 285, 449 | 201.00 |

| Health Financial Systems | JOHNSON MEMORI | AL HOSPI TAL | | In Lieu | u of Form CMS-2 | 2552-10 |
|--|--------------------|----------------------|-------------------------|--------------------------------|-------------------------|--------------------|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provi der CC | | eriod: | Worksheet B | 2002 10 |
| | | | Fr To | rom 01/01/2016 0 12/31/2016 | Part I Date/Time Pre | pared: |
| | | DATA | | | 1/16/2018 3:0 | |
| Cost Center Description | COMMUNI CATI ONS | DATA PROCESSI NG | MATERIALS MANAGEMENT | ADMI TTI NG | PATI ENT ACCOUNTI NG | |
| | 4.01 | 4. 02 | 4.03 | 4.04 | 4. 05 | |
| GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 1. 01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2. 00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1.01 2.00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 4. 01 00401 COMMUNI CATI ONS | 549, 257 | | | | | 4.01 |
| 4. 02 00402 DATA PROCESSI NG | 56, 174 | 3, 108, 574 | | | | 4. 02 |
| 4. 03 00403 MATERIALS MANAGEMENT | 12, 067 | 42, 233 | 478, 087 | | | 4.03 |
| 4. 04 00404 ADMITTING 4. 05 00405 PATIENT ACCOUNTING | 11,651 | 115, 180 | 1, 153 | 948, 610 | 2 241 217 | 4.04 |
| 4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL | 36, 617 32, 040 | 339, 142 336, 581 | 2, 251 6, 174 | 0 | 2, 341, 217 0 | 4.05 5.00 |
| 7. 00 00700 OPERATI ON OF PLANT | 16, 228 | 26, 875 | 247 | 0 | 0 | |
| 8.00 00800 LAUNDRY & LINEN SERVICE | 2,081 | 20, 476 | 1, 073 | 0 | 0 | |
| 9. 00 00900 HOUSEKEEPI NG | 5, 825 | 0 | 6, 038 | 0 | 0 | 9.00 |
| 10. 00 01000 DI ETARY | 10, 403 | 90, 864 | 14, 193 | 0 | 0 | 10.00 |
| 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION | 0 17, 892 | 110 0(1 | 0 | 0 | 0 | 11.00 13.00 |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY | 17, 092 | 110, 061 0 | 3, 645 3, 526 | 0 | 0 | 14.00 |
| 15. 00 01500 PHARMACY | 7, 906 | 30, 715 | 0, 520 | 0 | 0 | 15.00 |
| 16.00 01600 MEDICAL RECORDS & LIBRARY | 17,060 | 140, 775 | 83 | 0 | 0 | 16.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | 1 1 | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 43, 691 | 226, 520 | 13, 611 | 52, 593 | 129, 796 | • |
| 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF | 11, 651 7, 490 | 78, 066 58, 870 | 4, 174 1, 010 | 9, 457 8, 797 | 23, 338 21, 710 | |
| 43. 00 04300 NURSERY | 7,490 | 58, 870 | 1, 010 | 3, 200 | 7, 898 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | 0,200 | ., | 101 00 |
| 50. 00 05000 OPERATI NG ROOM | 34, 537 | 264, 913 | 22, 264 | 146, 884 | 362, 498 | 50.00 |
| 53.00 05300 ANESTHESI OLOGY | 0 | 0 | 167 | 16, 533 | 40, 803 | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 21, 637 | 191, 966 | 16, 016 | 180, 074 | 444, 539 | |
| 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY | 28, 295 7, 490 | 140, 775 75, 507 | 66, 799 6, 542 | 132, 861 27, 519 | 327, 889 67, 914 | 60.00 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 8, 738 | 19, 197 | 1, 214 | 15, 897 | 39, 233 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 1, 664 | 6, 399 | 1 | 9, 788 | 24, 155 | |
| 68.00 06800 SPEECH PATHOLOGY | 1, 664 | 3, 839 | 5 | 3, 113 | 7, 683 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 17, 892 | 122, 858 | 3, 941 | 25, 858 | 63, 815 | |
| 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 832 | 3, 839 0 | 63 197, 761 | 735 32, 277 | 1, 813 79, 658 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 197, 781 | 22, 099 | 54, 538 | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 51, 227 | 126, 423 | |
| 76. 00 03020 ONCOLOGY | 15, 396 | 21, 756 | 0 | 1, 058 | 2, 611 | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 0 | 451 | 2, 569 | 6, 340 | 76.97 |
| OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC | 8, 322 | 102, 382 | 28, 395 | 53, 071 | 130, 974 | 90.00 |
| 91. 00 09100 EMERGENCY | 23, 718 | 154, 853 | | 93, 412 | 230, 532 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 20,710 | 101,000 | 0, 700 | 70, 112 | 200,002 | 92.00 |
| OTHER REI MBURSABLE COST CENTERS | · · · | | | | | |
| 101.00 10100 HOME HEALTH AGENCY | 9, 570 | 57, 590 | 688 | 7, 460 | 18, 410 | 101.00 |
| SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE | 1 1 | | | | | 112 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | 468, 531 | 2, 782, 232 | 407, 388 | 896, 482 | 2, 212, 570 | 113.00 118.00 |
| NONREI MBURSABLE COST CENTERS | 100,001 | 2,702,202 | 1077 000 | 0,0,102 | 2,212,010 | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 6, 242 | 20, 476 | 864 | 0 | 0 | 190. 00 |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES | 63, 665 | 244, 437 | 64, 521 | 52, 128 | 128, 647 | |
| 192. 01 19201 SOUTH CLINIC | 0 | 0 | 0 | 0 | | 192.01 |
| 192. 02 19202 WEST CLINIC 192. 03 19203 DIABETES CENTER | 1, 248 | 3, 839 | 0 10 | 0 | | 192. 02 192. 03 |
| 193. 00 19300 NONPAI D WORKERS | 1, 240 | 3, 037 | 0 | 0 | | 193.00 |
| 193. 01 19301 ADULT/CHI LD CARE | 6, 242 | 26, 875 | 4, 164 | 0 | | 193.01 |
| 193.02 19302 PHYSICIAN OFFICE BUILDING | 0 | 0 | 0 | 0 | | 193. 02 |
| 193. 03 19303 OPTI FAST/FOUNDATI ON | 0 | 0 | 1, 079 | 0 | | 193.03 |
| 194. 00 07950 PARTNERSHI P_HFC 194. 01 07951 TRAFALGAR_CLI NI C | 3, 329 | 30, 715 | 57 0 | 0 | | 194. 00 194. 01 |
| 194. 01 07951 TRAFALGAR CLINIC 194. 02 07952 EDI NBURGH | 0 | 0 | 0 | 0 | | 194.01 194.02 |
| 194. 03 07953 JAI L | 0 | 0 | 0 | 0 | | 194.02 |
| 194. 04 07954 ATHLETI C TRAI NERS | 0 | 0 | 4 | 0 | | 194.04 |
| 200.00 Cross Foot Adjustments | | | | | | 200.00 |
| 201.00Negative Cost Centers202.00TOTAL (sum lines 118-201) | E40 257 | 2 100 574 | 470.007 | 040 410 | 0 2, 341, 217 | 201.00 |
| 202. 00 101AL (SUII 111185 118-201) | 549, 257 | 3, 108, 574 | 478, 087 | 948, 610 | 2, 341, 217 | ∠UZ. UU |
| | | | | | | |

| | Financial Systems LLOCATION - GENERAL SERVICE COSTS | JOHNSON MEMORI | AL HOSPITAL Provider CO | CN: 15-0001 P | In Lie eriod: | u of Form CMS- Worksheet B | 2552-10 |
|----------------|---|-------------------------|--------------------------------|---------------|--------------------------------|-------------------------------|--------------------|
| | | | | F | rom 01/01/2016 o 12/31/2016 | Part I | |
| | Cost Center Description | | ADMI NI STRATI VE & GENERAL | PLANT | LAUNDRY & LINEN SERVICE | HOUSEKEEPI NG | |
| | | 4A. 05 | 5.00 | 7.00 | 8.00 | 9.00 | |
| 1.00 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 1.01 | 00101 CAP REL COSTS-BLDG & FIXT - TOWER | | | | | | 1.01 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 4.01 | | | | | | | 4.01 |
| 4.02 4.03 | 00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT | | | | | | 4.02 4.03 |
| 4.03 | 00404 ADMI TTI NG | | | | | | 4.03 |
| 4.05 | 00405 PATIENT ACCOUNTING | | | | | | 4.05 |
| 5.00 | 00500 ADMI NI STRATI VE & GENERAL | 4, 698, 942 | 4, 698, 942 | | | | 5.00 |
| 7.00 | 00700 OPERATION OF PLANT | 3, 163, 916 | 202, 190 | | | | 7.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 276, 364 | 17,661 | | | | 8.00 |
| 9.00 10.00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 999, 217 685, 615 | 63, 855 43, 814 | | | | |
| 11.00 | 01100 CAFETERI A | 606, 277 | 38, 744 | | | 20, 022 | |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 2, 404, 622 | 153, 667 | | | 51, 946 | |
| 14.00 | 01400 CENTRAL SERVICES & SUPPLY | 253, 228 | 16, 183 | | | 8, 945 | 14.00 |
| 15.00 | 01500 PHARMACY | 3, 584, 657 | 229, 078 | | | 10, 771 | |
| 16.00 | 01600 MEDI CAL RECORDS & LI BRARY | 1, 170, 667 | 74, 811 | 58, 610 | 0 | 20, 422 | 16.00 |
| 30.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS | 5, 483, 338 | 350, 413 | 416, 680 | 85, 364 | 145, 184 | 30.00 |
| 30.00 | 03100 I NTENSI VE CARE UNI T | 2,017,718 | 128, 942 | | | 41, 517 | |
| 41.00 | 04100 SUBPROVI DER – I RF | 1, 158, 806 | 74, 053 | | | 35, 605 | |
| 43.00 | 04300 NURSERY | 345, 590 | 22, 085 | | | 3, 290 | |
| | ANCI LLARY SERVI CE COST CENTERS | I | | | | | |
| 50.00 | 05000 OPERATING ROOM | 4, 821, 056 | 308, 090 | | | 240, 918 | |
| 53.00 54.00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | 138, 551 4, 847, 541 | 8, 854 309, 782 | | | 2, 074 87, 035 | |
| 60.00 | 06000 LABORATORY | 4, 876, 536 | 311, 635 | | | 42, 375 | |
| 65.00 | 06500 RESPI RATORY THERAPY | 1, 632, 365 | 104, 316 | | | 17, 763 | |
| 66.00 | 06600 PHYSI CAL THERAPY | 1, 277, 721 | 81, 653 | | | 33, 367 | |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 359, 389 | 22, 967 | | | 7, 028 | |
| 68.00 | 06800 SPEECH PATHOLOGY | 198,038 | 12,656 | | | 437 | |
| 69.00 70.00 | 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY | 1, 053, 716 80, 211 | 67, 338 5, 126 | | | 5, 686 958 | |
| 70.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 221, 678 | 141, 976 | | | 930 | |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 1, 631, 370 | 104, 253 | | - | 0 | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 177, 650 | 11, 353 | 0 | 0 | 0 | 73.00 |
| 76.00 | 03020 ONCOLOGY | 280, 654 | 17, 935 | | | 36, 847 | |
| 76.97 | 07697 CARDI AC REHABI LI TATI ON | 237, 516 | 15, 178 | 37, 940 | 0 | 13, 220 | 76.97 |
| 90.00 | OUTPATIENT SERVICE COST CENTERS | 3, 241, 504 | 207, 148 | 174, 003 | 1, 799 | 60.628 | 90.00 |
| | 09100 EMERGENCY | 3, 361, 661 | 214, 827 | | | | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | 1 1 | | 1 | 1 | - | |
| 101.00 | 10100 HOME HEALTH AGENCY | 1, 145, 383 | 73, 196 | 19, 718 | 0 | 6, 870 | 101.00 |
| 113 00 | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | | 1 | | | 113.00 |
| 118.00 | | 58, 431, 497 | 3, 433, 779 | 2, 842, 042 | 326, 552 | 967, 766 | |
| | NONREI MBURSABLE COST CENTERS | 1 227 22.7 22.7 | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 176, 251 | 11, 263 | | | | 190. 00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES | 17, 627, 647 | 1, 126, 494 | | | 136, 486 | |
| | 19201 SOUTH CLINIC | 0 | 0 | 0 | 0 | | 192.01 |
| | 19202 WEST CLINIC 19203 DIABETES CENTER | 124, 314 | 7, 944 | 6,074 | 0 | | 192. 02 192. 03 |
| | 19300 NONPAI D WORKERS | 0 | 0 | 0,0,4 | 0 | | 193.00 |
| | 19301 ADULT/CHI LD CARE | 668, 742 | 42, 736 | 73, 010 | 0 | | 193.01 |
| | 19302 PHYSICIAN OFFICE BUILDING | 0 | 0 | 0 | 0 | | 193. 02 |
| | 19303 OPTI FAST/FOUNDATI ON | 753, 951 | 48, 181 | | 0 | | 193.03 |
| | 07950 PARTNERSHIP HFC | 89, 107 | 5, 694 | | 0 | | 194.00 |
| | 07951 TRAFALGAR CLINIC 07952 EDINBURGH | 0 | 0 | | 0 | | 194. 01 194. 02 |
| | 07953 JAI L | 48,000 | 3, 067 | 0 | 0 | | 194.02 |
| | 07954 ATHLETIC TRAINERS | 309, 590 | 19, 784 | | 0 | | 194.04 |
| 200.00 | | 0 | | | | | 200. 00 |
| 201.00 | | 0 | 0 | - | 0 | | 201.00 |
| 202.00 | TOTAL (sum lines 118-201) | 78, 229, 099 | 4, 698, 942 | 3, 366, 106 | 330, 349 | 1, 150, 365 | 1202. UU |

| Health Financial Systems | JOHNSON MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|--|----------------------|--------------------|-------------------------------|--------------------------|--------------------------------|----------------------|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provider C | | eriod: rom 01/01/2016 | Worksheet B Part I | |
| | | | To | | Date/Time Pre 1/16/2018 3:0 | |
| Cost Center Description | DI ETARY | CAFETERI A | NURSI NG ADMI NI STRATI ON | CENTRAL SERVICES & | PHARMACY | |
| | 10.00 | 11.00 | 13.00 | SUPPLY 14.00 | 15.00 | |
| GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1.00 1.01 2.00 |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 4. 01 00401 COMMUNI CATI ONS 4. 02 00402 DATA PROCESSI NG | | | | | | 4.01 |
| 4. 02 00402 DATA PROCESSING 4. 03 00403 MATERIALS MANAGEMENT | | | | | | 4.02 4.03 |
| 4. 04 00404 ADMI TTI NG | | | | | | 4.04 |
| 4. 05 00405 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 8.00 |
| 9. 00 00900 HOUSEKEEPING | | | | | | 9.00 |
| 10. 00 01000 DI ETARY | 814, 665 | | | | | 10.00 |
| | 0 | 730, 003 | | | | 11.00 |
| 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY | 0 | 22, 604 3, 757 | | 349, 272 | | 13.00 14.00 |
| 15. 00 01500 PHARMACY | 0 | 13, 749 | | 349, 272 | 3, 869, 169 | |
| 16.00 01600 MEDI CAL RECORDS & LI BRARY | 0 | 29, 801 | | 0 | 0 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 554 700 | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT | 556, 798 108, 247 | 93, 760 31, 698 | | 0 | 0 | |
| 41. 00 04100 SUBPROVIDER - IRF | 149, 620 | 18, 063 | | 0 | 0 | 41.00 |
| 43. 00 04300 NURSERY | 0 | 5, 642 | | Ő | 0 | |
| ANCI LLARY SERVICE COST CENTERS | | | L | | | |
| 50. 00 05000 OPERATI NG ROOM | 0 | 50, 656 | | 0 | 0 | |
| 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 217 56, 711 | | 0 | 0 | |
| 60. 00 06000 LABORATORY | 0 | 57, 372 | - | 0 | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 24, 543 | | 0 | 0 | 65.00 |
| 66.00 06600 PHYSI CAL THERAPY | 0 | 20, 950 | | 0 | 0 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY | 0 | 5, 577 3, 227 | | 0 | 0 | 67.00 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 11, 135 | | 0 | 0 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 1, 494 | | 0 | 0 | |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | C | | 349, 272 | 0 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 | 0 3, 869, 169 | |
| 76. 00 03020 0NC0L0GY | 0 | 4, 062 | - | 0 | 3, 809, 109 | |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 3, 222 | | 0 | 0 | |
| OUTPATIENT SERVICE COST CENTERS | | | -1 -1 | | | |
| 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY | 0 | 25, 084 48, 373 | | 0 | 0 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 40, 373 | 534, 117 | 0 | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 17, 828 | 3 0 | 0 | 0 | 101.00 |
| SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | 814, 665 | 549, 525 | 2, 781, 926 | 349, 272 | 3, 869, 169 | |
| NONREI MBURSABLE COST CENTERS | | | | <u> </u> | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 4, 659 | | 0 | | 190. 00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 123, 977 | | 0 | | 192.00 |
| 192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC | 0 | (| | 0 | | 192. 01 192. 02 |
| 192. 03 19203 DI ABETES CENTER | 0 | 2, 127 | - | 0 | | 192.02 |
| 193.00 19300 NONPALD WORKERS | 0 | C | 0 0 | 0 | | 193.00 |
| 193. 01 19301 ADULT/CHI LD CARE | 0 | 39, 966 | 0 | 0 | | 193.01 |
| 193. 02 19302 PHYSICIAN OFFICE BUILDING 193. 03 19303 OPTIFAST/FOUNDATION | 0 | 0 | | 0 | | 193. 02 193. 03 |
| 194. 00 07950 PARTNERSHI P HFC | 0 | 1, 283 | | 0 | | 193.03 |
| 194. 01 07951 TRAFALGAR CLINIC | 0 | ., 200 | o o | 0 | 0 | 194.01 |
| 194. 02 07952 EDI NBURGH | 0 | C | 0 0 | 0 | | 194. 02 |
| 194. 03 07953 JALL | 0 | 0 | 0 | 0 | | 194.03 |
| 194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments | 0 | 8, 466 | o 0 | 0 | 0 | 194. 04 200. 00 |
| 201.00 Negative Cost Centers | 0 | C | 0 | О | 0 | 200.00 |
| 202.00 TOTAL (sum lines 118-201) | 814, 665 | 730, 003 | 2, 781, 926 | 349, 272 | 3, 869, 169 | |
| | | | | | | |

| Health Financial Systems | JOHNSON MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2552-10 |
|--|-----------------------|----------------------------|---------------------------|----------------------------------|-----------------------|
| COST ALLOCATION - GENERAL SERVICE COSTS | | Provider CO | CN: 15-0001 | Peri od: | Worksheet B |
| | | | | From 01/01/2016 To 12/31/2016 | Date/Time Prepared: |
| | | | | | 1/16/2018 3:01 pm |
| Cost Center Description | MEDI CAL RECORDS & | Subtotal | Intern & Residents Cos | Total | |
| | LI BRARY | | & Post | | |
| | | | Stepdown | | |
| | 16.00 | 24.00 | Adjustments 25.00 | 26.00 | |
| GENERAL SERVICE COST CENTERS | 10.00 | 21.00 | 20.00 | 20.00 | |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | 1.00 |
| 1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | 1.01 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4.00 |
| 4. 01 00401 COMMUNI CATI ONS | | | | | 4.01 |
| 4. 02 00402 DATA PROCESSI NG | | | | | 4. 02 |
| 4. 03 00403 MATERIALS MANAGEMENT | | | | | 4.03 |
| 4. 04 00404 ADMI TTI NG 4. 05 00405 PATI ENT ACCOUNTI NG | | | | | 4.04 |
| 5. 00 00500 ADMINI STRATI VE & GENERAL | | | | | 5.00 |
| 7.00 00700 OPERATION OF PLANT | | | | | 7.00 |
| 8.00 00800 LAUNDRY & LI NEN SERVI CE | | | | | 8.00 |
| 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY | | | | | 9.00 10.00 |
| 11. 00 01100 CAFETERIA | | | | | 11.00 |
| 13.00 01300 NURSING ADMINISTRATION | | | | | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | | | | | 14.00 |
| 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY | 1, 354, 311 | | | | 15.00 |
| 16. 00 01600 MEDI CAL_RECORDS & LI BRARY I NPATI ENT_ROUTI NE_SERVI CE_COST_CENTERS | 1, 354, 311 | | | | 16.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 75, 082 | 8, 241, 872 | | 0 8, 241, 872 | 30.00 |
| 31.00 03100 I NTENSI VE CARE UNI T | 13, 500 | 2, 831, 465 | | 0 2, 831, 465 | 31.00 |
| 41. 00 04100 SUBPROVI DER – I RF | 12, 558 | 1, 765, 249 | | 0 1, 765, 249 | 41.00 |
| 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS | 4, 569 | 452, 922 | | 0 452, 922 | 43.00 |
| 50. 00 05000 OPERATI NG ROOM | 209, 692 | 6, 947, 347 | | 0 6, 947, 347 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 23, 603 | 179, 252 | | 0 179, 252 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 257, 147 | 5, 829, 384 | | 0 5, 829, 384 | 54.00 |
| 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY | 189, 673 39, 286 | 5, 599, 209 1, 869, 253 | | 0 5, 599, 209 0 1, 869, 253 | 60.00 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 22, 695 | 1, 533, 730 | | 0 1, 533, 730 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 13, 973 | 429, 105 | | 0 429, 105 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 4, 444 | 220, 056 | | 0 220, 056 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY | 36, 915 1, 049 | 1, 193, 462 91, 588 | | 0 1, 193, 462 0 91, 588 | 69.00 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 46, 079 | 2, 759, 005 | | 0 2, 759, 005 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 31, 549 | 1, 767, 172 | | 0 1, 767, 172 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 73, 132 | 4, 131, 304 | | 0 4, 131, 304 | 73.00 |
| | 1,510 | 446, 761 | | 0 446, 761 | 76.00 |
| 76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS | 3, 668 | 310, 744 | | 0 310, 744 | 76. 97 |
| 90. 00 09000 CLINIC | 75, 764 | 3, 785, 930 | | 0 3, 785, 930 | 90.00 |
| 91.00 09100 EMERGENCY | 133, 355 | 4, 542, 523 | | 0 4, 542, 523 | 91.00 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | | | | 0 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY | 10, 650 | 1, 273, 645 | 1 | 0 1, 273, 645 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | 10,000 | 172707010 | | | |
| 113.00 11300 INTEREST EXPENSE | | | | | 113.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS | 1, 279, 893 | 56, 200, 978 | | 0 56, 200, 978 | 118.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 218, 598 | | 0 218, 598 | 190.00 |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES | 74, 418 | 19, 484, 538 | | 0 19, 484, 538 | 192.00 |
| 192. 01 19201 SOUTH CLINIC | 0 | 0 | | 0 0 | 192. 01 |
| 192. 02 19202 WEST CLINIC | 0 | 0 | | 0 0 142 575 | 192.02 |
| 192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS | 0 | 142, 575 0 | | 0 142, 575 | 192. 03 193. 00 |
| 193. 01 19301 ADULT/CHI LD CARE | 0 | 849, 893 | | 0 849, 893 | 193.01 |
| 193. 02 19302 PHYSICIAN OFFICE BUILDING | 0 | 0 | | 0 0 | 193. 02 |
| 193. 03 19303 OPTI FAST/FOUNDATI ON | 0 | 802, 132 | | 0 802, 132 | 193.03 |
| 194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C | 0 | 141, 478 0 | | 0 141, 478 | 194. 00 194. 01 |
| 194. 02 07952 EDI NBURGH | 0 | 0 | | 0 0 | 194.01 |
| 194. 03 07953 JAI L | Ő | 51, 067 | | 0 51,067 | 194. 03 |
| 194. 04 07954 ATHLETI C TRAINERS | 0 | 337, 840 | | 0 337, 840 | 194.04 |
| 200.00Cross Foot Adjustments201.00Negative Cost Centers | | 0 | | 0 0 0 0 | 200. 00 201. 00 |
| 201.00 Negative cost centers 202.00 TOTAL (sum Lines 118-201) | 1, 354, 311 | 78, 229, 099 | | 0 78, 229, 099 | |
| | | | | | |

| From 01/01/2016 P | Worksheet B | |
|--|----------------------------------|--------------------|
| To 12/31/2016 D | Part II | |
| | Date/Time Prep 1/16/2018 3:01 | pm |
| CAPITAL RELATED COSTS | 17 10/2010 0.01 | pm |
| Cost Center Description Directly NEW BLDG & BLDG & FIXT - MVBLE EQUIP | Subtotal | |
| Assigned New FLXT TOWER | | |
| Capital Related Costs | | |
| 0 1.00 1.01 2.00 | 2A | |
| GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT | | 1.00 |
| 1.01 O0101 CAP REL COSTS-BLDG & FIXT - TOWER | | 1.01 |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 21,767 0 1,151 | 22, 918 | 2.00 4.00 |
| 4. 01 00401 COMMUNI CATI ONS 0 2, 867 0 0 | 2, 867 | 4.01 |
| 4. 02 00402 DATA PROCESSING 0 45, 664 0 1, 211, 900 4. 03 00403 MATERIALS MANAGEMENT 0 27, 909 0 5, 741 | 1, 257, 564 33, 650 | 4.02 4.03 |
| 4. 04 00404 ADMI TTI NG 0 16, 333 1, 842 0 | 18, 175 | 4.03 |
| 4. 05 00405 PATIENT ACCOUNTING 0 48, 509 0 10, 134 | 58, 643 | 4.05 |
| 5.00 00500 ADMI NI STRATI VE & GENERAL 0 69, 488 0 25, 435 7.00 00700 OPERATI ON OF PLANT 0 182, 073 12, 498 39, 014 | 94, 923 233, 585 | 5.00 7.00 |
| 8.00 00800 LAUNDRY & LI NEN SERVI CE 0 17, 536 0 4, 296 | 21, 832 | 8.00 |
| 9. 00 00900 HOUSEKEEPING 0 13, 619 937 3, 865 10. 00 01000 DI ETARY 0 28, 573 554 17, 992 | 18, 421 47, 119 | 9.00 10.00 |
| 11.00 01100 CAFETERIA 0 30,426 0 0 | 30, 426 | 11.00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON 0 71, 976 0 28, 359 14. 00 01400 CENTRAL SERVI CES & SUPPLY 0 12, 394 0 28, 604 | 100, 335 40, 998 | 13.00 14.00 |
| 15. 00 01500 PHARMACY 0 14, 925 0 4, 835 | 19, 760 | 15.00 |
| 16. 00 01600 MEDICAL RECORDS & LI BRARY 0 28, 296 0 6, 986 I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 35, 282 | 16.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS 0 201, 163 19, 566 112, 938 | 333, 667 | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T 0 57, 525 8, 861 30, 856 | 97, 242 | 31.00 |
| 41. 00 04100 SUBPROVI DER - I RF 0 49, 333 7, 599 17, 003 43. 00 04300 NURSERY 0 4, 559 0 0 | 73, 935 4, 559 | 41.00 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | | |
| 50. 00 05000 OPERATI NG ROOM 0 333, 810 802 386, 374 53. 00 05300 ANESTHESI OLOGY 0 2, 874 0 12, 303 | 720, 986 15, 177 | 50.00 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 120, 594 12, 062 297, 737 | 430, 393 | 54.00 |
| 60. 00 06000 LABORATORY 0 58, 714 6, 924 122, 412 65. 00 06500 RESPI RATORY 0 24, 612 1, 203 13, 422 | 188, 050 39, 237 | 60. 00 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY 0 46, 233 0 8, 754 | 54, 987 | 66. 00 |
| 67.00 06700 OCCUPATI ONAL THERAPY 0 9, 738 0 2, 069 | 11, 807 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY 0 605 93 324 69. 00 06900 ELECTROCARDI OLOGY 0 7, 878 99 29, 422 | 1, 022 37, 399 | 68.00 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 1, 328 204 1, 603 | 3, 135 | 70.00 |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 12, 162 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 | 12, 162 0 | 71.00 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 | 0 | 73.00 |
| 76. 00 03020 0NCOLOGY 0 51, 055 0 1, 875 76. 97 07697 CARDI AC REHABI LI TATI ON 0 18, 317 0 8, 953 | 52, 930 27, 270 | |
| OUTPATIENT SERVICE COST CENTERS | 27,270 | 76. 97 |
| 90.00 09000 CLINIC 0 84,004 496 14,318 91,00 09100 EMERGENCY 0 72,464 10,860 26,955 | 98, 818 | 90.00 |
| 91. 00 09100 EMERGENCY 0 72, 464 10, 860 26, 955 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | 110, 279 0 | 91.00 92.00 |
| OTHER REIMBURSABLE COST CENTERS | 0.575 | |
| 101.00 10100 HOME HEALTH AGENCY 0 9, 519 0 56 SPECIAL PURPOSE COST CENTERS | 9, 575 | 101.00 |
| 113.00 11300 I NTEREST EXPENSE | | 113.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 1,786,680 84,600 2,487,848 NONREI MBURSABLE COST CENTERS | 4, 359, 128 | 118.00 |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 9, 461 1, 457 3, 868 | 14, 786 | 190. 00 |
| 192.00 PHYSI CLANS' PRI VATE OFFICES 0 189, 112 0 92, 862 192.01 19201 SOUTH CLINIC 0 | 281, 974 | 192. 00 192. 01 |
| 192. 02 19202 WEST CLINIC 0 0 0 | | 192.01 |
| 192. 03 19203 DI ABETES CENTER 0 2, 932 452 471 | 3, 855 | |
| 193. 00 19300 NONPAI D WORKERS 0 <td>0 35, 247</td> <td>193.00 193.01</td> | 0 35, 247 | 193.00 193.01 |
| 193. 02 19302 PHYSI CI AN OFFICE BUILDING 0 0 0 | | 193.02 |
| 193. 03 19303 OPTI FAST/FOUNDATI ON 0 0 0 0 | | 193.03 |
| 194. 00 07950 PARTNERSHI P HFC 0 16, 252 0 0 194. 01 07951 TRAFALGAR CLINIC 0 0 0 0 | 16, 252 0 | 194.00 194.01 |
| 194. 02 07952 EDI NBURGH 0 0 0 0 | 0 | 194. 02 |
| 194. 03 07953 JAIL 0 0 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 0 0 0 | | 194. 03 194. 04 |
| 200.00 Cross Foot Adjustments | 0 | 200. 00 |
| 201.00 Negative Cost Centers 0 </td <td>0 4, 711, 242</td> <td>201.00</td> | 0 4, 711, 242 | 201.00 |
| 202.00 TOTAL (sum lines 118-201) 0 2,039,684 86,509 2,585,049 | +, / I I, Z4Z | 202.00 |

| Health Financial Systems | JOHNSON MEMORI | AL HOSPITAL | | In Lieu | u of Form CMS-2 | 2552-10 |
|--|------------------------------------|------------------|---------------------|---------------------------------------|--------------------------------|----------------------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provider CC | | eriod: rom 01/01/2016 | Worksheet B Part II | |
| | | | To | | Date/Time Pre 1/16/2018 3:0 | |
| Cost Center Description | EMPLOYEE BENEFITS DEPARTMENT | COMMUNI CATI ONS | DATA PROCESSI NG | MATERIALS MANAGEMENT | ADMI TTI NG | |
| | 4.00 | 4.01 | 4.02 | 4.03 | 4.04 | |
| GENERAL SERVICE COST CENTERS | | | | | | 1.00 |
| 1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 01 2. 00 |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG | 22, 918 122 467 | 2, 989 306 | 1, 258, 337 | | | 4.00 4.01 4.02 |
| 4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG | 159 359 | 66 63 | 17, 096 46, 624 | 50, 971 123 | 65, 344 | 4.03 4.04 |
| 4. 05 00405 PATIENT ACCOUNTING | 575 | 199 | 137, 283 | 240 | 05, 344 | 4.04 |
| 5. 00 00500 ADMINI STRATI VE & GENERAL | 1, 244 | 174 | 136, 246 | 658 | 0 | 5.00 |
| 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE | 388 73 | 88 11 | 10, 879 8, 289 | 26 114 | 0 | 7.00 8.00 |
| 9. 00 00900 HOUSEKEEPI NG | 392 | 32 | 0, 20, | 644 | 0 | 9.00 |
| 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A | 183 298 | 57 0 | 36, 781 0 | 1, 513 0 | 0 | 10. 00 11. 00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON | 912 | 97 | 44, 552 | 389 | 0 | 13.00 |
| 14.00 01400 CENTRAL SERVICES & SUPPLY | 51 | 0 | 0 | 376 | 0 | 14.00 |
| 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY | 296 338 | 43 93 | 12, 433 56, 985 | 0 | 0 | 15.00 16.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS | 330 | /3 | 30, 703 | · · · · · · · · · · · · · · · · · · · | | 10.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T | 2, 287 725 | 238 | 91, 694 | 1,451 | 3, 619 | 30.00 |
| 41. 00 04100 SUBPROVIDER - IRF | 441 | 63 41 | 31, 601 23, 830 | 445 108 | 651 605 | 31.00 41.00 |
| 43. 00 04300 NURSERY | 128 | 0 | 0 | 0 | 220 | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM | 1, 214 | 188 | 107, 236 | 2, 374 | 10, 106 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 14 | 0 | 107, 230 | 18 | 1, 138 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 1, 254 | 118 | 77, 707 | 1, 708 | 12, 463 | 54.00 |
| 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY | 903 561 | 154 41 | 56, 985 30, 565 | 7, 122 698 | 9, 142 1, 893 | 60. 00 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 456 | 48 | 7, 771 | 129 | 1, 094 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY | 140 83 | 9 | 2, 590 1, 554 | 0 | 673 214 | 67.00 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 282 | 9 97 | 49, 733 | 420 | 1, 779 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 29 | 5 | 1, 554 | 7 | 51 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | 0 | 21, 084 0 | 2, 221 1, 521 | 71.00 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 3, 525 | 73.00 |
| 76.00 03020 0NC0L0GY | 79 | 84 | 8, 807 | 0 | 73 | 76.00 |
| 76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS | 73 | 0 | 0 | 48 | 177 | 76.97 |
| 90. 00 09000 CLI NI C | 419 | | | 3, 028 | | 90.00 |
| 91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) | 1, 117 | 129 | 62, 684 | 629 | 6, 427 | 91.00 92.00 |
| OTHER REIMBURSABLE COST CENTERS | <u> </u> | | | I | | 72.00 |
| 101.00 10100 HOME HEALTH AGENCY | 407 | 52 | 23, 312 | 73 | 513 | 101.00 |
| SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE | | | | | | 113.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | 16, 469 | 2, 550 | 1, 126, 235 | 43, 434 | 61, 757 | |
| NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 48 | 34 | 8, 289 | 92 | 0 | 190. 00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 5, 963 | 346 | 98, 947 | 6, 879 | | 192.00 |
| 192. 01 19201 SOUTH CLINIC | 0 | 0 | 0 | 0 | | 192.01 |
| 192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER | 0 50 | 0 | 0 1, 554 | 0 | | 192. 02 192. 03 |
| 193. 00 19300 NONPAI D WORKERS | 0 | 0 | 0 | 0 | 0 | 193.00 |
| 193. 01 19301 ADULT/CHI LD CARE 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG | 247 | 34 | 10, 879 | 444 | | 193.01 |
| 193. 02 19302 PHYSICIAN OFFICE BUILDING 193. 03 19303 OPTI FAST/FOUNDATI ON | 0 | 0 | 0 | 0 115 | | 193. 02 193. 03 |
| 194. 00 07950 PARTNERSHI P HFC | 16 | 18 | 12, 433 | 6 | 0 | 194.00 |
| 194. 01 07951 TRAFALGAR CLI NI C 194. 02 07952 EDI NBURGH | 0 | 0 | 0 | 0 | | 194. 01 194. 02 |
| 194. 02 07952 EDI NBORGH 194. 03 07953 JAI L | 0 | 0 | 0 | 0 | | 194. 02 194. 03 |
| 194. 04 07954 ATHLETI C TRAI NERS | 125 | 0 | 0 | Ō | | 194. 04 |
| 200.00Cross Foot Adjustments201.00Negative Cost Centers | 0 | 0 | 0 | 0 | 0 | 200. 00 201. 00 |
| 202.00 TOTAL (sum lines 118-201) | 22, 918 | 2, 989 | 1, 258, 337 | 50, 971 | 65, 344 | |
| | | | | | | |

| Health Financial Systems | JOHNSON MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|---|--------------------|--------------------|-------------------|--------------------------|--------------------------------|--------------------|
| ALLOCATION OF CAPITAL RELATED COSTS | | Provider C | | eriod: rom 01/01/2016 | Worksheet B Part II | |
| | | | T | | Date/Time Pre | pared: |
| Cost Center Description | PATIENT | ADMI NI STRATI VE | OPERATION OF | LAUNDRY & | 1/16/2018 3:0 HOUSEKEEPI NG | 1 pm |
| | ACCOUNTI NG | & GENERAL | PLANT | LINEN SERVICE | | |
| GENERAL SERVICE COST CENTERS | 4.05 | 5.00 | 7.00 | 8.00 | 9.00 | |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER | | | | | | 1.01 |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 2.00 4.00 |
| 4. 01 00401 COMMUNI CATI ONS | | | | | | 4.01 |
| 4. 02 00402 DATA PROCESSI NG | | | | | | 4. 02 |
| 4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG | | | | | | 4.03 4.04 |
| 4. 05 00405 PATI ENT ACCOUNTI NG | 196, 940 | | | | | 4.05 |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL | 0 | 233, 245 | | | | 5.00 |
| 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE | 0 | 10, 036 877 | | 33, 948 | | 7.00 8.00 |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG | 0 | 3, 170 | | 6, 072 | 30, 868 | 1 |
| 10. 00 01000 DI ETARY | 0 | 2, 175 | 4, 484 | 558 | 553 | 10.00 |
| | 0 | 1, 923 | | 0 | 589 | 11.00 |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY | 0 | 7, 627 803 | 11, 294 1, 945 | 0 | 1, 394 240 | 13.00 14.00 |
| 15. 00 01500 PHARMACY | 0 | 11, 371 | | 0 | 289 | 15.00 |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY | 0 | 3, 713 | 4, 440 | 0 | 548 | 16.00 |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS | 10, 923 | 17, 393 | 31, 566 | 8, 772 | 3, 896 | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | 1, 964 | 6, 400 | | 2, 126 | 1, 114 | 31.00 |
| 41.00 04100 SUBPROVIDER - IRF | 1, 827 | 3, 676 | | 1, 532 | 955 | 41.00 |
| 43.00 04300 NURSERY | 665 | 1, 096 | 715 | 0 | 88 | 43.00 |
| ANCI LLARY SERVICE COST CENTERS | 30, 505 | 15, 292 | 52, 381 | 6, 801 | 6, 464 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 3, 434 | 439 | | 0 | 56 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 37, 326 | 15, 376 | | 2, 197 | 2, 335 | 54.00 |
| 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY | 27, 593 5, 715 | 15, 468 5, 178 | | 0 | 1, 137 477 | 60.00 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 3, 302 | 4, 053 | | 162 | 895 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 2,033 | 1, 140 | | 0 | 189 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY | 647 5, 370 | 628 3, 342 | | 0 242 | 12 153 | 68.00 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 153 | 254 | | 242 | 26 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 6, 703 | 7,047 | | 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 4, 590 | 5, 175 | | 0 | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 ONCOLOGY | 10, 639 220 | 564 890 | | 0 | 0 989 | 73.00 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 534 | 753 | | 0 | 355 | 76.97 |
| | 11 020 | 10, 202 | 10,100 | 105 | 1 () 7 | |
| 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY | 11, 022 19, 400 | 10, 282 10, 663 | | 185 4, 911 | 1, 627 1 403 | 90.00 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 10,000 | , | ., , | 1, 100 | 92.00 |
| OTHER REI MBURSABLE COST CENTERS | 4 5 4 0 | 0. (0.0 | 1 404 | | 104 | 101.00 |
| 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 1, 549 | 3, 633 | 1, 494 | 0 | 184 | 101.00 |
| 113. 00 11300 I NTEREST EXPENSE | | | | | | 113.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | 186, 114 | 170, 437 | 215, 301 | 33, 558 | 25, 968 | 118.00 |
| NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 559 | 1, 485 | 0 | 183 | 190.00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES | 10, 826 | 55, 925 | | 390 | | 192.00 |
| 192. 01 19201 SOUTH CLINIC | 0 | 0 | 0 | 0 | | 192. 01 |
| 192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER | 0 | 0 394 | 0 460 | 0 | | 192. 02 192. 03 |
| 193. 00 19300 NONPAID WORKERS | 0 | 0 | 400 | 0 | | 192.03 |
| 193. 01 19301 ADULT/CHI LD CARE | 0 | 2, 121 | 5, 531 | 0 | 683 | 193. 01 |
| 193. 02 19302 PHYSI CLAN OFFICE BUILDING | 0 | 0 | 0 | 0 | | 193.02 |
| 193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC | 0 | 2, 392 283 | | 0 | | 193. 03 194. 00 |
| 194. 01 07951 TRAFALGAR CLINIC | 0 | 0 | | 0 | 0 | 194. 01 |
| 194. 02 07952 EDI NBURGH | 0 | 0 | 0 | 0 | | 194.02 |
| 194. 03 07953 JAI L 194. 04 07954 ATHLETI C TRAI NERS | 0 | 152 982 | | 0 | | 194. 03 194. 04 |
| 200.00 Cross Foot Adjustments | | 702 | | U | | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | | 0 | | 201.00 |
| 202.00 TOTAL (sum lines 118-201) | 196, 940 | 233, 245 | 255, 002 | 33, 948 | 30, 868 | 202.00 |
| | | | | | | |

| Heal th | Financial Systems | JOHNSON MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|--|---------------------------------------|---|-------------------------------|----------------------------------|--------------------------------|--|
| | TION OF CAPITAL RELATED COSTS | | Provider C | | eriod: .om 01/01/2016 | Worksheet B Part II | |
| | | | | To | | Date/Time Pre 1/16/2018 3:0 | pared: 1 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 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 1. 01 2. 00 4. 00 4. 01 4. 02 4. 03 | 00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-BLDG & FIXT - TOWER 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT | | | | | | 1. 01 2. 00 4. 00 4. 01 4. 02 4. 03 |
| 4.04 4.05 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 | 00404 ADMITTING 00405 PATIENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY | 93, 423 0 0 0 0 0 0 | 38, 010 1, 177 196 716 1, 552 | 167, 777 2, 502 0 | 47, 111 0 0 | 47, 250 0 | |
| | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | | | | _ | | |
| 30.00 31.00 41.00 43.00 | 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04300 NURSERY | 63, 852 12, 413 17, 158 0 | 4, 882 1, 650 941 294 | 21, 108 12, 029 | 0 0 0 0 | 0 0 0 0 | 31.00 41.00 |
| F0 00 | ANCI LLARY SERVICE COST CENTERS | | 2 (20 | | 0 | | |
| 50.00 53.00 | 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY | 0 | 2, 638 11 | | 0 | 0 | 50.00 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | 2, 953 | | 0 | 0 | 54.00 |
| 60.00 | | 0 | 2, 987 | | 0 | 0 | 60.00 |
| 65.00 66.00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 0 | 1, 278 1, 091 | | 0 | 0 | 65.00 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | 290 | | 0 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | 168 | | 0 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0 | 580 | | 0 | 0 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 78 | | 0 | 0 | 70.00 |
| 71.00 72.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 47, 111 0 | 0 | 71.00 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | C | - | 0 | 47, 250 | |
| 76.00 | 03020 ONCOLOGY | 0 | 212 | | 0 | 0 | |
| 76.97 | 07697 CARDI AC REHABI LI TATI ON | 0 | 168 | 0 | 0 | 0 | 76. 97 |
| 00.00 | OUTPATIENT SERVICE COST CENTERS | | 1.00/ | | | | |
| | 09000 CLINIC 09100 EMERGENCY | 0 | 1, 306 2, 519 | | 0 | 0 | 90.00 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 2,017 | 02,212 | 0 | Ũ | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101.00 | 10100 HOME HEALTH AGENCY | 0 | 928 | 0 | 0 | 0 | 101.00 |
| 112 00 | SPECIAL PURPOSE COST CENTERS | | | | | | 113.00 |
| 118.00 | | 93, 423 | 28, 615 | 167, 777 | 47, 111 | 47, 250 | 118.00 |
| | NONREIMBURSABLE COST CENTERS | | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 243 | | 0 | | 190.00 |
| | 19200 PHYSI CLANS' PRI VATE OFFI CES 19201 SOUTH CLINI C | 0 | 6, 452 0 | | 0 | | 192. 00 192. 01 |
| | 19202 WEST CLINIC | 0 | 0 | - | 0 | | 192.01 |
| | 19203 DI ABETES CENTER | 0 | 111 | | 0 | | 192.02 |
| | 19300 NONPALD WORKERS | 0 | C | 0 | 0 | | 193.00 |
| | 19301 ADULT/CHI LD CARE | 0 | 2, 081 | 0 | 0 | 0 | 193. 01 |
| | 19302 PHYSICIAN OFFICE BUILDING | 0 | 0 | 0 | 0 | | 193. 02 |
| | 19303 OPTI FAST/FOUNDATI ON | 0 | 0 | | 0 | | 193.03 |
| | 07950 PARTNERSHI P HFC 07951 TRAFALGAR CLINIC | 0 | 67 | 0 | 0 | | 194. 00 194. 01 |
| | 07951 TRAFALGAR CLINIC | 0 | | | 0 | | 194.01 |
| | 07953 JAI L | 0 | C | 0 | 0 | | 194.02 |
| | 07954 ATHLETI C TRAI NERS | 0 | 441 | | Ő | | 194.04 |
| 200.00 | Cross Foot Adjustments | | | | - | | 200. 00 |
| 201.00 | Negative Cost Centers | 0 | 0 | 0 | 0 | | 201.00 |
| 202.00 | TOTAL (sum lines 118-201) | 93, 423 | 38, 010 | 167, 777 | 47, 111 | 47, 250 | 202.00 |

| | Financial Systems TION OF CAPITAL RELATED COSTS | JOHNSON MEMORIA | | CN: 15-0001 | In Lie Period: | eu of Form CMS-2552-10 Worksheet B |
|--|--|--|-------------------------------|--|---|--|
| ALLUUF | TION OF CAFILLE KELATED CUSTS | | FIOVIDEL C | UUU 13-UUU 1 | From 01/01/2016 To 12/31/2016 | Part II |
| | Cost Center Description | MEDI CAL RECORDS & LI BRARY | Subtotal | Intern & Residents Cos & Post Stepdown Adjustments | | , 17 10, 2010 3. 01 pin |
| | | 16.00 | 24.00 | 25.00 | 26.00 | |
| 1.00 | GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT | | | | | 1.00 |
| 1.01 | 00101 CAP REL COSTS-BLDG & FIXT - TOWER | | | | | 1.01 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | 2.00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4.00 |
| 4.01 4.02 | 00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG | | | | | 4.01 |
| 4.03 | 00403 MATERIALS MANAGEMENT | | | | | 4.03 |
| 4.04 | 00404 ADMI TTI NG | | | | | 4.04 |
| 4.05 | 00405 PATIENT ACCOUNTING | | | | | 4.05 |
| 5.00 7.00 | 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT | | | | | 5.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | | | | | 9.00 |
| 10.00 | 01000 DI ETARY | | | | | 10.00 |
| 11.00 13.00 | 01100 CAFETERIA 01300 NURSING ADMINISTRATION | | | | | 11.00 |
| 13.00 | 01400 CENTRAL SERVICES & SUPPLY | | | | | 13.00 |
| 15.00 | 01500 PHARMACY | | | | | 15.00 |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY | 102, 960 | | | | 16.00 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | F 70/ | 642.382 | | 0 (42.202 | 20.00 |
| 30.00 31.00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT | 5, 706 1, 026 | 642, 382 187, 555 | | 0 642, 382 0 187, 555 | |
| 41.00 | 04100 SUBPROVI DER – I RF | 954 | 145, 773 | | 0 145, 773 | |
| 43.00 | 04300 NURSERY | 347 | 11, 869 | 2 | 0 11, 869 | 43.00 |
| F0 00 | ANCI LLARY SERVICE COST CENTERS | 15 025 | 1 005 052 | | 0 1,005,853 | E0.00 |
| 50.00 53.00 | 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY | 15, 935 1, 794 | 1, 005, 853 22, 532 | | 0 1, 005, 853 0 22, 532 | 50.00 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 19, 585 | 622, 338 | | 0 622, 338 | 54.00 |
| 60.00 | 06000 LABORATORY | 14, 413 | 333, 167 | | 0 333, 167 | 60.00 |
| 65.00 | | 2, 985 | 92, 490 | | 0 92, 490 0 82, 968 | 65.00 |
| 66.00 67.00 | 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY | 1, 725 1, 062 | 82, 968 21, 461 | | 0 82,968 0 21,461 | 66.00 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 338 | 4, 770 | | 0 4, 770 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | 2, 805 | 103, 438 | | 0 103, 438 | |
| 70.00 71.00 | 07000 ELECTROENCEPHALOGRAPHY | 80 | 5, 580 | | 0 5,580 0 99,830 | 70.00 |
| 72.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT | 3, 502 2, 397 | 99, 830 13, 683 | | 0 99, 830 0 13, 683 | 71.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 5, 557 | 67, 535 | | 0 67, 535 | 73.00 |
| | 03020 ONCOLOGY | 115 | 72, 410 | | 0 72, 410 | |
| 76.97 | 07697 CARDI AC REHABI LI TATI ON | 279 | 32, 531 | | 0 32, 531 | 76.97 |
| 90.00 | OUTPATIENT SERVICE COST CENTERS | 5, 757 | 190, 767 | 7 | 0 190, 767 | 90.00 |
| 91.00 | 09100 EMERGENCY | 10, 134 | 273, 878 | | 0 273, 878 | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 0 | 92.00 |
| 101 00 | OTHER REIMBURSABLE COST CENTERS | 809 | 42 520 | | 0 42 520 | 101.00 |
| 101.00 | 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 809 | 42, 529 | * | 0 42, 529 | 101.00 |
| 113.00 | 11300 INTEREST EXPENSE | | | | | 113.00 |
| 118.00 | | 97, 305 | 4, 075, 339 | 9 | 0 4, 075, 339 | 118.00 |
| 100.00 | NONREIMBURSABLE COST CENTERS | 0 | 25, 719 | | 0 25, 719 | 190.00 |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES | 5, 655 | 510, 281 | | 0 510, 281 | 190.00 |
| | 19201 SOUTH CLINIC | 0 | C | | 0 0 | 192.01 |
| | 19202 WEST CLINIC | 0 | C | D | 0 0 | 192. 02 |
| | 19203 DI ABETES CENTER 19300 NONPAI D WORKERS | 0 | 6, 489 | | 0 6, 489 | 192. 03 193. 00 |
| | 117JUUNEALD WURKERJ | 0 | 57, 267 | 7 | 0 57, 267 | 193.00 |
| 193.00 | | | 0.,20, | b | 0 0 | 193. 02 |
| 193. 00 193. 01 | 19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING | 0 | C C | | | |
| 193.00 193.01 193.02 193.03 | 19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION | 0 | 2, 507 | | 0 2, 507 | 193. 03 |
| 193.00 193.01 193.02 193.03 194.00 | 19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION 07950 PARTNERSHIP HFC | 000000 | 2, 507 31, 940 | | 0 2, 507 0 31, 940 | 194.00 |
| 193.00 193.01 193.02 193.03 194.00 194.01 | 19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION 07950 PARTNERSHIP HFC 07951 TRAFALGAR CLINIC | | | | 0 31, 940 0 0 | 194. 00 194. 01 |
| 193.00 193.01 193.02 193.03 194.00 194.01 194.02 | 19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION 07950 PARTNERSHIP HFC | 0 0 0 0 0 | | | | 194.00 |
| 193. 00 193. 01 193. 02 193. 03 194. 00 194. 01 194. 02 194. 03 194. 04 | 19301 ADULT/CHI LD CARE 19302 PHYSI CI AN OFFI CE BUI LDI NG 19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI PHFC 07951 TRAFALGAR CLI NI C 07952 EDI NBURGH 07953 JAI L 07954 ATHLETI C TRAI NERS | 0 0 0 0 0 0 | 31, 940 C C | D D 2 | 0 31,940 0 0 0 0 | 194.00 194.01 194.02 194.03 194.03 |
| 193. 00 193. 01 193. 02 193. 03 194. 00 194. 01 194. 02 194. 03 194. 04 200. 00 | 19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION 07950 PARTNERSHIP HFC 07951 TRAFALGAR CLINIC 07952 EDINBURGH 07953 JAIL 07954 ATHLETIC TRAINERS Cross Foot Adjustments | | 31, 940 C C 152 | 2 2 3 | 0 31,940 0 0 0 0 0 152 0 1,548 0 0 | 194.00 194.01 194.02 194.03 194.03 194.04 200.00 |
| 193. 00 193. 01 193. 02 193. 03 194. 00 194. 01 194. 02 194. 03 194. 04 | 19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION 07950 PARTNERSHIP HFC 07951 TRAFALGAR CLINIC 07952 EDINBURGH 07953 JAIL 07954 ATHLETIC TRAINERS Cross Foot Adjustments Negative Cost Centers | 0 0 0 0 0 0 0 0 0 0 102, 960 | 31, 940 C 152 1, 548 |)) 2 3 0 | 0 31,940 0 0 0 0 0 152 0 1,548 | 194.00 194.01 194.02 194.03 194.04 200.00 201.00 |

| | Financial Systems LLOCATION - STATISTICAL BASIS | JOHNSON MEMOR | IAL HOSPITAL Provider C | | Period: | worksheet B-1 | |
|------------------|--|-----------------------|----------------------------|---------------------|--------------------------------|------------------|--------------------|
| | | | | | rom 01/01/2016 o 12/31/2016 | | |
| | | CAPITAL RELATED COSTS | | | | 1/16/2018 3:0 | |
| | Cost Center Description | NEW BLDG & | BLDG & FIXT - | MVBLE EQUIP | EMPLOYEE | COMMUNI CATI ONS | |
| | | FI XT (TOTAL | TOWER (SQUARE FEET) | (DOLLAR VALUE) | BENEFI TS DEPARTMENT | (# NON PT | |
| | | FEET) | | | (GROSS | PHONES) | |
| | | 1.00 | 1.01 | 2.00 | SALARIES) 4.00 | 4.01 | |
| 4 . 0.0 | GENERAL SERVICE COST CENTERS | | | | | 1 | 1.00 |
| 1.00 1.01 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - TOWER | 279, 616 0 | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | 2, 575, 452 | | | 2.00 |
| 4.00 4.01 | 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS | 2, 984 393 | | 1, 147 | | 1, 320 | 4.00 4.01 |
| 4.02 | 00402 DATA PROCESSING | 6, 260 | 0 | 1, 207, 398 | 8 824, 374 | 135 | 4. 02 |
| 4.03 4.04 | 00403 MATERI ALS MANAGEMENT 00404 ADMI TTI NG | 3, 826 2, 239 | | 5, 720 | | 29 | • |
| 4.05 | 00405 PATIENT ACCOUNTING | 6, 650 | 0 | 10, 096 | 1, 015, 677 | 88 | 4.05 |
| 5.00 7.00 | 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT | 9, 526 24, 960 | | 25, 341 38, 869 | | 77 | 5.00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | 2, 404 | 0 | 4, 280 | 128, 115 | 5 | 8.00 |
| 9. 00 10. 00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | 1,867 | | | | 14 | 9.00 |
| 11.00 | 01100 CAFETERI A | 4, 171 | 0 | | 527, 173 | 0 | 11.00 |
| 13.00 14.00 | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY | 9,867 | | 28, 254 28, 498 | | 43 | • |
| 15.00 | 01500 PHARMACY | 2,046 | 0 | 4, 817 | | - | • |
| 16.00 | 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS | 3, 879 | 0 | 6, 960 | 597, 171 | 41 | 16.00 |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 27, 577 | | 112, 519 | 4, 041, 385 | 105 | 30.00 |
| 31.00 41.00 | 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF | 7,886 | | | | 28 | • |
| 43.00 | 04300 NURSERY | 625 | | 10, 940 | | 0 | • |
| 50.00 | ANCI LLARY SERVI CE COST CENTERS | 45, 761 | 714 | 384, 940 | 2, 145, 569 | 83 | 50.00 |
| 53. 00 | 05300 ANESTHESI OLOGY | 394 | | 12, 257 | | | • |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY | 16, 532 8, 049 | | | | | • |
| 60. 00 65. 00 | 06500 RESPIRATORY THERAPY | 3, 374 | | 121, 958 13, 372 | | 68 18 | • |
| 66.00 | 06600 PHYSI CAL THERAPY | 6, 338 | | 8, 722 | | 21 | 66.00 |
| 67.00 68.00 | 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | 1, 335 | | 2, 061 323 | | 4 | 67.00 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 1,080 | | | | 43 | |
| 70. 00 71. 00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 182 | | | | 2 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | | C | 0 0 | | |
| | 07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY | 0 6, 999 | - |) 1, 868 | | - | |
| | 07697 CARDI AC REHABI LI TATI ON | 2, 511 | | 8, 920 | | | |
| 90.00 | OUTPATIENT SERVICE COST CENTERS | 11, 516 | 441 | 14, 265 | 739, 689 | 20 | 90.00 |
| 91.00 | 09100 EMERGENCY | 9, 934 | | | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 101.00 | 10100 HOME HEALTH AGENCY | 1, 305 | 0 | 56 | 5 718, 367 | 23 | 101.00 |
| 113.00 | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 | SUBTOTALS (SUM OF LINES 1-117) | 244, 932 | 75, 292 | 2, 478, 612 | 2 29, 099, 607 | 1, 126 | 118.00 |
| 190.00 | NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 1, 297 | 1, 297 | 3, 854 | 84, 104 | 15 | 190.00 |
| 192.00 | 19200 PHYSI CLANS' PRI VATE OFFI CES | 25, 925 | 0 | 92, 517 | | 153 | 192.00 |
| | 19201 SOUTH CLINIC 19202 WEST CLINIC | | - | | | | 192.01 192.02 |
| 192.03 | 19203 DI ABETES CENTER | 402 | | 469 | | 3 | 192.03 |
| | 19300 NONPAI D WORKERS 19301 ADULT/CHI LD CARE | 0 4,832 | 0 | |) 0 0 436, 731 | | 193. 00 193. 01 |
| 193.02 | 19302 PHYSICIAN OFFICE BUILDING | 4, 832 | | |) 430,731 | 0 | 193. 02 |
| | 19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHIP HFC | 0 2, 228 | 0 | | | | 193.03 194.00 |
| | 07950 PARTNERSHTP HEC 07951 TRAFALGAR CLINIC | 2,228 | 0 | |) 27,708) 0 | | 194.00 |
| 194.02 | 07952 EDI NBURGH | 0 | - | | - | | 194.02 |
| | 07953 JAI L 07954 ATHLETI C TRAI NERS | | 0 | | - | | 194. 03 194. 04 |
| 200.00 | Cross Foot Adjustments | | | | | | 200.00 |
| 201.00 202.00 | | 2, 039, 684 | 86, 509 | 2, 585, 049 | 9, 285, 449 | 549, 257 | 201.00 202.00 |
| | Part I) | | | | | | |

| Health Financial Systems | JOHNSON MEMOR | IAL HOSPITAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|--|-------------------------------|---|------------------------------|----------------------------|-------------------------------|----------------|
| COST ALLOCATION - STATISTICAL BASIS | | Provider C | | Period: From 01/01/2016 | Worksheet B-1 | |
| | | | | To 12/31/2016 | | pared: 1 pm |
| | CAP | ITAL RELATED CO | OSTS | | | |
| Cost Center Description | NEW BLDG & FI XT (TOTAL | BLDG & FIXT - TOWER (SQUARE FEET) | MVBLE EQUIP (DOLLAR VALUE | | COMMUNI CATI ONS (# NON PT | |
| | FEET) | (SUUARE TEET) | | (GROSS SALARI ES) | PHONES) | |
| | 1.00 | 1.01 | 2.00 | 4.00 | 4.01 | |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 7. 294590 | 1. 123625 | 1.00372 | 6 0. 229410 | 416. 103788 | 203.00 |
| 204.00 Cost to be allocated (per Wkst. B, Part II) | | | | 22, 918 | 2, 989 | 204. 00 |
| 205.00 Unit cost multiplier (Wkst. B, Part | | | | 0. 000566 | 2. 264394 | 205. 00 |

| Health Financial Systems COST ALLOCATION - STATISTICAL BASIS | JOHNSON MEMORI | AL HOSPITAL Provider CC | N: 15 0001 F | In Lie Period: | Worksheet B-1 | 552-10 |
|--|---------------------|-----------------------------------|------------------------------|---------------------------------|---|---|
| CUST ALLUCATION - STATISTICAL DASIS | | Provider CC | F | From 01/01/2016 o 12/31/2016 | Date/Time Prep | |
| Cost Center Description | DATA PROCESSI NG | MATERIALS MANAGEMENT | ADMI TTI NG (GROSS | PATI ENT ACCOUNTI NG | <u>1/16/2018</u> 3:01 Reconciliation | l pm |
| | (WORK ORDERS) | (SUPPLY USAGE) | REVENUE) | (GROSS REVENUE) | | |
| | 4.02 | 4.03 | 4.04 | 4. 05 | 5A | |
| GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT | | T | | 1 | | 1.00 |
| 1. 01 00101 CAP REL COSTS BLDG & FLXT TOWER 2. 00 00200 CAP REL COSTS BLDG & FLXT TOWER 2. 00 00200 CAP REL COSTS BLDG & FLXT TOWER 2. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATIONS 4. 02 00402 DATA PROCESSING COSTS COSTS <thcosts< th=""> <thcosts< th=""> <thcosts< th=""></thcosts<></thcosts<></thcosts<> | 2, 429 | | | | | 1. 01 2. 00 4. 00 4. 01 4. 02 |
| 4. 03 00403 MATERIALS MANAGEMENT 4. 04 00404 ADMITTING ADMITTING 4. 05 00405 PATIENT ACCOUNTING | 33 90 265 | 8, 280, 362 19, 966 38, 987 | 200, 227, 357 C | 200, 227, 357 | 4 (00 042 | 4.03 4.04 4.05 |
| 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT | 263 21 | 106, 935 4, 284 | C | 0 | -4, 698, 942 0 | 5.00 7.00 |
| 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG | 16 0 | 18, 582 104, 585 | C | - | 0 | 8.00 9.00 |
| 10. 00 01000 DI ETARY | 71 | 245, 830 | C | 0 | 0 | 10.00 |
| 11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON | 0 86 | 0 63, 123 | C | | 0 | 11.00 13.00 |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY | 0 24 | 61, 074 0 | C | - | 0 | 14.00 15.00 |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY | 24 110 | 0 1, 431 | C | - | 0 | 16.00 |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS | 177 | 235, 743 | 11, 100, 282 | 11, 100, 282 | 0 | 30.00 |
| 31.00 03100 I NTENSI VE CARE UNI T | 61 | 72, 290 | 1, 995, 911 | 1, 995, 911 | 0 | 31.00 |
| 41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY | 46 0 | 17, 490 0 | 1, 856, 636 675, 431 | | 0 | 41.00 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI 0LOGY | 207 0 | 385, 611 2, 900 | 31, 001, 255 3, 489, 516 | | 0 | 50.00 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY | 150 110 | 277, 403 | 38, 020, 982 | | 0 | 54.00 |
| 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY | 59 | 1, 156, 946 113, 309 | 28, 041, 519 5, 808, 115 | | 0 | 60.00 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY | 15 5 | 21, 026 12 | 3, 355, 255 2, 065, 797 | | 0 | 66.00 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 3 | 78 | 657, 049 | 657, 049 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY | 96 3 | 68, 257 1, 086 | 5, 457, 512 155, 063 | | 0 | 69.00 70.00 |
| 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0 | 3, 425, 123 | 6, 812, 458 | 6, 812, 458 | 0 | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 0 | 0 0 | 4, 664, 200 10, 811, 878 | | 0 | 72.00 73.00 |
| 76. 00 03020 ONCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON | 17 0 | 0 7, 817 | 223, 288 542, 217 | | 0 | 76.00 76.97 |
| OUTPATIENT SERVICE COST CENTERS | | | | | 0 | 70. 77 |
| 90. 00 09000 CLINIC 91. 00 09100 EMERGENCY | 80 121 | 491, 803 102, 236 | 11, 201, 072 19, 715, 418 | | 0 | 90.00 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | ,, | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY | 45 | 11, 913 | 1, 574, 485 | 1, 574, 485 | 0 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | 112 00 |
| 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117) | 2, 174 | 7, 055, 840 | 189, 225, 339 | 189, 225, 339 | | 113. 00 118. 00 |
| NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN | 16 | 14, 964 | C | | 0 | 190. 00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 191 | 1, 117, 498 | 11, 002, 018 | | 0 | 192.00 |
| 192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC | 0 0 | 0 0 | C | | | 192. 01 192. 02 |
| 192. 03 19203 DI ABETES CENTER | 3 | 175 | C | 0 | 0 | 192. 03 193. 00 |
| 193. 00 19300 NONPALD WORKERS 193. 01 19301 ADULT/CHI LD CARE | 0 21 | 0 72, 122 | C | | 0 | 193. 01 |
| 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON | 0 | 0 18, 696 | C | | | 193. 02 193. 03 |
| 194. 00 07950 PARTNERSHI P HFC | 24 | 994 | C | 0 | 0 | 194.00 |
| 194. 01 07951 TRAFALGAR CLINIC 194. 02 07952 EDI NBURGH | 0 | 0 0 | C | | | 194. 01 194. 02 |
| 194. 03 07953 JAI L | 0 | 0 | C | 0 | 0 | 194. 03 |
| 194.0407954ATHLETICTRAINERS200.00Cross FootAdjustments | 0 | 73 | C | 0 | | 194. 04 200. 00 |
| 201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B, | 3, 108, 574 | 478, 087 | 948, 610 | 2, 341, 217 | | 201. 00 202. 00 |
| Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) | 1, 279. 775216 | 0. 057737 | 0. 004738 | 0. 011693 | | 203.00 |
| 204.00 Cost to be allocated (per Wkst. B, | 1, 258, 337 | 50, 971 | 65, 344 | | | 203.00 204.00 |

| Health Financial Systems | JOHNSON MEMORI | AL_HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|----------------------|-----------------------|--------------------|----------------------------|-----------------|---------|
| COST ALLOCATION - STATISTICAL BASIS | | Provider CO | | Period: From 01/01/2016 | Worksheet B-1 | |
| | | | | To 12/31/2016 | | |
| Cost Center Description | DATA | MATERI ALS | ADMI TTI NG | | Reconciliation | |
| | PROCESSI NG (WORK | MANAGEMENT (SUPPLY | (GROSS REVENUE) | ACCOUNTING (GROSS | | |
| | 0RDERS) 4. 02 | USAGE) 4.03 | 4.04 | | 5A | |
| 205.00 Unit cost multiplier (Wkst. B, Part | 518. 047345 | | | | | 205.00 |

| ST AI | Financial Systems LOCATION - STATISTICAL BASIS | JOHNSON MEMORI | Provi der CO | | eriod: | u of Form CMS-25 Worksheet B-1 |
|--|---|--|--|---|--|---|
| | | | | | rom 01/01/2016 o 12/31/2016 | |
| | Cost Center Description | ADMI NI STRATI VE & GENERAL (ACCUM. COST) | OPERATI ON OF PLANT (TOTAL FEET) | LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY) | HOUSEKEEPI NG (TOTAL FEET) | 1/16/2018 3:01 DI ETARY (MEALS SERVED) |
| | | 5.00 | 7.00 | 8.00 | 9.00 | 10.00 |
| | GENERAL SERVICE COST CENTERS | 1 | | | | |
| 01 00 01 02 03 04 05 00 00 00 00 00 00 00 00 00 00 00 00 | 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-NVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATIONS 00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT 00404 ADMITTING 00405 PATIENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY | 73, 530, 157 3, 163, 916 276, 364 999, 217 685, 615 606, 277 2, 404, 622 253, 228 | 222, 778 2, 404 1, 867 3, 917 4, 171 9, 867 1, 699 | 503, 873 90, 117 8, 281 C C C | 218, 507 3, 917 4, 171 9, 867 | 7, 955 0 0 0 |
| | 01500 PHARMACY | 3, 584, 657 | 2, 046 | C | | 0 |
| 00 | 01600 MEDICAL RECORDS & LIBRARY | 1, 170, 667 | 3, 879 | C | 3, 879 | 0 |
| 00 00 00 | 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY | 5, 483, 338 2, 017, 718 1, 158, 806 345, 590 | 27, 577 7, 886 6, 763 625 | 130, 204 31, 561 22, 740 0 | 7, 886 6, 763 | 5, 437 1, 057 1, 461 0 |
| | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | 4, 821, 056 | 45, 761 | 100, 938 | 45, 761 | 0 |
| 00 | 05300 ANESTHESI OLOGY | 138, 551 | 394 | C | 394 | 0 |
| | 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY | 4, 847, 541 4, 876, 536 | 16, 532 8, 049 | 32, 603 C | | 0 |
| | 06500 RESPI RATORY THERAPY | 1, 632, 365 | 8, 049 3, 374 | | | 0 |
| | 06600 PHYSI CAL THERAPY | 1, 277, 721 | 6, 338 | 2, 408 | | 0 |
| | 06700 OCCUPATIONAL THERAPY | 359, 389 | 1, 335 | | | 0 |
| | 06800 SPEECH PATHOLOGY | 198,038 | 83 | 0 | | 0 |
| | 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY | 1, 053, 716 80, 211 | 1, 080 182 | 3, 590 0 | | 0 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 221, 678 | 0 | C | 0 | 0 |
| | 07200 I MPL. DEV. CHARGED TO PATIENT | 1, 631, 370 | 0 | C | 0 | 0 |
| | 07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY | 177, 650 280, 654 | 0 6, 999 | | 0 6, 999 | 0 |
| | 07697 CARDI AC REHABI LI TATI ON | 230, 034 | 2, 511 | | | 0 |
|] | OUTPATIENT SERVICE COST CENTERS | | | | | |
| | | 3, 241, 504 | 11, 516 | | | 0 |
| | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 3, 361, 661 | 9, 934 | 72, 895 | 9, 934 | 0 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |
| . 00 | 10100 HOME HEALTH AGENCY | 1, 145, 383 | 1, 305 | C | 1, 305 | 0 1 |
| 00 | SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE | | | | | 1 |
| . 00 | | 53, 732, 555 | 188, 094 | 498, 081 | 183, 823 | 7, 955 1 |
| | NONREIMBURSABLE COST CENTERS | | | | | |
| | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES | 176, 251 17, 627, 647 | 1, 297 25, 925 | | ., = | 0 1 |
| | 19200 PHYSICIANS PRIVATE OFFICES | 17,027,047 | 25, 925 | 5, 792 | 25, 925 | 01 |
| . 02 | 19202 WEST CLINIC | 0 | 0 | C | 0 | 0 1 |
| | 19203 DI ABETES CENTER | 124, 314 | 402 | C | 402 | 01 |
| | 19300 NONPALD WORKERS 19301 ADULT/CHILD CARE | 0 668, 742 | 0 4, 832 | | 0 4, 832 | 0 1 |
| | 19302 PHYSI CI AN OFFICE BUILDING | 000, 712 | 0 | C | 0 | 0 1 |
| | 19303 OPTI FAST/FOUNDATI ON | 753, 951 | 0 | C | 0 | 0 1 |
| | 07950 PARTNERSHIP HFC 07951 TRAFALGAR CLINIC | 89, 107 | 2, 228 | | 2, 228 | 01 |
| | 07951 TRAFALGAR_CLINIC 07952 EDINBURGH | 0 | 0 | | 0 | 0 1 0 1 |
| . 03 | 07953 JAI L | 48, 000 | 0 | c c | 0 | 01 |
| | 07954 ATHLETIC TRAINERS | 309, 590 | 0 | C | 0 | 01 |
| 0. 00 | Cross Foot Adjustments | | | | | 2 |
| . 00 . 00 | Negative Cost Centers Cost to be allocated (per Wkst. B, | 4, 698, 942 | 3, 366, 106 | 330, 349 | 1, 150, 365 | 2 814, 665 2 |
| | Part I) Unit cost multiplier (Wkst. B, Part I) | 0. 063905 | 15. 109688 | 0. 655620 | 5. 264660 | 102. 409177 2 |
| 3. 00 | | | | | | |

| Health Financial Systems | JOHNSON MEMORI | AL_HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--|-------------------|---------------|---------------|----------------------------------|--------------------------------|---------|
| COST ALLOCATION - STATISTICAL BASIS | | Provider C | | Period: | Worksheet B-1 | |
| | | | | From 01/01/2016 Fo 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | |
| Cost Center Description | ADMI NI STRATI VE | OPERATI ON OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | & GENERAL | PLANT | LINEN SERVICE | (TOTAL | (MEALS | |
| | (ACCUM. | (TOTAL | (POUNDS OF | FEET) | SERVED) | |
| | COST) | FEET) | LAUNDRY) | | | |
| | 5.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| 205.00 Unit cost multiplier (Wkst. B, Part | 0. 003172 | 1. 144646 | 0.067374 | 0. 141268 | 11.743935 | 205.00 |
| | | | | | | |

| Health Financial Systems COST ALLOCATION - STATISTICAL BASIS | JOHNSON MEMOR | IAL HOSPITAL Provider CC | N. 15-0001 P | In Lieu eriod: | of Form CMS-: Worksheet B-1 | |
|--|---|---|---|--|---|--|
| | | | F | rom 01/01/2016 | Date/Time Pre | pared: |
| Cost Center Description | CAFETERI A (HOURS PAI D) 11.00 | NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS) 13. 00 | CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14.00 | PHARMACY (COSTED REQUIS.) 15.00 | 1/16/2018 3:0 MEDI CAL RECORDS & LI BRARY (GROSS REVENUE) 16.00 | 1 pm |
| GENERAL SERVICE COST CENTERS | 11.00 | 13.00 | 14.00 | 13.00 | 10.00 | |
| 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 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 CATI ONS 4.02 00402 DATA PROCESSI NG 4.03 00403 MATERI ALS MANAGEMENT 4.04 00404 ADMI TTI NG 4.05 00405 PATI ENT ACCOUNTI NG 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 004000 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS | 816, 756 25, 290 4, 204 15, 383 33, 343 | 281, 892 4, 204 0 | 100 0 0 | 100 | 200, 227, 357 | $\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 01\\ 4.\ 02\\ 4.\ 03\\ 4.\ 04\\ 4.\ 05\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$ |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 104, 902 | | 0 | | 11, 100, 282 | • |
| 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF | 35, 465 20, 210 | | 0 0 | | 1, 995, 911 1, 856, 636 | 1 |
| 43. 00 04300 NURSERY | 6, 313 | | 0 | | 675, 431 | 1 |
| ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM | 56, 676 | 56, 676 | 0 | 0 | 31, 001, 255 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 243 63, 450 | 1 | 0 | | 3, 489, 516 38, 020, 982 | • |
| 60. 00 06000 LABORATORY | 64, 190 | 0 | 0 | 0 | 28, 041, 519 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY | 27, 460 23, 440 | | 0 | | 5, 808, 115 3, 355, 255 | • |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 6, 240 | | 0 | | 2, 065, 797 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY | 3,610 | | 0 | | 657,049 | • |
| 70. 00 07000 ELECTROEARDI OLOGY | 12, 458 1, 672 | | 0 | | 5, 457, 512 155, 063 | • |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | C | 0 | 100 | | 6, 812, 458 | • |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS | | 0 | 0 | 0 100 | 4, 664, 200 10, 811, 878 | • |
| 76.00 03020 ONCOLOGY | 4,545 | | 0 | 0 | 223, 288 | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVICE COST CENTERS | 3, 605 | 0 | 0 | 0 | 542, 217 | 76.97 |
| 90. 00 09000 CLINIC | 28, 065 | 0 | 0 | 0 | 11, 201, 072 | 90.00 |
| 91.00 09100 EMERGENCY | 54, 122 | 54, 122 | 0 | 0 | 19, 715, 418 | • |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 19, 947 | 0 | 0 | 0 | 1, 574, 485 | 101.00 |
| 113. 00 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1-117) | 614, 833 | 281, 892 | 100 | 100 | 189, 225, 339 | 118.00 |
| NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 5, 213 | 0 | 0 | 0 | | 190.00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 138, 706 | 0 | 0 | 0 | 11, 002, 018 | |
| 192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC | | | 0 | 0 | | 192. 01 192. 02 |
| 192. 03 19203 DI ABETES CENTER | 2, 380 | 0 | 0 | 0 | 0 | 192. 03 |
| 193. 00 19300 NONPALD WORKERS 193. 01 19301 ADULT/CHI LD CARE | C 44, 716 | 0 | 0 | 0 | | 193.00 193.01 |
| 193. 02 19302 PHYSI CI AN OFFICE BUILDING | C | 0 | 0 | 0 | | 193.02 |
| 193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC | C | 0 | 0 | 0 | | 193.03 194.00 |
| 194. 00 07950 PARTNERSHIP HPC 194. 01 07951 TRAFALGAR CLINIC | 1,436 C | 0 | 0 | 0 | | 194.00 |
| 194. 02 07952 EDI NBURGH | C | 0 | 0 | 0 | | 194.02 |
| 194. 03 07953 JAI L 194. 04 07954 ATHLETI C TRAI NERS | 0 9,472 | | 0 | 0 | | 194.03 194.04 |
| 200.00 Cross Foot Adjustments | ,,,,,,, | | 0 | | 0 | 200. 00 |
| 201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B, | 730, 003 | 2, 781, 926 | 349, 272 | 3, 869, 169 | 1, 354, 311 | 201.00 |
| Part I) | | | | | | |
| 203.00 Unit cost multiplier (Wkst. B, Part I) | 0. 893783 | 9. 868/65 | 3, 492. 720000 | 38, 691. 690000 | 0. 006764 | J2U3. UU |

| Heal th Financ | cial Systems | JOHNSON MEMOR | I AL HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|----------------|--|---------------|-------------------|------------|----------------------------------|-----------------|---------|
| COST ALLOCATI | ION - STATISTICAL BASIS | | Provider CC | | Period: | Worksheet B-1 | |
| | | | | | From 01/01/2016 To 12/31/2016 | | |
| (| Cost Center Description | CAFETERI A | NURSI NG | CENTRAL | PHARMACY | MEDI CAL | |
| | | (HOURS | ADMI NI STRATI ON | SERVICES & | (COSTED | RECORDS & | |
| | | PAID) | | SUPPLY | REQUIS.) | LI BRARY | |
| | | | (DI RECT | (COSTED | | (GROSS | |
| | | | NRSING HRS) | REQUIS.) | | REVENUE) | |
| | | 11.00 | 13.00 | 14.00 | 15.00 | 16.00 | |
| | Cost to be allocated (per Wkst. B, Part II) | 38, 010 | 167, 777 | 47, 11 | 1 47, 250 | 102, 960 | 204.00 |
| | Unit cost multiplier (Wkst. B, Part II) | 0. 046538 | 0. 595182 | 471.110000 | 472.500000 | 0. 000514 | 205. 00 |

| Heal th | Financial Systems | JOHNSON MEMORI | AL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|---------|--|---|-----------------------|---------------|---|---|---------|
| COMPUT | ATION OF RATIO OF COSTS TO CHARGES | | Provider C | CN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Pre 1/16/2018 3:C | epared: |
| | | | Title | e XVIII | Hospi tal | PPS | |
| | | | | | Costs | 115 | |
| | Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | | RCE Di sal I owance | Total Costs | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 1 | l | 1 | | | |
| | 03000 ADULTS & PEDI ATRI CS | 8, 241, 872 | | 8, 241, 8 | | 8, 241, 872 | |
| | 03100 I NTENSI VE CARE UNI T | 2, 831, 465 | | 2, 831, 40 | | 2, 831, 465 | |
| | 04100 SUBPROVI DER – I RF | 1, 765, 249 | | 1, 765, 24 | | 1, 765, 249 | |
| | 04300 NURSERY | 452, 922 | | 452, 92 | 22 0 | 452, 922 | 43.00 |
| | ANCILLARY SERVICE COST CENTERS | 1 | I | 1 | | | |
| | 05000 OPERATING ROOM | 6, 947, 347 | | 6, 947, 34 | | -, , | |
| | 05300 ANESTHESI OLOGY | 179, 252 | | 179, 25 | | 179, 252 | |
| | 05400 RADI OLOGY-DI AGNOSTI C | 5, 829, 384 | | 5, 829, 38 | | 5, 829, 384 | |
| | 06000 LABORATORY | 5, 599, 209 | | 5, 599, 20 | | 5, 599, 209 | |
| | 06500 RESPI RATORY THERAPY | 1, 869, 253 | | 1 .7 00 77 2. | | 1, 869, 253 | |
| | 06600 PHYSI CAL THERAPY | 1, 533, 730 | | 1, 533, 73 | | 1, 533, 730 | |
| | 06700 OCCUPATI ONAL THERAPY | 429, 105 | | 429, 10 | | 429, 105 | |
| | 06800 SPEECH PATHOLOGY | 220, 056 | | 220, 05 | | 220, 056 | |
| | 06900 ELECTROCARDI OLOGY | 1, 193, 462 | | 1, 193, 40 | | 1, 193, 462 | |
| | 07000 ELECTROENCEPHALOGRAPHY | 91, 588 | | 91, 58 | 38 0 | 91, 588 | 70.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 759, 005 | | 2, 759, 00 | 05 0 | 2, 759, 005 | |
| | 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 767, 172 | | 1, 767, 1 | /2 0 | 1, 767, 172 | |
| | 07300 DRUGS CHARGED TO PATIENTS | 4, 131, 304 | | 4, 131, 30 | 04 0 | 4, 131, 304 | |
| | 03020 ONCOLOGY | 446, 761 | | 446, 70 | 0 0 | 446, 761 | 76.00 |
| | 07697 CARDI AC REHABI LI TATI ON | 310, 744 | | 310, 74 | 4 0 | 310, 744 | 76.97 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90.00 | 09000 CLINIC | 3, 785, 930 | | 3, 785, 93 | 30 0 | 3, 785, 930 | 90.00 |
| 91.00 | 09100 EMERGENCY | 4, 542, 523 | | 4, 542, 52 | 23 0 | 4, 542, 523 | 91.00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 537, 638 | | 1, 537, 63 | 38 | 1, 537, 638 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | | | _ | | | |
| 101.00 | 10100 HOME HEALTH AGENCY | 1, 273, 645 | | 1, 273, 64 | 15 | 1, 273, 645 | 101.00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | | |
| 113.00 | 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 200.00 | Subtotal (see instructions) | 57, 738, 616 | C | 57, 738, 6 | 6 0 | 57, 738, 616 | 200.00 |
| 201.00 | Less Observation Beds | 1, 537, 638 | | 1, 537, 63 | 88 | 1, 537, 638 | 201.00 |
| 202.00 | Total (see instructions) | 56, 200, 978 | 0 | 56, 200, 9 | 78 0 | 56, 200, 978 | 202.00 |
| | | | • | | | | |

| Health Financial Systems | JOHNSON MEMORI | | | In Lie | u of Form CMS- | 2552-10 |
|---|----------------|---------------|-------------|----------------------------------|----------------|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | CN: 15-0001 | Peri od: | Worksheet C | |
| | | | | From 01/01/2016 To 12/31/2016 | | nared |
| | | | | 10 12/31/2010 | 1/16/2018 3:0 |)1 pm |
| | | Title | XVIII | Hospi tal | PPS | |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | | 6 Cost or Other | TEFRA | |
| | | | + col. 7) | Rati o | Inpati ent | |
| | (| | | | Ratio | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 11 100 000 | | 44,400,0 | | | 0.00 |
| 30. 00 03000 ADULTS & PEDIATRICS | 11, 100, 282 | | 11, 100, 20 | | | 30.00 |
| 31.00 03100 I NTENSI VE CARE UNI T | 1, 995, 911 | | 1, 995, 9 | | | 31.00 |
| 41.00 O4100 SUBPROVIDER - IRF | 1, 856, 636 | | 1, 856, 6 | | | 41.00 |
| 43.00 04300 NURSERY | 675, 431 | | 675, 43 | 31 | | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | 6 0 (1 0 0 0 | 04 700 070 | 01.001.00 | | 0.00000 | 1 50 00 |
| 50. 00 O5000 OPERATI NG ROOM | 6, 261, 382 | 24, 739, 873 | | | | |
| 53.00 05300 ANESTHESI OLOGY | 757, 859 | 2, 731, 657 | | | | |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 4,093,142 | 33, 927, 840 | | | | |
| 60. 00 06000 LABORATORY | 5, 963, 738 | 22, 077, 781 | | | | |
| 65.00 06500 RESPI RATORY THERAPY | 2, 923, 539 | 2, 884, 576 | | | | |
| 66. 00 06600 PHYSI CAL THERAPY | 1, 233, 140 | 2, 122, 115 | | | 0.00000 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 1, 212, 604 | 853, 193 | | | | |
| 68.00 06800 SPEECH PATHOLOGY | 352, 352 | 304, 697 | | | | |
| 69.00 06900 ELECTROCARDI OLOGY | 844, 395 | 4, 398, 429 | | | 0.00000 | |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 47, 783 | 107, 280 | | | | |
| 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 3, 558, 153 | 3, 254, 305 | | | 0.00000 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 4, 664, 200 | | | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 4, 717, 274 | 6,094,603 | | | | |
| 76.00 03020 ONCOLOGY | 2, 200 | 152, 554 | | | 0.00000 | |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 542, 217 | 542, 2 | 0. 573099 | 0.00000 | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLI NI C | 61, 559 | 10, 945, 431 | | | | |
| 91.00 09100 EMERGENCY | 2, 886, 868 | 16, 828, 550 | | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 145, 085 | 1, 477, 406 | 1, 622, 4 | 0. 947702 | 0.00000 | 92.00 |
| OTHER REI MBURSABLE COST CENTERS | | | 1 | | | |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 1, 574, 485 | 1, 574, 48 | 35 | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | 1 1 | | | | | |
| 113.00 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 200.00 Subtotal (see instructions) | 50, 689, 333 | 139, 681, 192 | 190, 370, 5 | 25 | | 200.00 |
| 201.00 Less Observation Beds | | | | | | 201.00 |
| 202.00 Total (see instructions) | 50, 689, 333 | 139, 681, 192 | 190, 370, 5 | 25 | | 202.00 |

| Health Financial Systems | JOHNSON MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2552-10 |
|--|---------------------------------|------------------------|---|---|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provi der CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Prepared: 1/16/2018 3:01 pm |
| | | Title XVIII | Hospi tal | PPS |
| Cost Center Description | PPS Inpatient Ratio 11.00 | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | • • • • | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | | 31.00 |
| 41.00 04100 SUBPROVIDER - IRF | | | | 41.00 |
| 43.00 04300 NURSERY | | | | 43.00 |
| ANCI LLARY SERVICE COST CENTERS | | | | |
| 50. 00 05000 OPERATI NG ROOM | 0, 224099 | | | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0.051369 | | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 153320 | | | 54.00 |
| 60. 00 06000 LABORATORY | 0. 199676 | | | 60.00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0. 321835 | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 457113 | | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 207719 | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 334916 | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 227637 | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0. 590650 | | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 404994 | | | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENT | 0. 378880 | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0. 382108 | | | 73.00 |
| 76. 00 03020 ONCOLOGY | 2. 886911 | | | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0. 573099 | | | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | 01070077 | | | |
| 90. 00 09000 CLINIC | 0. 343957 | | | 90,00 |
| 91. 00 09100 EMERGENCY | 0. 230405 | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 947702 | | | 92.00 |
| OTHER REI MBURSABLE COST CENTERS | | | | |
| 101.00 10100 HOME HEALTH AGENCY | | | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | |
| 113.00 11300 INTEREST EXPENSE | | | | 113.00 |
| 200.00 Subtotal (see instructions) | | | | 200.00 |
| 201.00 Less Observation Beds | | | | 201.00 |
| 202.00 Total (see instructions) | | | | 202.00 |
| | | | | |

| Heal th Financial Systems | JOHNSON MEMORI | | 01 45 0004 | | u of Form CMS- | 2552-10 |
|--|----------------|---------------|-----------------|----------------------------|-----------------------|----------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | CN: 15-0001 | Period: From 01/01/2016 | Worksheet C Part I | |
| | | | | To 12/31/2016 | Date/Time Pre | epared: |
| | | | | | 1/16/2018 3:0 |)1 pm |
| | | liti | e XIX | Hospital | Cost | |
| Cost Center Description | Total Cost | Therapy Limit | Total Cost | Costs S RCE | Total Costs | |
| cost center bescription | (from Wkst, B. | Adj. | | 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 | 0.00 | 1.00 | 0.00 | |
| 30. 00 03000 ADULTS & PEDIATRICS | 8, 241, 872 | | 8, 241, 8 | 72 0 | 8, 241, 872 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 2, 831, 465 | | 2, 831, 4 | | 2, 831, 465 | |
| 41. 00 04100 SUBPROVI DER – I RF | 1, 765, 249 | | 1, 765, 2 | | 1, 765, 249 | |
| 43. 00 04300 NURSERY | 452, 922 | | 452, 9 | | 452, 922 | |
| ANCI LLARY SERVI CE COST CENTERS | | | 1 | | | |
| 50. 00 05000 OPERATI NG ROOM | 6, 947, 347 | | 6, 947, 3 | 47 0 | 6, 947, 347 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 179, 252 | | 179, 2 | 52 0 | 179, 252 | 53.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C | 5, 829, 384 | | 5, 829, 3 | | 5, 829, 384 | |
| 60. 00 06000 LABORATORY | 5, 599, 209 | | 5, 599, 2 | 09 0 | 5, 599, 209 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 1, 869, 253 | C | 1, 869, 2 | 53 0 | 1, 869, 253 | |
| 66. 00 06600 PHYSI CAL THERAPY | 1, 533, 730 | C | 1, 533, 7 | 30 0 | 1, 533, 730 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 429, 105 | C | 429, 1 | 05 0 | 429, 105 | 67. OC |
| 68.00 06800 SPEECH PATHOLOGY | 220, 056 | C | 220, 0 | 56 0 | 220, 056 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 1, 193, 462 | | 1, 193, 4 | 62 0 | 1, 193, 462 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 91, 588 | | 91, 5 | 88 0 | 91, 588 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 2, 759, 005 | | 2, 759, 0 | 05 0 | 2, 759, 005 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 1, 767, 172 | | 1, 767, 1 | 72 0 | 1, 767, 172 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 4, 131, 304 | | 4, 131, 3 | 04 0 | 4, 131, 304 | |
| 76.00 03020 ONCOLOGY | 446, 761 | | 446, 7 | 61 0 | 446, 761 | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 310, 744 | | 310, 7 | 44 0 | 310, 744 | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLINIC | 3, 785, 930 | | 3, 785, 9 | | -, | |
| 91.00 09100 EMERGENCY | 4, 542, 523 | | 4, 542, 5 | | 1, 012, 020 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 1, 537, 638 | | 1, 537, 6 | 38 | 1, 537, 638 | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | · |
| 101.00 10100 HOME HEALTH AGENCY | 1, 273, 645 | | 1, 273, 6 | 45 | 1, 273, 645 | _101. OC |
| SPECIAL PURPOSE COST CENTERS | 1 | | 1 | | | 440.00 |
| 113.00 11300 INTEREST EXPENSE | F7 700 (4) | _ | F7 7 6 6 | | F7 700 /1/ | 113.00 |
| 200.00 Subtotal (see instructions) | 57, 738, 616 | | | | | |
| 201.00 Less Observation Beds | 1, 537, 638 | | 1, 537, 6 | | 1, 537, 638 | |
| 202.00 Total (see instructions) | 56, 200, 978 | C | 56, 200, 9 | 78 0 | 56, 200, 978 | 202.00 |

| Health Financial Systems | JOHNSON MEMORI | | | In Lie | u of Form CMS- | 2552-10 |
|---|----------------------------|-----------------------------|---------------------------------------|----------------------------------|----------------|----------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider C | CN: 15-0001 | Period: | Worksheet C | |
| | | | | From 01/01/2016 To 12/31/2016 | | pared. |
| | | | | 10 12/01/2010 | 1/16/2018 3:0 | 1 pm |
| | | | e XIX | Hospi tal | Cost | |
| | | Charges | | | | |
| Cost Center Description | I npati ent | Outpati ent | | 6 Cost or Other | TEFRA | |
| | | | + col. 7) | Rati o | Inpati ent | |
| | (00 | 7.00 | 0.00 | 0.00 | Ratio | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS | 11 100 202 | | 11 100 20 | 2 | | 30.00 |
| | 11, 100, 282 | | 11, 100, 28 | | | 30.00 |
| | 1, 995, 911 | | 1, 995, 9 | | | |
| 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY | 1,856,636 | | 1, 856, 63 | | | 41.00 43.00 |
| 43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS | 675, 431 | | 675, 43 | i I | | 43.00 |
| 50. 00 05000 OPERATING ROOM | 6, 261, 382 | 24, 739, 873 | 31, 001, 2 | 0. 224099 | 0. 000000 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 757, 859 | 24, 739, 873 2, 731, 657 | | | | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 4,093,142 | 33, 927, 840 | | | | |
| 60. 00 06000 LABORATORY | 4, 093, 142 5, 963, 738 | 22, 077, 781 | | | | |
| 65. 00 06500 RESPIRATORY THERAPY | 2, 923, 539 | 2, 884, 576 | | | | |
| 66. 00 06600 PHYSICAL THERAPY | 1, 233, 140 | 2, 884, 576 | | | 0. 000000 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 1, 233, 140 | 853, 193 | | | | |
| 68. 00 06800 SPEECH PATHOLOGY | 352, 352 | 304, 697 | | | | |
| 69. 00 06900 ELECTROCARDI OLOGY | 844, 395 | 4, 398, 429 | | | 0. 000000 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 47, 783 | 4, 398, 429 | | | | |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 3, 558, 153 | 3, 254, 305 | | | 0. 000000 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 3, 558, 153 | 4, 664, 200 | | | | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 4, 717, 274 | 6, 094, 603 | | | | |
| 76. 00 03020 0NC0L0GY | 2,200 | 152, 554 | | | 0. 000000 | |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 2,200 | 542, 217 | | | | |
| OUTPATIENT SERVICE COST CENTERS | <u> </u> | 542,217 | 542,2 | 0. 373077 | 0.000000 | /0. // |
| 90. 00 09000 CLINIC | 61, 559 | 10, 945, 431 | 11, 006, 99 | 0 0.343957 | 0.00000 | 90.00 |
| 91. 00 09100 EMERGENCY | 2, 886, 868 | 16, 828, 550 | | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 145,085 | 1, 477, 406 | | | 0. 000000 | |
| OTHER REIMBURSABLE COST CENTERS | 143,003 | 1, 477, 400 | 1,022,4 | 0.747702 | 0.00000 | /2.00 |
| 101. 00 10100 HOME HEALTH AGENCY | 0 | 1, 574, 485 | 1, 574, 48 | 5 | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | ч <u>ч</u> | 1, 0, 1, 400 | 1, 0, 4, 40 | | | 1.51.50 |
| 113. 00 11300 I NTEREST EXPENSE | | | | | | 1113.00 |
| 200.00 Subtotal (see instructions) | 50, 689, 333 | 139, 681, 192 | 190, 370, 52 | 5 | | 200.00 |
| 201.00 Less Observation Beds | 00,007,000 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 201.00 |
| 202.00 Total (see instructions) | 50, 689, 333 | 139, 681, 192 | 190, 370, 52 | 5 | | 202.00 |
| | | 107,001,172 | 1 | | 1 | 1202.00 |

| Heal th | Financial Systems | JOHNSON MEMORIAL | HOSPI TAL | In Lie | u of Form CMS- | 2552-10 |
|---------|--|---------------------------------|-----------------------|---|---|---------|
| COMPUT | ATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet C Part I Date/Time Pre 1/16/2018 3:0 | |
| | | | Title XIX | Hospi tal | Cost | |
| | Cost Center Description | PPS Inpatient Ratio 11.00 | | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | | | | | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | | | | | 31.00 |
| 41.00 | 04100 SUBPROVI DER – I RF | | | | | 41.00 |
| 43.00 | 04300 NURSERY | | | | | 43.00 |
| | ANCI LLARY SERVICE COST CENTERS | | | | | |
| 50.00 | 05000 OPERATI NG ROOM | 0.000000 | | | | 50.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 000000 | | | | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | | | | 54.00 |
| 60.00 | 06000 LABORATORY | 0. 000000 | | | | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0. 000000 | | | | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0. 000000 | | | | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0. 000000 | | | | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0. 000000 | | | | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0. 000000 | | | | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | | | | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | | | | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 000000 | | | | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | | | | 73.00 |
| 76.00 | 03020 ONCOLOGY | 0. 000000 | | | | 76.00 |
| 76.97 | 07697 CARDI AC REHABI LI TATI ON | 0. 000000 | | | | 76.97 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 90.00 | 09000 CLI NI C | 0. 000000 | | | | 90.00 |
| 91.00 | 09100 EMERGENCY | 0. 000000 | | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | | | | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | · · · | | | | |
| 101.00 | 10100 HOME HEALTH AGENCY | | | | | 101.00 |
| 110 00 | SPECIAL PURPOSE COST CENTERS | 1 | | | | 112 00 |
| | 11300 INTEREST EXPENSE | | | | | 113.00 |
| 200.00 | | | | | | 200.00 |
| 201.00 | | | | | | 201.00 |
| 202.00 | Total (see instructions) | | | | | 202.00 |

| Provider CCN: 15-0001 Period: From 01/01/2016 Worksheet D Part I Date/Time Prepa 1/16/2018 3:01 Title XVIII Hospital PPS Swing Bed Adjustment Reduced Capital Related Cost (col. 1 - col. Total Patient Days Per Diem (col. 3 / col. 4) | |
|---|--|
| Swing Bed AdjustmentReducedTotal PatientPer Diem (col.AdjustmentCapital Related CostDays3 / col. 4) | |
| AdjustmentCapitalDays3 / col. 4)Related Cost | |
| | |
| 2.00 3.00 4.00 5.00 | |
| 2.00 3.00 4.00 3.00 | |
| 187, 555 1, 057 177. 44 3 0 145, 773 1, 461 99. 78 4 11, 869 744 15. 95 4 | 30.00 31.00 41.00 43.00 200.00 |
| 7.00 | |
| | |
| 69, 734 64, 757 | 30.00 31.00 41.00 43.00 200.00 |
| : | 69, 734 64, 757 0 |

| Health Financial Systems | JOHNSON MEMOR | AL HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|----------------|---------------|---|--|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS | Provider CO | | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part II Date/Time Pre 1/16/2018 3:0 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Total Charges | Ratio of Cos | t Inpatient | Capital Costs | |
| | Related Cost | (from Wkst. C, | to Charges | Program | (column 3 x | |
| | (from Wkst. B, | Part I, col. | (col. 1 ÷ col | . Charges | column 4) | |
| | Part II, col. | 8) | 2) | | | |
| | 26) | | | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | |
| 50. 00 05000 OPERATING ROOM | 1, 005, 853 | 31, 001, 255 | | | 78, 623 | |
| 53. 00 05300 ANESTHESI OLOGY | 22, 532 | 3, 489, 516 | 0.00645 | 7 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 622, 338 | 38, 020, 982 | 0. 01636 | 8 1, 998, 964 | 32, 719 | 54.00 |
| 60. 00 06000 LABORATORY | 333, 167 | 28, 041, 519 | 0. 01188 | 3, 029, 297 | 35, 991 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 92, 490 | 5, 808, 115 | 0. 01592 | 4 1, 276, 599 | 20, 329 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 82, 968 | 3, 355, 255 | 0. 02472 | 8 303, 025 | 7, 493 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 21, 461 | 2, 065, 797 | 0. 01038 | 9 270, 406 | 2, 809 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 4, 770 | 657, 049 | 0. 00726 | 0 77, 919 | 566 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 103, 438 | 5, 242, 824 | 0. 01972 | 9 735, 504 | 14, 511 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 5, 580 | 155, 063 | 0. 03598 | 5 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 99, 830 | 6, 812, 458 | 0. 01465 | 4 2, 085, 282 | 30, 558 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 13, 683 | 4, 664, 200 | 0. 00293 | 4 0 | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 67, 535 | 10, 811, 877 | 0. 00624 | 6 2, 039, 471 | 12, 739 | 73.00 |
| 76. 00 03020 ONCOLOGY | 72, 410 | 154, 754 | 0. 46790 | 4 0 | 0 | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 32, 531 | 542, 217 | 0. 05999 | 6 0 | 0 | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | 1 |
| 90. 00 09000 CLINIC | 190, 767 | 11, 006, 990 | 0. 01733 | 49, 271 | 854 | 90.00 |
| 91.00 09100 EMERGENCY | 273, 878 | 19, 715, 418 | 0. 01389 | 1, 322, 801 | 18, 376 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 119, 845 | 1, 622, 491 | 0. 07386 | | 9, 404 | 92.00 |
| 200.00 Total (lines 50-199) | 3, 165, 076 | 173, 167, 780 | | 15, 739, 043 | 264, 972 | 200 00 |

| Health Financial Systems | JOHNSON MEMOR | I AL_HOSPI TAL | | In Lie | eu of Form CMS- | 2552-10 |
|--|------------------|------------------|---------------|---|--------------------------------|----------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER | PASS THROUGH COS | | | Period: From 01/01/2016 To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | |
| | | Title | e XVIII | Hospi tal | PPS | |
| Cost Center Description | Nursing School | Allied Health | All Other | Swi ng-Bed | Total Costs | |
| | | Cost | Medi cal | Adj ustment | (sum of cols. | |
| | | | Education Cos | t Amount (see | 1 through 3, | |
| | | | | instructions) | minus col. 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | C | C |) | 0 0 | 0 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | C | o c | | o | 0 | 31.00 |
| 41.00 04100 SUBPROVIDER - IRF | 0 | | | 0 0 | 0 | 41.00 |
| 43. 00 04300 NURSERY | 0 | | | 0 | 0 | |
| 200.00 Total (lines 30-199) | | | | 0 | 0 | 200.00 |
| Cost Center Description | Total Patient | Per Diem (col. | Inpati ent | Inpati ent | | |
| p | Days | $5 \div col. 6)$ | Program Days | | | |
| | | | | Pass-Through | | |
| | | | | Cost (col. 7 x | | |
| | | | | col . 8) | | |
| | 6,00 | 7.00 | 8,00 | 9,00 | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | 1 | |
| 30. 00 03000 ADULTS & PEDIATRICS | 6, 684 | 0.00 | 2, 55 | 1 0 | | 1 30. 00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | 1,057 | | | | | 31.00 |
| 41. 00 04100 SUBPROVI DER – I RF | 1, 461 | | | | | 41.00 |
| 43. 00 04300 NURSERY | 744 | | | 0 0 | | 43.00 |
| 200.00 Total (lines 30-199) | 9, 946 | | 3, 59 | 3 0 | | 200.00 |
| 200.00 [10101 (11103 30-177)] | 7, 740 | 'I | 1 5,57 | J 0 | 1 | 200.00 |

| Health Financial Systems | JOHNSON MEMORIA | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|------------------|---------------|--------------|----------------------------------|-----------------|----------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | RVICE OTHER PASS | Provider C | CN: 15-0001 | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 01/01/2016 To 12/31/2016 | | narod |
| | | | | 10 12/31/2010 | 1/16/2018 3:0 | pareu. 1 pm |
| | | Title | × XVIII | Hospi tal | PPS | |
| Cost Center Description | Non Physician N | ursing School | Allied Healt | h All Other | Total Cost | |
| | Anesthetist | | | Medi cal | (sum of col 1 | |
| | Cost | | | Education Cost | through col. | |
| | | | | | 4) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVICE COST CENTERS | - | | | - | | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | 0 0 | 0 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | 0 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | 0 0 | 0 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 0 | 0 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 0 | 0 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 0 | 0 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 0 | 0 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 0 | 0 | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | 0 0 | 0 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 0 | 0 | 70.00 |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 0 | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 73.00 |
| 76. 00 03020 ONCOLOGY | 0 | 0 | | 0 0 | 0 | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 0 | | 0 0 | 0 | 76. 97 |
| OUTPATIENT SERVICE COST CENTERS | | | | | 0 | |
| 90. 00 09000 CLI NI C | 0 | 0 | | 0 0 | 0 | 90.00 |
| 91.00 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | 91.00 |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) | 0 | 0 | | 0 | 0 | 92.00 |
| 200.00 Total (lines 50-199) | I O | 0 | 1 | 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 THROUGH COSTS | RVICE OTHER PASS | S Provider C | | Period: From 01/01/2016 To 12/31/2016 | | parod: |
| | | | | 10 12/31/2010 | 1/16/2018 3:0 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Total | Total Charges | Ratio of Cost | 0utpati ent | Inpati ent | |
| | | (from Wkst. C, | | Ratio of Cost | | |
| | Cost (sum of | | · | | Charges | |
| | col. 2, 3 and | 8) | 7) | (col. 6 ÷ col. | | |
| | 4) | | | 7) | | |
| | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | |
| ANCI LLARY SERVICE COST CENTERS | - | | | | | |
| 50. 00 05000 OPERATI NG ROOM | 0 | 31,001,255 | | | | |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 3, 489, 516 | | | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 38, 020, 982 | | | | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 28, 041, 519 | | | 3, 029, 297 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 5, 808, 115 | | | | |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 3, 355, 255 | | | 303, 025 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 2,065,797 | | | | |
| 68. 00 06800 SPEECH PATHOLOGY | 0 | 657, 049 | | | | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 5, 242, 824 | | | | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 155, 063 | | | | 70.00 |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS | 0 | 6, 812, 458 | | | | 71.00 |
| 72.00 07200 I MPL. DEV. CHARGED TO PATIENT | 0 | 4, 664, 200 | | | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 10, 811, 877 | | | | 73.00 |
| 76.00 03020 ONCOLOGY | 0 | 154, 754 | | | | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 542, 217 | 0.00000 | 0 0. 000000 | 0 | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | 1 | | | | | |
| 90. 00 09000 CLINIC | 0 | | | | | |
| 91. 00 09100 EMERGENCY | 0 | 19, 715, 418 | | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 1, 622, 491 | | 0 0. 000000 | | |
| 200.00 Total (lines 50-199) | 0 | 173, 167, 780 | l | | 15, 739, 043 | 200. 00 |

| Health Financial Systems | JOHNSON MEMORI | AL HOSPI TAL | | In Lie | u of Form CMS- | 2552-10 |
|---|------------------|--------------|--------------|----------------------------------|----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | Provider C | CN: 15-0001 | Period: | Worksheet D | |
| THROUGH COSTS | | | | From 01/01/2016 To 12/31/2016 | | narod |
| | | | | 10 12/31/2010 | 1/16/2018 3:0 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Inpatient | Outpati ent | Outpati ent | | | |
| | Program | Program | Program | | | |
| | Pass-Through | Charges | Pass-Through | 1 | | |
| | Costs (col. 8 | | Costs (col. | 9 | | |
| | x col. 10) | | x col. 12) | | | |
| | 11.00 | 12.00 | 13.00 | | | |
| ANCI LLARY SERVI CE COST CENTERS | | | | - | | |
| 50. 00 05000 OPERATI NG ROOM | 0 | 4, 901, 718 | | 0 | | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 742, 604 | | 0 | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 8, 575, 209 | | 0 | | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 1, 547, 811 | | 0 | | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 212, 649 | | 0 | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 309 | | 0 | | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0 | 1, 927 | | 0 | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 664 | | 0 | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 2, 261, 013 | | 0 | | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 918, 145 | | 0 | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 762, 038 | | 0 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 2, 280, 006 | | 0 | | 73.00 |
| 76.00 03020 ONCOLOGY | 0 | 23, 596 | | 0 | | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 145, 559 | | 0 | | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 09000 CLINIC | 0 | 2, 640, 870 | | 0 | | 90.00 |
| 91.00 09100 EMERGENCY | 0 | 3, 079, 683 | | 0 | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 573, 081 | | 0 | | 92.00 |
| 200.00 Total (lines 50-199) | 0 | 28, 666, 882 | | 0 | | 200.00 |
| | | | | | | |

| Health Financial Systems | JOHNSON MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-: | 2552-10 |
|--|----------------|---------------|--------------|---|-----------------|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider CO | | Period: From 01/01/2016 To 12/31/2016 | | |
| | | Title | XVIII | Hospi tal | PPS | |
| | | | Charges | - | Costs | |
| Cost Center Description | Cost to Charge | | | Cost | PPS Services | |
| | | Services (see | Reimbursed | Rei mbursed | (see inst.) | |
| | Worksheet C, | inst.) | Servi ces | Services Not | | |
| | Part I, col. 9 | | Subject To | Subject To | | |
| | | | Ded. & Coins | | | |
| | 1.00 | | (see inst.) | (see inst.) | 5.00 | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 0.004000 | 4 004 740 | | | 1 000 170 | 50.00 |
| 50. 00 05000 OPERATI NG ROOM | 0. 224099 | 4, 901, 718 | | 0 0 | 1, 098, 470 | |
| 53. 00 05300 ANESTHESI OLOGY | 0.051369 | 742, 604 | | 0 0 | 38, 147 | • |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 153320 | 8, 575, 209 | | 0 0 | 1, 314, 751 | |
| 60. 00 06000 LABORATORY | 0. 199676 | 1, 547, 811 | | 0 0 | 309, 061 | • |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 321835 | 212, 649 | | 0 0 | 68, 438 | |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 457113 | 309 | | 0 0 | 141 | |
| 67.00 06700 OCCUPATI ONAL THERAPY | 0. 207719 | 1, 927 | | 0 0 | 400 | |
| 68.00 06800 SPEECH PATHOLOGY | 0. 334916 | 664 | | 0 0 | 222 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 227637 | 2, 261, 013 | | 0 0 | 514, 690 | |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0. 590650 | 0 | | 0 0 | 0 | |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 404994 | 918, 145 | | 0 0 | 371, 843 | • |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0. 378880 | 762, 038 | | 0 0 | 288, 721 | • |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0. 382108 | 2, 280, 006 | | 9 4, 145 | 871, 209 | • |
| 76.00 03020 ONCOLOGY | 2. 886911 | 23, 596 | | 0 0 | 68, 120 | • |
| 76. 97 07697 CARDI AC REHABILI TATI ON | 0. 573099 | 145, 559 | | 0 0 | 83, 420 | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | | | 1 | | | - |
| 90. 00 09000 CLINIC | 0. 343957 | 2, 640, 870 | | | 908, 346 | • |
| 91.00 09100 EMERGENCY | 0. 230405 | 3, 079, 683 | | 0 0 | 709, 574 | • |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 947702 | 573, 081 | | 0 0 | 543, 110 | • |
| 200.00 Subtotal (see instructions) | | 28, 666, 882 | 65 | 1 4, 145 | 7, 188, 663 | |
| 201.00 Less PBP Clinic Lab. Services-Program Only Charges | | | | 0 0 | | 201.00 |
| 202.00 Net Charges (line 200 +/- line 201) | | 28, 666, 882 | 65 | 1 4, 145 | 7, 188, 663 | 202.00 |

| Health Financial Systems | JOHNSON MEMOR | | | In Lie | u of Form CMS | -2552-1 |
|--|----------------|---------------|-------|---|---|---------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN | D VACCINE COST | Provider CC | | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Pro 1/16/2018 3:0 | |
| | | | XVIII | Hospi tal | PPS | _ |
| | Cos | | | | | |
| Cost Center Description | Cost | Cost | | | | |
| | Reimbursed | Reimbursed | | | | |
| | Servi ces | Services Not | | | | |
| | Subject To | Subject To | | | | |
| | | Ded. & Coins. | | | | |
| | (see inst.) | (see inst.) | | | | |
| | 6.00 | 7.00 | | | | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | - |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | | | 50.0 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | | | 53.0 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | | | 54.0 |
| 50. 00 06000 LABORATORY | 0 | 0 | | | | 60.0 |
| 55. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | | | 65.0 |
| 56. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | | | 66.0 |
| 57.00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | | | 67.0 |
| 58.00 06800 SPEECH PATHOLOGY | 0 | 0 | | | | 68.0 |
| 59. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | | 69.0 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | | | 70.0 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | | 71. (|
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | | | 72.0 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 84 | 1, 584 | | | | 73.0 |
| 76. 00 03020 ONCOLOGY | 0 | 0 | | | | 76.0 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 0 | | | | 76. 9 |
| OUTPATIENT SERVICE COST CENTERS | 1 | | | | | |
| 90. 00 09000 CLINIC | 149 | 0 | | | | 90.0 |
| 91. 00 09100 EMERGENCY | 0 | 0 | | | | 91.0 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | | | 92.0 |
| 200.00 Subtotal (see instructions) | 233 | 1, 584 | | | | 200. 0 |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | | 201.0 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 +/- line 201) | 233 | 1, 584 | | | | 202.0 |

| Health Financial Systems | JOHNSON MEMOR | I AL HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--------------------|----------------|---------------|----------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS | Provider C | | Peri od: | Worksheet D | |
| | | Component | CCN: 15-T001 | From 01/01/2016 To 12/31/2016 | | narod |
| | | component | CCN. 15-1001 | 10 12/31/2010 | 1/16/2018 3:0 | |
| | | Title | × XVIII | Subprovider - | PPS | |
| | | | | I RF | | |
| Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| | | (from Wkst. C, | 5 | Program | (column 3 x | |
| | (from Wkst. B, | | (col. 1 ÷ col | . Charges | column 4) | |
| | Part II, col. | 8) | 2) | | | |
| | 26) | | | | 5.00 | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| ANCI LLARY SERVI CE COST CENTERS | 1 005 052 | 21 001 255 | 0.0224 | 0.057 | 20.4 | F0 00 |
| | 1,005,853 | | | | | |
| 53. 00 05300 ANESTHESI OLOGY | 22, 532 | | | | | |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 622, 338 | | | | | |
| | 333, 167 | | | | | |
| 65. 00 06500 RESPI RATORY THERAPY | 92, 490 | | | | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 82, 968 | | | | 7, 745 | 66.00 |
| 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY | 21, 461 | | | | | |
| 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY | 4, 770 103, 438 | | | | | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 5, 580 | | | | 0 | 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 99, 830 | | | | 196 | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | 13, 683 | | | | 0 | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 67, 535 | | | | 336 | |
| 76. 00 03020 ONCOLOGY | 72, 410 | | | | 0 | |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 32, 531 | | | | 0 | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | 52, 551 | 542,217 | 0.0077 | 0 0 | 0 | /0. // |
| 90. 00 09000 CLINIC | 190, 767 | 11,006,990 | 0.01733 | 31 0 | 0 | 90.00 |
| 91. 00 09100 EMERGENCY | 273, 878 | | | | - | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 2/0,0/0 | | | | | |
| 200.00 Total (lines 50-199) | 3, 045, 231 | | | 1, 155, 526 | | |

| Health Financial Systems | JOHNSON MEMORIA | JOHNSON MEMORIAL HOSPITAL | | | In Lieu of Form CMS-2552-10 | | | |
|---|------------------|---------------------------|---------------|----------------------------------|-----------------------------|---------|--|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | RVICE OTHER PASS | Provider CO | CN: 15-0001 | Peri od: | Worksheet D | | | |
| THROUGH COSTS | | Component (| CCN: 15-T001 | From 01/01/2016 To 12/31/2016 | | nared | | |
| | | component | 5011. 13 1001 | 10 12/31/2010 | 1/16/2018 3:0 | | | |
| | | Title | XVIII | Subprovider - | PPS | | | |
| | | | | I RF | | | | |
| Cost Center Description | Non Physician N | ursing School | Allied Healt | | Total Cost | | | |
| | Anestheti st | | | Medical | (sum of col 1 | | | |
| | Cost | | | Education Cost | 4) | | | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | | | |
| ANCI LLARY SERVI CE COST CENTERS | | 2100 | 0100 | | 0100 | | | |
| 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 PATIENTS | 0 | 0 | | 0 0 | 0 | 71.00 | | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 0 | 0 | 72.00 | | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | | 0 0 | 0 | 73.00 | | |
| 76.00 03020 ONCOLOGY | 0 | 0 | | 0 0 | 0 | 76.00 | | |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 0 | | 0 0 | 0 | 76.97 | | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 90. 00 09000 CLI NI C | 0 | 0 | | 0 0 | 0 | 101.00 | | |
| 91.00 09100 EMERGENCY | 0 | 0 | | 0 0 | 0 | 91.00 | | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 0 | 0 | | | |
| 200.00 Total (lines 50-199) | I U | 0 | l | 0 | 0 | 200. 00 | | |

| Health Financial Systems | JOHNSON MEMOR | I AL HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------------------|---|--------------------|---|--------------------------|--------------------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PAS | S Provider C | | Period: | Worksheet D | |
| THROUGH COSTS | | Component (| | From 01/01/2016 To 12/31/2016 | Part IV Date/Time Pre | pared [.] |
| | | | | | 1/16/2018 3:0 | 1 pm |
| | | Title | XVIII | Subprovider - | PPS | |
| | | | | I RF | | |
| Cost Center Description | Total | Total Charges (from Wkst. C, | | t Outpatient Ratio of Cost | Inpati ent | |
| | Outpatient Cost (sum of | | | | Program | |
| | col. 2, 3 and | | (COL 5 ÷ COL 7) | (col. 6 ÷ col. | Charges | |
| | 4) | 6) | () | 7) | | |
| | 6,00 | 7.00 | 8,00 | 9,00 | 10, 00 | |
| ANCI LLARY SERVICE COST CENTERS | 0100 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 0100 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 10100 | |
| 50. 00 05000 OPERATI NG ROOM | 0 | 31,001,255 | 0.00000 | 0 0.00000 | 9, 057 | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 3, 489, 516 | 0. 00000 | 0.000000 | 2, 020 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 38, 020, 982 | 0. 00000 | 0.000000 | 21, 772 | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 28, 041, 519 | 0. 00000 | 0 0. 000000 | 165, 413 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 5, 808, 115 | 0. 00000 | 0.000000 | 102, 880 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 3, 355, 255 | 0.00000 | 0 0. 000000 | 313, 221 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 2, 065, 797 | 0.00000 | 0 0.000000 | 328, 712 | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 657, 049 | | | 120, 725 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 5, 242, 824 | | | 8, 252 | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 155, 063 | | | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 6, 812, 458 | | | 13, 382 | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 4, 664, 200 | | | 0 | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 10, 811, 877 | | | 53, 752 | 1 |
| 76.00 03020 ONCOLOGY | 0 | 154, 754 | | | 0 | |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 542, 217 | 0.00000 | 0 0.00000 | 0 | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | | 11.00/.000 | 0.0000 | 0 0 00000 | 0 | |
| 90. 00 09000 CLINIC | 0 | 11,006,990 | | | 0 | 90.00 |
| 91.00 09100 EMERGENCY | 0 | 19, 715, 418 | | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50-199) | | 1, 622, 491 | | 0 0.00000 | 14, 192 1, 155, 526 | |
| 200.00 10tal (111es 50-199) | 0 | 173, 167, 780 | I | I | 1, 155, 526 | 1200. OU |

| Health Financial Systems | JOHNSON MEMORI | AL HOSPI TAL | | In Lie | eu of Form CMS- | 2552-10 |
|---|------------------|--------------|--------------|----------------------------------|-----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | Provider C | CN: 15-0001 | Peri od: | Worksheet D | |
| THROUGH COSTS | | Component | CCN: 15-T001 | From 01/01/2016 To 12/31/2016 | | parad |
| | | Component | CCN. 15-1001 | 10 12/31/2010 | 1/16/2018 3:0 |)1 pm |
| | | Title | e XVIII | Subprovider - | PPS | |
| | | | 1 | I RF | | |
| Cost Center Description | Inpati ent | Outpati ent | Outpati ent | | | |
| | Program | Program | Program | | | |
| | Pass-Through | Charges | Pass-Throug | | | |
| | Costs (col. 8 | | Costs (col. | 9 | | |
| | x col. 10) | | x col. 12) | | | |
| | 11.00 | 12.00 | 13.00 | | | |
| ANCI LLARY SERVI CE COST CENTERS | | | 1 | 0 | | 50.00 |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | 0 | | 50.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | 0 | | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 636 | | 0 | | 54.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | 0 | | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0 | 0 | | 0 | | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | 0 | | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | 0 | | 67.00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | 0 | | 68.00 |
| 69.00 06900 ELECTROCARDI OLOGY | 0 | 544 | | 0 | | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | 0 | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 0 | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | 0 | | 72.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 0 | 60 | | 0 | | 73.00 |
| 76.00 03020 ONCOLOGY | 0 | 0 | | 0 | | 76.00 |
| 76. 97 07697 CARDI AC REHABI LI TATI ON | 0 | 0 | | 0 | | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | 1 1 | | 1 | | | |
| 90. 00 09000 CLINIC | 0 | 0 | | 0 | | 90.00 |
| 91. 00 09100 EMERGENCY | 0 | 0 | | 0 | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | 0 | | 92.00 |
| 200.00 Total (lines 50-199) | 0 | 1, 240 | 1 | 0 | | 200.00 |
| | | | | | | |

| Heal th | Financial Systems | JOHNSON MEMOR | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|--------------------------------|---------------|------------------------|----------------------------|--------------------------------|---------|
| APPORT | IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider C | | Period: From 01/01/2016 | | |
| | | | Component | CCN: 15-T001 | To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | |
| | | | Title | XVIII | Subprovider - | PPS | |
| | | | | | I RF | | |
| | | | | Charges | 0.1 | Costs | |
| | Cost Center Description | Cost to Charge | | | Cost | PPS Services | |
| | | | Services (see | Reimbursed Services | Reimbursed Services Not | (see inst.) | |
| | | Worksheet C, Part I, col. 9 | inst.) | Subject To | Subject To | | |
| | | | | Ded. & Coins | | | |
| | | | | (see inst.) | (see inst.) | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | ANCILLARY SERVICE COST CENTERS | | <u> </u> | • | | | |
| 50.00 | 05000 OPERATI NG ROOM | 0. 224099 | 0 | | 0 0 | 0 | 50.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 051369 | 0 | 1 | 0 0 | 0 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 153320 | 636 | | 0 0 | 98 | 54.00 |
| 60.00 | 06000 LABORATORY | 0. 199676 | 0 | | 0 0 | 0 | 60.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0. 321835 | 0 | | 0 0 | 0 | 65.00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0. 457113 | | | 0 0 | 0 | 66.00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0. 207719 | | | 0 0 | 0 | 67.00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0. 334916 | | | 0 0 | 0 | 68.00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | 0. 227637 | | | 0 0 | 124 | 69.00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 590650 | | | 0 0 | 0 | 70.00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 404994 | | | 0 0 | 0 | 71.00 |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENT | 0. 378880 | | | 0 0 | 0 | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0. 382108 | | | 0 134 | 23 | 73.00 |
| | | 2. 886911 | 0 | | 0 0 | 0 | 76.00 |
| 76.97 | 07697 CARDI AC REHABI LI TATI ON | 0. 573099 | 0 | | 0 0 | 0 | 76.97 |
| ~~~~~ | OUTPATIENT SERVICE COST CENTERS | 0.040057 | | | | 0 | 00.00 |
| | 09000 CLINIC | 0. 343957 | | | 0 0 | 0 | |
| 91.00 | 09100 EMERGENCY | 0. 230405 | | | 0 0 | 0 | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 947702 | | | 0 0 | 0 | 92.00 |
| 200.00 | | | 1, 240 | | 0 134 | 245 | 200.00 |
| 201.00 | Less PBP Clinic Lab. Services-Program Only Charges | | | | 0 0 | | 201.00 |
| 202.00 | | | 1, 240 | | 0 134 | 245 | 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 | Provider Concernent | CN: 15-0001 CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet D Part V Date/Time Pre 1/16/2018 3:0 | |
| | | Title | XVIII | Subprovider - | PPS | |
| | Cos | sts | | | 1 | |
| Cost Center Description | Cost Reimbursed Services | Cost Reimbursed Services Not | | | | |
| | Subject To | Subject To | | | | |
| | Ded. & Coins. (see inst.) | Ded. & Coins. (see inst.) | | | | |
| | 6,00 | 7.00 | | | | |
| ANCI LLARY SERVI CE COST CENTERS | 0.00 | 1100 | | | | |
| 50. 00 05000 OPERATI NG 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 OCCUPATIONAL THERAPY | 0 | 0 | | | | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | | 68.00 69.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | 0 | | | | 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | | | 71.00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT | 0 | 0 | | | | 72.00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 51 | | | | 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 | | | - | | | |
| 90. 00 09000 CLI NI C | 0 | 0 | | | | 90.00 |
| 91.00 09100 EMERGENCY | 0 | 0 | | | | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | 0 | | | | 92.00 |
| 200.00 Subtotal (see instructions) | 0 | 51 | | | | 200.00 |
| 201.00 Less PBP Clinic Lab. Services-Program Only Charges | 0 | | | | | 201.00 |
| 202.00 Net Charges (line 200 +/- line 201) | 0 | 51 | | | | 202.00 |

| | Financial Systems JOHNSON MEMORIAL ATLON OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Period: | u of Form CMS-2 Worksheet D-1 | |
|----------------|--|----------------------------|----------------------------------|----------------------------------|------------|
| | | | From 01/01/2016 To 12/31/2016 | Date/Time Pre | pared |
| | | Title XVIII | Hospi tal | 1/16/2018 3:0 PPS | трп |
| | Cost Center Description | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | |
| 00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed day | s oveluding nowhorn) | 1 | 6, 684 | 1. |
| 00 | Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- | | | 6, 684 | 2. |
| 00 | Private room days (excluding swing-bed and observation bed day | | rivate room days, | 0,001 | 3. |
| | do not complete this line. | | - | 5 107 | |
| 00 00 | Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro | | or 31 of the cost | 5, 437 0 | 4. 5. |
| 00 | reporting period | on days) through becchib | | 0 | 3. |
| 00 | Total swing-bed SNF type inpatient days (including private ro | om days) after December | 31 of the cost | 0 | 6. |
| 00 | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo | m days) through Docombo | 21 of the cost | 0 | 7. |
| 00 | reporting period | in days) thi ough becember | ST OF THE COST | 0 | /. |
| 00 | Total swing-bed NF type inpatient days (including private roo | m days) after December 3 | 31 of the cost | 0 | 8. |
| | reporting period (if calendar year, enter 0 on this line) | | | | |
| 00 | Total inpatient days including private room days applicable to newborn days) | o the Program (excluding | g swing-bed and | 2, 551 | 9. |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII o | nly (including private i | room days) | 0 | 10. |
| | through December 31 of the cost reporting period (see instruc | | 5 | | |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII o | | room days) after | 0 | 11. |
| . 00 | December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI | | te room days) | 0 | 12. |
| | through December 31 of the cost reporting period | | | Ũ | |
| . 00 | Swing-bed NF type inpatient days applicable to titles V or XI. | | | 0 | 13. |
| . 00 | after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr | | | 0 | 14. |
| | Total nursery days (title V or XIX only) | an (excluding swing-bed | uays) | 0 | 15 |
| | Nursery days (title V or XIX only) | | | 0 | 16. |
| 00 | SWING BED ADJUSTMENT | thursuph December 21 | C 11 | 0.00 | 1 1 7 |
| . 00 | Medicare rate for swing-bed SNF services applicable to servic reporting period | es through December 31 d | or the cost | 0.00 | 17. |
| . 00 | Medicare rate for swing-bed SNF services applicable to servic | es after December 31 of | the cost | 0.00 | 18. |
| | reporting period | | | | |
| . 00 | Medicaid rate for swing-bed NF services applicable to service reporting period | s through December 31 of | f the cost | 0.00 | 19 |
| . 00 | Medicaid rate for swing-bed NF services applicable to service | s after December 31 of t | the cost | 0.00 | 20 |
| | reporting period | | | | |
| . 00 | Total general inpatient routine service cost (see instruction | | | 8, 241, 872 | |
| . 00 | Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17) | er 31 of the cost report | ting period (line | 0 | 22. |
| . 00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reportin | ng period (line 6 | 0 | 23. |
| | x line 18) | | | | |
| . 00 | Swing-bed cost applicable to NF type services through Decembe | r 31 of the cost reporti | ng period (line | 0 | 24. |
| . 00 | 7 x line 19) Swing-bed cost applicable to NF type services after December | 31 of the cost reporting | period (line 8 | 0 | 25. |
| | x line 20) | | | | |
| . 00 | Total swing-bed cost (see instructions) | | | 0 | 26. |
| . 00 | General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | (line 21 minus line 26) | | 8, 241, 872 | 27. |
| . 00 | General inpatient routine service charges (excluding swing-be | d and observation bed ch | narges) | 0 | 28. |
| . 00 | Private room charges (excluding swing-bed charges) | | 5 / | 0 | 29. |
| | Semi-private room charges (excluding swing-bed charges) | | | 0 | 30 |
| . 00 | General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) | ÷ line 28) | | 0.000000 | 31. 32. |
| . 00 | Average semi-private room per diem charge (line 29 ÷ line 3) | | | 0.00 | |
| . 00 | Average per diem private room charge differential (line 32 mi | nus line 33)(see instruc | ctions) | 0.00 | |
| . 00 | Average per diem private room cost differential (line 34 x li | ne 31) | | 0.00 | |
| 00 | Private room cost differential adjustment (line 3 x line 35) | and private room cost d | fforontial (line | 0 | 36. |
| . 00 | General inpatient routine service cost net of swing-bed cost 27 minus line 36) | and private room cost di | inerential (IINe | 8, 241, 872 | 37. |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | 1 |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ | | | | |
| . 00 | Adjusted general inpatient routine service cost per diem (see | - | | 1,233.07 | 38 |
| 0. 00 0. 00 | Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program | | | 3, 145, 562 0 | 39 40 |
| | Total Program general inpatient routine service cost (line 39 | | | 3, 145, 562 | |

| OMPUT | Financial Systems ATION OF INPATIENT OPERATING COST | | Provider C | | Period: | Worksheet D-1 | 1 |
|---------|--|------------------|----------------|-----------------|----------------------------------|----------------------------|-------|
| | | | | | From 01/01/2016 To 12/31/2016 | Date/Time Pre | |
| | | | Title | e XVIII | Hospi tal | 1/16/2018 3: 0 PPS | JIpr |
| | Cost Center Description | Total | Total | Average Per | Program Days | Program Cost | |
| | | Inpatient Cost | npatient Days | | ÷ | (col. 3 x col. | |
| | | 1.00 | 2.00 | col. 2) 3.00 | 4.00 | 4) 5.00 | |
| 2.00 | NURSERY (title V & XIX only) | 0 | 0 | | | |) 42. |
| | Intensive Care Type Inpatient Hospital Units | | | | | | |
| | INTENSIVE CARE UNIT | 2, 831, 465 | 1, 057 | 2, 678. 7 | 7 393 | 1, 052, 757 | |
| | CORONARY CARE UNIT | | | | | | 44. |
| | BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT | | | | | | 45. |
| | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47. |
| | Cost Center Description | I | | | | | |
| | D | | | | | 1.00 | |
| | Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4 | | | nc) | | 4, 319, 665 8, 517, 984 | |
| | PASS THROUGH COST ADJUSTMENTS | FI through 40)(S | | 115) | | 0, 317, 904 | 49 |
| | Pass through costs applicable to Program inpa | atient routine s | ervices (from | Wkst. D, sum | of Parts I and | 314, 911 | 1 50 |
| | | | | | | | |
| . 00 | Pass through costs applicable to Program inpa | atient ancillary | services (fr | om Wkst. D, s | um of Parts II | 264, 972 | 2 51 |
| 2.00 | and IV) Total Program excludable cost (sum of lines { | 50 and 51) | | | | 579, 883 | 3 52 |
| | Total Program inpatient operating cost exclud | | ated, non-phy | sician anesth | etist, and | 7, 938, 101 | |
| | medical education costs (line 49 minus line 5 | | . , | | | L | |
| | TARGET AMOUNT AND LIMIT COMPUTATION | | | | | | |
| | Program discharges Target amount per discharge | | | | | 0.00 | |
| | Target amount (line 54 x line 55) | | | | | 0.00 | |
| | Difference between adjusted inpatient operati | ng cost and tar | get amount (I | ine 56 minus | line 53) | 0 | |
| | Bonus payment (see instructions) | | | | | 0 | |
| . 00 | Lesser of lines 53/54 or 55 from the cost rep | porting period e | nding 1996, u | pdated and co | mpounded by the | 0.00 | 59 |
| . 00 | market basket Lesser of lines 53/54 or 55 from prior year of | ost report und | lated by the m | arket basket | | 0.00 | 60 |
| | If line 53/54 is less than the lower of lines | | | | the amount by | 0.00 | |
| | which operating costs (line 53) are less than | n expected costs | (lines 54 x | 60), or 1% of | the target | | |
| | amount (line 56), otherwise enter zero (see i | nstructions) | | | | | |
| | Relief payment (see instructions) Allowable Inpatient cost plus incentive payme | ant (see instruc | tions) | | | | |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| | Medicare swing-bed SNF inpatient routine cost | s through Decem | ber 31 of the | cost reporti | ng period (See | C | 64 |
| | instructions)(title XVIII only) | | | | | | |
| 5. 00 | Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only) | s arter Decembe | er 31 of the c | ost reporting | period (See | C | 65 |
| . 00 | Total Medicare swing-bed SNF inpatient routin | ne costs (line 6 | 4 plus line 6 | 5)(title XVII | l only). For | C | 66 |
| | CAH (see instructions) | , | | <i>,</i> , , | 57 | | |
| 7.00 | Title V or XIX swing-bed NF inpatient routine | e costs through | December 31 c | f the cost re | porting period | 0 | 67. |
| 3. 00 | (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine | a coste after De | comber 31 of | the cost repo | rting period | | 68. |
| 5.00 | (line 13 x line 20) | | | the cost repo | ting period | Ĭ | |
| 9.00 | Total title V or XIX swing-bed NF inpatient i | routine costs (I | ine 67 + line | : 68) | | 0 | 69. |
| | PART III - SKILLED NURSING FACILITY, OTHER NU | | | | | | |
| | Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co | 5 | | . , | | | 70 |
| | Program routine service cost (line 9 x line 3 | | ne vo ÷ rine | <i>~</i>) | | 1 | 72 |
| | Medically necessary private room cost applica | , | (line 14 x li | ne 35) | | 1 | 73 |
| | Total Program general inpatient routine servi | • | | | | | 74 |
| . 00 | Capital-related cost allocated to inpatient r | 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) | | | | 1 | 76 |
| | Program capital -related costs (line 9 x line | | | | | 1 | 77 |
| 00 | Inpatient routine service cost (line 74 minus | s line 77) | | | | | 78 |
| | Aggregate charges to beneficiaries for excess | | | | 11 76 | | 79 |
| | Total Program routine service costs for compa | | st limitation | (line 78 min | us line 79) | | 80 |
| 1 | Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li | | | | | | 81 |
| | Reasonable inpatient routine service cost frim tation (in | , | | | | 1 | 83 |
| | Program inpatient ancillary services (see ins | | | | | 1 | 84 |
| | Utilization review - physician compensation | | | | | | 85 |
| | Total Program inpatient operating costs (sum | | ough 85) | | | l | 86 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions) | | | | | 1, 247 | 7 87 |
| | Adjusted general inpatient routine cost per o | | line 2) | | | 1, 233. 07 | |
| J. UU I | | | | | | | |

| Health Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of Form CMS | | | | | | 2552-10 |
|--|----------|----------------|------------|----------------------------------|----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CC | | Period: | Worksheet D-1 | |
| | | | | From 01/01/2016 To 12/31/2016 | | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH (| COST | | | | | |
| 90.00 Capital-related cost | 642, 382 | 8, 241, 872 | 0. 07794 | 1 1, 537, 638 | 119, 845 | 90.00 |
| 91.00 Nursing School cost | 0 | 8, 241, 872 | 0.00000 | 0 1, 537, 638 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 8, 241, 872 | 0.00000 | 0 1, 537, 638 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 8, 241, 872 | 0. 00000 | 0 1, 537, 638 | 0 | 93.00 |

| MPUTATION OF INPATIENT OPERATING COST | MEMORIAL HOSPITAL Provider CCN: 15-0001 | Peri od: | u of Form CMS-2 Worksheet D-1 | |
|--|--|----------------------------------|----------------------------------|---------|
| | Component CCN: 15-T001 | From 01/01/2016 To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pared |
| | Title XVIII | Subprovider - | PPS | 'i piii |
| Cost Center Description | | - | 1.00 | |
| PART I - ALL PROVIDER COMPONENTS | | 1 | | |
| INPATIENT DAYS | had davic avaluding nowharn) | | 1 441 | 1 1 |
| 00 Inpatient days (including private room days and swing- 00 Inpatient days (including private room days, excluding | | | 1, 461 1, 461 | |
| 00 Private room days (excluding private room days, excluding do not complete this line. | | rivate room days, | 0 | |
| 00 Semi-private room days (excluding swing-bed and observ 00 Total swing-bed SNF type inpatient days (including pri | | er 31 of the cost | 1, 461 0 | |
| reporting period Total swing-bed SNF type inpatient days (including pri reporting period (if calendar year, enter 0 on this li | | 31 of the cost | 0 | 6. |
| Total swing beriod VF type inpatient days (including priv reporting period | 31 of the cost | 0 | 7. | |
| Total swing bed NF type inpatient days (including priv reporting period (if calendar year, enter 0 on this li | 31 of the cost | 0 | 8. | |
| 00 Total inpatient days including private room days appli newborn days) | | 649 | | |
| .00 Swing-bed SNF type inpatient days applicable to title through December 31 of the cost reporting period (see | | 0 | | |
| .00 Swing-bed SNF type inpatient days applicable to title December 31 of the cost reporting period (if calendar .00 Swing-bed NF type inpatient days applicable to titles | year, enter 0 on this line) | 5 | 0 | |
| through December 31 of the cost reporting period. | <u> </u> | 3 . | 0 | |
| after December 31 of the cost reporting period (if cal .00 Medically necessary private room days applicable to th | lendar year, enter 0 on this lir | ne) | 0 | |
| .00 Total nursery days (title V or XIX only) .00 Nursery days (title V or XIX only) | | | 0 | 15 |
| SWING BED ADJUSTMENT .00 Medicare rate for swing-bed SNF services applicable to | o services through December 31 c | of the cost | 0.00 | 17 |
| reporting period .00 Medicare rate for swing-bed SNF services applicable to | 5 | | 0.00 | |
| reporting period .00 Medicaid rate for swing-bed NF services applicable to | services through December 31 of | f the cost | 0.00 | 19 |
| .00 Medicaid rate for swing-bed NF services applicable to | services after December 31 of t | the cost | 0.00 | 20 |
| reporting period .00 Total general inpatient routine service cost (see inst | | | 1, 765, 249 | |
| .00 Swing-bed cost applicable to SNF type services through 5 x line 17) | | 01 | 0 | |
| .00 Swing-bed cost applicable to SNF type services after [x line 18] | | | 0 | |
| .00 Swing-bed cost applicable to NF type services through 7 x line 19) .00 Swing-bed cost applicable to NF type services after Definition | | | 0 | |
| .00 Swing-bed cost applicable to NF type services after De x line 20) .00 Total swing-bed cost (see instructions) | | y perioù (iine o | 0 | |
| 00 General inpatient routine service cost net of swing-be PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | ed cost (line 21 minus line 26) | | 1, 765, 249 | |
| .00 General inpatient routine service charges (excluding s | swing-bed and observation bed ch | narges) | 0 | |
| .00 Private room charges (excluding swing-bed charges) | X X X X X X X X X X X X X X X X X X X | | 0 | |
| .00 Semi-private room charges (excluding swing-bed charges .00 General inpatient routine service cost/charge ratio (I | | | 0.000000 | |
| .00 General inpatient routine service cost/charge ratio (1 .00 Average private room per diem charge (line 29 ÷ line 3 | , | | 0.000000 | |
| .00 Average semi-private room per diem charge (line 30 ÷ l | | | 0.00 | |
| .00 Average per diem private room charge differential (lir | | ctions) | 0.00 | |
| .00 Average per diem private room cost differential (line | | | 0.00 | |
| .00 Private room cost differential adjustment (line 3 x li .00 General inpatient routine service cost net of swing-be | ine 35) | fferential (line | 0 1, 765, 249 | 36 |
| 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH C | | | 1 200 25 | 1 20 |
| .00 Adjusted general inpatient routine service cost per di .00 Program general inpatient routine service cost (line 9 | | | 1, 208. 25 784, 154 | |
| .00 Program general inpatient routine service cost (line 9 .00 Medically necessary private room cost applicable to th | | | 784, 154 0 | |
| .00 Total Program general inpatient routine service cost (| | | 784, 154 | |

| alth Financial Systems MPUTATION OF INPATIENT OPERATING COST | JOHNSON MEMORIAL | Provi der C | CN: 15-0001 | Peri od: | eu of Form CMS- Worksheet D-1 | |
|--|---------------------------------------|-----------------------|---|----------------------------------|----------------------------------|-------|
| | | Component | CCN: 15-T001 | From 01/01/2016 To 12/31/2016 | Date/Time Pre | |
| | | Title | e XVIII | Subprovider - | 1/16/2018 3:0 PPS | JIpm |
| Cost Center Description | Total Inpatient CostIn | Total patient Days | | | Program Cost (col. 3 x col. | |
| | 1.00 | 2.00 | col. 2) 3.00 | 4.00 | 4) 5.00 | _ |
| . OO NURSERY (title V & XIX only) | 0 | <u> </u> | | | |) 42. |
| Intensive Care Type Inpatient Hospital Unit | IS al | | | | 1 | |
| 00 INTENSIVE CARE UNIT | 0 | C | 0. | 00 0 | C | 43 |
| 00 BURN INTENSIVE CARE UNIT | | | | | | 45 |
| . 00 SURGI CAL I NTENSI VE CARE UNI T | | | | | | 46 |
| . 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description | | | | | | 47 |
| | | | | | 1.00 | |
| 8.00 Program inpatient ancillary service cost (1 9.00 Total Program inpatient costs (sum of lines | | | ns) | | 365, 283 1, 149, 437 | |
| PASS THROUGH COST ADJUSTMENTS | 3 41 thi bugh 40) (30 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 1, 147, 437 | |
| . 00 Pass through costs applicable to Program in | npatient routine se | rvices (from | n Wkst. D, su | m of Parts I and | 64, 757 | 7 50 |
| .00 Pass through costs applicable to Program in | anatient ancillary | services (fr | om Wkst D | sum of Parts II | 17, 027 | 7 51 |
| and IV) | parient uncritaly | 501 11 1003 (11 | on mot. D, | | 17,027 | |
| 2.00 Total Program excludable cost (sum of line | | | | | 81, 784 | |
| 5.00 Total Program inpatient operating cost excl medical education costs (line 49 minus line | | ted, non-phy | sician anesti | netist, and | 1, 067, 653 | 3 53 |
| TARGET AMOUNT AND LIMIT COMPUTATION | | | | | C | 54 |
| .00 Target amount per discharge | | | | | 0.00 | 55 |
| .00 Target amount (line 54 x line 55) | | -++ (1 | i | 1: 52) | C | |
| .00 Difference between adjusted inpatient opera .00 Bonus payment (see instructions) | ating cost and targ | et amount (i | ine 56 minus | Tine 53) | | |
| .00 Lesser of lines 53/54 or 55 from the cost | reporting period en | ding 1996, ι | updated and c | ompounded by the | | |
| market basket | | | | | | |
| 0.00 Lesser of lines 53/54 or 55 from prior year .00 If line 53/54 is less than the lower of lin | | | | the amount by | 0.00 | |
| which operating costs (line 53) are less th | | | | | | |
| amount (line 56), otherwise enter zero (see | e instructions) | | | | | |
| 2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive pay | ument (see instruct | ions) | | | | |
| PROGRAM INPATIENT ROUTINE SWING BED COST | | 10113) | | | | |
| .00 Medicare swing-bed SNF inpatient routine co | osts through Decemb | er 31 of the | e cost report | ng period (See | C | 64 |
| instructions)(title XVIII only) .00 Medicare swing-bed SNF inpatient routine co | osts after December | 31 of the c | ost reportin | a period (See | c c | 65 |
| instructions)(title XVIII only) | | | | | | |
| 00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions) | tine costs (line 64 | plus line 6 | 5)(title XVI | ll only). For | C | 66 |
| 7.00 Title V or XIX swing-bed NF inpatient rout | ne costs through D | ecember 31 c | of the cost r | eporting period | c c | 67 |
| (line 12 x line 19) | Ũ | | | | | |
| 2.00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20) | ne costs after Dec | ember 31 of | the cost rep | orting period | C | 68 |
| 0.00 Total title V or XIX swing-bed NF inpatien | | | | | C | 69 |
| PART III - SKILLED NURSING FACILITY, OTHER 0.00 Skilled nursing facility/other nursing fac | | | |) | | 70 |
| . 00 Adjusted general inpatient routine service | 5 | | |) | | 71 |
| .00 Program routine service cost (line 9 x line | · · · · · · · · · · · · · · · · · · · | | · | | | 72 |
| .00 Medically necessary private room cost appl .00 Total Program general inpatient routine se | υ, | | | | | 73 |
| .00 Capital related cost allocated to inpatient 26, line 45) | • | | | Part II, column | | 75 |
| .00 Per diem capital-related costs (line 75 ÷ 1 | ine 2) | | | | | 76 |
| .00 Program capital -related costs (line 9 x lin | | | | | | 77 |
| .00 Inpatient routine service cost (line 74 min .00 Aggregate charges to beneficiaries for exc. | | vider record | ls) | | | 78 |
| .00 Total Program routine service costs for co | • • | | | nus line 79) | | 80 |
| .00 Inpatient routine service cost per diem lin | | | | | | 81 |
| 00 Inpatient routine service cost limitation 00 Reasonable inpatient routine service costs | • • • | | | | | 82 |
| . 00 Program inpatient ancillary services (see i | • • • | | | | | 84 |
| .00 Utilization review - physician compensation | n (see instructions | | | | | 85 |
| . 00 Total Program inpatient operating costs (su | | ugh 85) | | | | 86 |
| PART IV - COMPUTATION OF OBSERVATION BED PA . 00 Total observation bed days (see instruction | | | | | C | 87 |
| 8.00 Adjusted general inpatient routine cost per | | ine 2) | | | 0.00 | |
| 0.00 Observation bed cost (line 87 x line 88) (| · · · · · · · · · · · · · · · · · · · | | | | |) 89 |

| Health Financial Systems | JOHNSON MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------------|----------------|------------|----------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CO | | Period: From 01/01/2016 | Worksheet D-1 | |
| | | Component (| | To 12/31/2016 | | |
| | | Title | XVIII | Subprovider - IRF | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | • | | | | |
| 90.00 Capital-related cost | 145, 773 | 1, 765, 249 | 0. 08257 | 9 0 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 1, 765, 249 | 0. 00000 | 0 0 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 1, 765, 249 | 0. 00000 | 0 0 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 1, 765, 249 | 0. 00000 | 0 0 | 0 | 93.00 |

| OMPUT | Financial Systems JOHNSON MEMORIAL ATION OF INPATIENT OPERATING COST | Provider CCN: 15-0001 | Peri od: | u of Form CMS-2 Worksheet D-1 | |
|----------------|--|--------------------------------|----------------------------------|----------------------------------|----------------|
| | | | From 01/01/2016 To 12/31/2016 | Date/Time Pre | pared |
| | | Ti the VIV | | 1/16/2018 3:0 | |
| | Cost Center Description | Title XIX | Hospi tal | Cost | |
| | | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | - |
| 00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed day | vs. excluding newborn) | | 6, 684 | 1 1.0 |
| 00 | Inpatient days (including private room days, excluding swing- | | | 6, 684 | 2.0 |
| 00 | Private room days (excluding swing-bed and observation bed da | ays). If you have only p | rivate room days, | 0 | 3. |
| 00 | do not complete this line. | | | F 407 | |
| 00 | Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro | 5 / | or 31 of the cost | 5, 437 0 | 4. 5. |
| 00 | reporting period | this days) this digit becenibe | a si oi the cost | 0 | J. |
| 00 | Total swing-bed SNF type inpatient days (including private ro | oom days) after December | 31 of the cost | 0 | 6. |
| | reporting period (if calendar year, enter 0 on this line) | | | _ | |
| 00 | Total swing-bed NF type inpatient days (including private roo | om days) through December | - 31 of the cost | 0 | 7. |
| 00 | reporting period Total swing-bed NF type inpatient days (including private roo | om davs) after December (| 31 of the cost | 0 | 8. |
| | reporting period (if calendar year, enter 0 on this line) | | | - | |
| 00 | Total inpatient days including private room days applicable t | to the Program (excluding | g swing-bed and | 69 | 9. |
| | newborn days) | | | 0 | 10 |
| 0. 00 | Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc | | com days) | 0 | 10. |
| 1.00 | Swing-bed SNF type inpatient days applicable to title XVIII o | | room davs) after | 0 | 11. |
| | December 31 of the cost reporting period (if calendar year, e | | | | |
| 2.00 | Swing-bed NF type inpatient days applicable to titles V or XI | X only (including privat | e room days) | 0 | 12. |
| 3. 00 | through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI | V only (including privat | o room davc) | 0 | 13. |
| 5.00 | after December 31 of the cost reporting period (if calendar y | | | 0 | 13. |
| 4.00 | Medically necessary private room days applicable to the Progr | | | 0 | 14. |
| | Total nursery days (title V or XIX only) | | | | 15. |
| 5. 00 | Nursery days (title V or XIX only) | | | 58 | 16. |
| 7.00 | SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic | ces through December 31 (| of the cost | 0.00 | 1 17 |
| /.00 | reporting period | the ough becember of t | | 0.00 | 17. |
| 3. 00 | Medicare rate for swing-bed SNF services applicable to servic | ces after December 31 of | the cost | 0.00 | 18. |
| | reporting period | | | | 1.0 |
| 9.00 | Medicaid rate for swing-bed NF services applicable to service reporting period | es through December 31 of | the cost | 0.00 | 19. |
| 0. 00 | Medicaid rate for swing-bed NF services applicable to service | es after December 31 of t | he cost | 0.00 | 20. |
| | reporting period | | | | |
| 1.00 | Total general inpatient routine service cost (see instruction | 2 | | 8, 241, 872 | |
| 2.00 | Swing-bed cost applicable to SNF type services through Decemb 5 x line 17) | per 31 of the cost report | ing period (line | 0 | 22. |
| 3. 00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reportion | na period (line 6 | 0 | 23. |
| 5.00 | x line 18) | | ig por rou (rrite o | Ũ | 20. |
| 4.00 | Swing-bed cost applicable to NF type services through Decembe | er 31 of the cost reporti | ng period (line | 0 | 24. |
| - 00 | 7 x line 19) | | | 0 | 25 |
| 5.00 | Swing-bed cost applicable to NF type services after December x line 20) | 31 of the cost reporting | period (line 8 | 0 | 25. |
| 5. 00 | Total swing-bed cost (see instructions) | | | 0 | 26. |
| | General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 8, 241, 872 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | |
| | General inpatient routine service charges (excluding swing-be | ed and observation bed ch | narges) | | 28. |
| 9.00 | Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) | | | 0 | |
| 1.00 | General inpatient routine service cost/charge ratio (line 27 | ÷line 28) | | 0.000000 | |
| 2.00 | Average private room per diem charge (line 29 ÷ line 3) | | | 0.00 | |
| 3.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | |
| | Average per diem private room charge differential (line 32 mi | , , | ctions) | 0.00 | |
| 5.00 | Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35) | ne 31) | | 0.00 | 35. 36. |
| 5.00 7.00 | General inpatient routine service cost net of swing-bed cost | and private room cost di | fferential (line | 0 8, 241, 872 | |
| , | 27 minus line 36) | and private room cost u | | 0,241,072 | ^{37.} |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | 1 |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ | | | | |
| 3.00 | Adjusted general inpatient routine service cost per diem (see | - | | 1, 233. 07 | |
| 9.00 | Program general inpatient routine service cost (line 9 x line | | | 85, 082 | 39. |
|). 00). 00 | Medically necessary private room cost applicable to the Progr | -am (line 14 v line 25) | | 0 | 40. |

| OMPUT | Financial Systems ATION OF INPATIENT OPERATING COST | JOHNSON MEMORIA | Provi der C | CN: 15-0001 | Period: From 01/01/2016 | worksheet D-1 | | |
|--------------|--|--------------------------|------------------------|--|----------------------------|--------------------------------------|------------|--|
| | | | | | To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | | |
| | | | | e XIX | Hospi tal | Cost | | |
| | Cost Center Description | Total Inpatient Costl | Total npatient Days | Average Per Diem (col. 1 col. 2) | | Program Cost (col. 3 x col. 4) | | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | | |
| 2.00 | NURSERY (title V & XIX only) | 452, 922 | 744 | 608.7 | 7 58 | 35, 309 | 42.0 | |
| 3. 00 | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT | 2, 831, 465 | 1, 057 | 2, 678, 7 | 77 14 | 37, 503 | 43. | |
| 4.00 | CORONARY CARE UNIT | 2, 031, 403 | 1,057 | 2,070.7 | 14 | 37, 503 | 43. | |
| 5.00 | BURN INTENSIVE CARE UNIT | | | | | | 45. | |
| | SURGI CAL I NTENSI VE CARE UNI T | | | | | | 46. | |
| 7.00 | 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) | | | 1.00 76,271 | 48. | |
| 9.00 | Total Program inpatient costs (sum of lines 4 | | | ns) | | 234, 165 | | |
| | PASS THROUGH COST ADJUSTMENTS | <u> </u> | | , | | | | |
| 0. 00 | Pass through costs applicable to Program inpa | atient routine s | services (from | Wkst. D, sum | n of Parts I and | C | 50. | |
| 1. 00 |) Dass through costs applicable to Drogram input | tiont oncillary | , convigos (fr | om Wkat D a | um of Dorte II | c c | 51. | |
| 1.00 | Pass through costs applicable to Program inpa and IV) | attent and trans | services (II | UNI WKSL. D, S | Sum of Parts II | | 1 51. | |
| 2.00 | Total Program excludable cost (sum of lines ! | 50 and 51) | | | | C | 52. | |
| 3.00 | Total Program inpatient operating cost exclud | ding capital rel | ated, non-phy | sician anestr | netist, and | 0 | | |
| | medical education costs (line 49 minus line 5 | 52) | | | | | | |
| 4.00 | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | | | | | C | 54. | |
| 4.00 5.00 | Target amount per discharge | | | | | | 55. | |
| 5.00 | Target amount (line 54 x line 55) | | | | | 0.00 | | |
| 7.00 | Difference between adjusted inpatient operati | ng cost and tar | get amount (I | ine 56 minus | line 53) | 0 | | |
| 3. 00 | Bonus payment (see instructions) | 0 | 0 | | , | 0 | 58. | |
| 9.00 | | | | | | | | |
| 0. 00 | market basket Lesser of lines 53/54 or 55 from prior year of | act conart und | lated by the m | arkat backat | | 0.00 | 60. | |
| 1.00 | If line 53/54 is less than the lower of lines | | | | the amount by | 0.00 | | |
| | which operating costs (line 53) are less than | | | | | | | |
| | amount (line 56), otherwise enter zero (see i | nstructions) | | | 0 | | | |
| 2.00 | Relief payment (see instructions) | | | | | 0 | | |
| 3.00 | Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST | ent (see instruc | ctions) | | | C |) 63. | |
| 4.00 | Medicare swing-bed SNF inpatient routine cost | ts through Decem | ber 31 of the | cost reporti | ng period (See | C | 64. | |
| | instructions)(title XVIII only) | 0 | | • | 0 1 1 | | | |
| 5.00 | Medicare swing-bed SNF inpatient routine cost | ts after Decembe | er 31 of the c | ost reporting | period (See | 0 | 65. | |
| 6. 00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin | no costs (lino 4 | A plus lino 6 | 5) (+i +l o V/II | Lonly) For | l c | 66. | |
| 5.00 | CAH (see instructions) | | prus rine o | 5)(title xiii | i oniy). Toi | | 00. | |
| 7.00 | Title V or XIX swing-bed NF inpatient routine | e costs through | December 31 o | f the cost re | eporting period | 0 | 67. | |
| | (line 12 x line 19) | | | | | | | |
| 8.00 | Title V or XIX swing-bed NF inpatient routine | e costs after De | ecember 31 of | the cost repo | orting period | C | 68. | |
| 9.00 | (line 13 x line 20) Total title V or XIX swing-bed NF inpatient n | coutine costs (1 | ine 67 + line | 68) | | C | 69. | |
| | PART III - SKILLED NURSING FACILITY, OTHER NU | | | | | | | |
| 0. 00 | Skilled nursing facility/other nursing facili | ty/ICF/IID rout | ine service c | ost (line 37) | | | 70. | |
| 1.00 | Adjusted general inpatient routine service co | | ne 70 ÷ line | 2) | | | 71. | |
| 2.00 | Program routine service cost (line 9 x line 1 | | (1) - 14 - 11 | 25) | | | 72. | |
| 3.00 1.00 | Medically necessary private room cost applica Total Program general inpatient routine servi | 0 | • | | | | 73. | |
| 5.00 | Capital -related cost allocated to inpatient i | • | | | Part II column | | 75. | |
| | 26, line 45) | | | | | | | |
| 5.00 | Per diem capital-related costs (line 75 ÷ lin | | | | | | 76. | |
| 7.00 | Program capital -related costs (line 9 x line | | | | | | 77. | |
| . 00 | Inpatient routine service cost (line 74 minus | | | -> | | | 78. | |
| . 00 . 00 | Aggregate charges to beneficiaries for excess Total Program routine service costs for compa | • • | | | us line 70) | | 79. 80. | |
| . 00 | Inpatient routine service cost per diem limit | | | | 143 IIIC / 7) | | 81. | |
| 2.00 | Inpatient routine service cost per dreim rim | | 1 | | | | 82. | |
| 3.00 | Reasonable inpatient routine service costs (s | , | | | | | 83. | |
| 1.00 | Program inpatient ancillary services (see ins | structions) | | | | | 84. | |
| | Utilization review - physician compensation | | | | | | 85. | |
| 6. 00 | Total Program inpatient operating costs (sum | | ough 85) | | | | 86. | |
| 7.00 | PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions) | | | | | 1, 247 | 87. | |
| | | | 1:00 2) | | | 1, 233. 07 | | |
| 8.00 | Adjusted general inpatient routine cost per d | alem (line ∠/÷ | rine z) | | | 1,233.07 | 00. | |

| Health Financial Systems | JOHNSON MEMOR | RIAL HOSPITAL In Lieu of Form CMS- | | | | 2552-10 |
|---|---------------|------------------------------------|------------|----------------------------|----------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CO | | Period: From 01/01/2016 | Worksheet D-1 | |
| | | | | To 12/31/2016 | | pared: 1 pm |
| | | Titl | e XIX | Hospi tal | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital-related cost | 642, 382 | 8, 241, 872 | 0. 07794 | 1 1, 537, 638 | 119, 845 | 90.00 |
| 91.00 Nursing School cost | 0 | 8, 241, 872 | 0.00000 | 0 1, 537, 638 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 8, 241, 872 | 0.00000 | 0 1, 537, 638 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 8, 241, 872 | 0.00000 | 0 1, 537, 638 | 0 | 93.00 |

| OMPUT | ATION OF INPATIENT OPERATING COST | L HOSPITAL Provider CCN: 15-0001 | Peri od: | u of Form CMS-2 Worksheet D-1 | |
|--------------|---|-------------------------------------|----------------------------------|----------------------------------|--------------|
| | | Component CCN: 15-T001 | From 01/01/2016 To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pare |
| | | Title XIX | Subprovider - | Cost | <u>, hii</u> |
| | Cost Center Description | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | Ц | | |
| 00 | INPATIENT DAYS | vc oveluding nowhern) | I | 1 461 | 1 1 |
| . 00 . 00 | Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing | | | 1, 461 1, 461 | 1. 2. |
| 00 | Private room days (excluding swing-bed and observation bed days) | 5, | ivate room days, | 0 | 3. |
| | do not complete this line. | | | | |
| 00 00 | Semi-private room days (excluding swing-bed and observation I Total swing-bed SNF type inpatient days (including private ro | | r 31 of the cost | 1, 461 0 | 4. 5. |
| 00 | reporting period Total swing-bed SNF type inpatient days (including private ro | oom days) after December | 31 of the cost | 0 | 6. |
| 00 | reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo | om dave) through Decombor | 21 of the cost | 0 | 7 |
| 00 | reporting period | un days) thi dugh becember | ST OF THE COST | 0 | / · |
| 00 | Total swing-bed NF type inpatient days (including private roo | om days) after December 3 | 1 of the cost | 0 | 8. |
| 00 | reporting period (if calendar year, enter 0 on this line) | to the Drognom (avaluding | owing bod and | 13 | |
| 00 | Total inpatient days including private room days applicable newborn days) | to the Program (excluding | swing-bed and | 13 | 9 |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII of | | oom days) | 0 | 10 |
| 00 | through December 31 of the cost reporting period (see instruction and SNE type instruction and instructions) | | | 0 | 1.1 |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, of | | oom days) arter | 0 | 11 |
| . 00 | Swing-bed NF type inpatient days applicable to titles V or XI | | e room days) | 0 | 12 |
| | through December 31 of the cost reporting period | | | | 1.0 |
| . 00 | Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary | 3 (31 | <i>,</i> | 0 | 13 |
| . 00 | Medically necessary private room days applicable to the Program | | | 0 | 14 |
| . 00 | Total nursery days (title V or XIX only) | × 5 5 | 5.7 | 744 | |
| . 00 | Nursery days (title V or XIX only) | | | 58 | 16 |
| . 00 | SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service | ces through December 31 c | f the cost | 0.00 | 17 |
| | reporting period | | | 0.00 | |
| . 00 | Medicare rate for swing-bed SNF services applicable to service | ces after December 31 of | the cost | 0.00 | 18 |
| . 00 | reporting period Medicaid rate for swing-bed NF services applicable to service | es through December 31 of | the cost | 0.00 | 19 |
| | reporting period | C C | | | |
| . 00 | Medicaid rate for swing-bed NF services applicable to service reporting period | es after December 31 of t | he cost | 0.00 | 20 |
| . 00 | Total general inpatient routine service cost (see instruction | ns) | | 1, 765, 249 | 21 |
| 2.00 | Swing-bed cost applicable to SNF type services through Decem | ber 31 of the cost report | ing period (line | 0 | 22 |
| 8. 00 | 5 x line 17) Swing-bed cost applicable to SNF type services after December | r 21 of the cost reportin | a pariod (line 4 | 0 | 23 |
| . 00 | x line 18) | i si oi the cost reporti | | | |
| . 00 | Swing-bed cost applicable to NF type services through December 7×1 (ine 19) | er 31 of the cost reporti | ng period (line | 0 | 24 |
| 5.00 | Swing-bed cost applicable to NF type services after December | 31 of the cost reporting | period (line 8 | 0 | 25 |
| | x line 20) | | | | |
| | Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 0 1, 765, 249 | 26 |
| . 00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | I | 1,700,217 | 1 - 1 |
| | General inpatient routine service charges (excluding swing-be | ed and observation bed ch | arges) | 0 | |
| | 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) | 20) | | 0.00000 | |
| | Average semi-private room per diem charge (line 30 ÷ line 4) | | | 0.00 | |
| . 00 | Average per diem private room charge differential (line 32 mi | | tions) | 0.00 | |
| 5.00 5.00 | Average per diem private room cost differential (line 34×16) Private room cost differential adjustment (line $3 \times 160 \times 100$) | ine 31) | | 0.00 0 | 35. 36. |
| | Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost | and private room cost di | fferential (line | 0 1, 765, 249 | |
| | 27 minus line 36) | | | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | ILISTMENTS | | | |
| 3. 00 | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see | | I | 1, 208. 25 | 38 |
| | Program general inpatient routine service cost per drem (ser | | | 15, 707 | |
| | | | | 0 | 40 |
| 0. 00 | Medically necessary private room cost applicable to the Program general inpatient routine service cost (line 34 | | | 15, 707 | |

| | Financial Systems ATION OF INPATIENT OPERATING COST | JOHNSON MEMORIAL | HOSPITAL | CN: 15-0001 | In Lie Period: | eu of Form CMS- Worksheet D-1 | |
|--------------|---|---------------------------|-----------------------|-----------------------|----------------------------------|----------------------------------|--------------|
| | | | | CCN: 15-T001 | From 01/01/2016 To 12/31/2016 | | epare |
| | | | Ti tl | e XIX | Subprovider - | Cost | or pin |
| | Cost Center Description | Total Inpatient CostIn | Total patient Days | | | Program Cost (col. 3 x col. | |
| | | 1.00 | 2.00 | <u>col.2)</u> 3.00 | 4.00 | 4) 5.00 | |
| 2.00 | NURSERY (title V & XIX only) | 0 | C | | | | 42. |
| 3. 00 | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT | 0 | C | 0. | 00 0 | | 3 43. |
| | CORONARY CARE UNIT | 0 | C | 0. | | | 44. |
| | BURN INTENSIVE CARE UNIT | | | | | | 45. |
| | SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) | | | | | | 46. |
| . 00 | Cost Center Description | <u> </u> | | | | 1.00 | |
| . 00 | Program inpatient ancillary service cost (Wk | st. D-3, col. 3, | line 200) | | | 1.00 | 9 48. |
| . 00 | Total Program inpatient costs (sum of lines | | | ons) | | 18, 756 | 5 49 |
| | PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp | atient routine se | rvices (from | n Wkst. D, su | m of Parts I and | | 50 |
| | | | | | | | |
| . 00 | Pass through costs applicable to Program inp and IV) | atient ancillary | services (fr | OM WKST. D, | sum ot Parts II | 0 | 51 |
| | Total Program excludable cost (sum of lines | | | | | 0 | |
| | Total Program inpatient operating cost exclu medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION | | ited, non-phy | sician anest | hetist, and | (| 53 |
| . 00 | Program discharges | | | | | (| |
| | Target amount per discharge Target amount (line 54 x line 55) | | | | | 0.00 | |
| | Difference between adjusted inpatient operat | ing cost and targ | et amount (I | ine 56 minus | line 53) | | |
| | Bonus payment (see instructions) | | | | | (| |
| . 00 | Lesser of lines 53/54 or 55 from the cost re market basket | porting period en | idi ng 1996, ι | ipdated and c | ompounded by the | 0.00 | 59 |
| | Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less tha | s 55, 59 or 60 en | iter the less | er of 50% of | the amount by | 0.00 | |
| | amount (line 56), otherwise enter zero (see | | | 00), 01 1% 0 | i the target | | |
| | Relief payment (see instructions) Allowable Inpatient cost plus incentive paym | ent (see instruct | ions) | | | |) 62) 63 |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| . 00 | Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) | ts through Decemb | er 31 of the | e cost report | ing period (See | 0 | 64 |
| . 00 | Medicare swing-bed SNF inpatient routine cos | ts after December | 31 of the c | ost reportin | g period (See | 0 | 65 0 |
| . 00 | <pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre> | ne costs (line 64 | plus line 6 | 5)(title XVI | II only). For | 0 | 66 |
| 00 | CAH (see instructions) | a casts through D | Jocombor 21 c | f the cost r | operting period | | 47 |
| . 00 | Title V or XIX swing-bed NF inpatient routin (line 12 x line 19) | e costs through L | ecember 31 c | on the cost r | eporting period | | 67 |
| . 00 | Title V or XIX swing-bed NF inpatient routin (line 13 x line 20) | e costs after Dec | ember 31 of | the cost rep | orting period | 0 | 68 |
| | Total title V or XIX swing-bed NF inpatient | , | | | | | 69 |
| | PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil | | | |) | | 70 |
| | Adjusted general inpatient routine service c | 5 | | | / | | 71 |
| | Program routine service cost (line 9 x line | | 1100 14 | no 25) | | | 72 |
| . 00 . 00 | Medically necessary private room cost applic Total Program general inpatient routine serv | 0 | | | | | 73 |
| . 00 | Capital-related cost allocated to inpatient 26, line 45) | routine service c | | | Part II, column | | 75 |
| | Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line | | | | | | 76 |
| . 00 | Inpatient routine service cost (line 74 minu | s line 77) | | | | | 78 |
| | Aggregate charges to beneficiaries for exces | | | | nus lino 70) | | 79 |
| . 00 . 00 | Total Program routine service costs for comp Inpatient routine service cost per diem limi | | or remitation | i (iine /ơ mì | nus i ne 79) | | 80 |
| . 00 | Inpatient routine service cost limitation (I | ine 9 x line 81) | | | | | 82 |
| | Reasonable inpatient routine service costs (| | | | | | 83 |
| | Program inpatient ancillary services (see in Utilization review - physician compensation | | .) | | | | 84 |
| | Total Program inpatient operating costs (sum | | | | | | 86 |
| | PART IV - COMPUTATION OF OBSERVATION BED PAS | S THROUGH COST | | | | | |
| | Total observation bed days (see instructions Adjusted general inpatient routine cost per | | ine 2) | | | 0.00 | |
| | Observation bed cost (line 87 x line 88) (se | • | 2) | | | | 0 89 |

| Health Financial Systems | JOHNSON MEMOR | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------|----------------|------------|----------------------------|-----------------|----------------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provider CO | | Period: From 01/01/2016 | Worksheet D-1 | |
| | | Component (| | To 12/31/2016 | | pared: 1 pm |
| | | Titl | e XIX | Subprovider - IRF | Cost | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital-related cost | 145, 773 | 1, 765, 249 | 0. 08257 | 9 0 | 0 | 90.00 |
| 91.00 Nursing School cost | 0 | 1, 765, 249 | 0.00000 | 0 0 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 1, 765, 249 | 0.00000 | 0 0 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 1, 765, 249 | 0.00000 | 0 0 | 0 | 93.00 |

| Health Financial Systems | JOHNSON MEMORIAL | HOSPI TAL | | | In Lie | u of Form CMS-: | 2552-10 |
|--|--------------------|------------|--------------|----|--------------|----------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | | Provider C | CN: 15-0001 | | i od: | Worksheet D-3 | |
| | | | | | m 01/01/2016 | D . (T) D | |
| | | | | То | 12/31/2016 | Date/Time Pre | |
| | | Title | 2 XVIII | | Hospi tal | 1/16/2018 3:0 PPS | трш |
| Cost Center Description | | , in the | Ratio of Cos | st | Inpatient | Inpatient | |
| | | | To Charges | | | Program Costs | |
| | | | 5 | | | (col. 1 x col. | |
| | | | | | Ũ | 2) | |
| | | | 1.00 | | 2.00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | | | | | 3, 597, 270 | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | | | 608, 792 | | 31.00 |
| 41.00 04100 SUBPROVIDER – IRF | | | | | 0 | | 41.00 |
| 43. 00 04300 NURSERY | | | | | | | 43.00 |
| ANCI LLARY SERVI CE COST CENTERS | | | | | | | |
| 50.00 05000 OPERATI NG ROOM | | | 0. 2240 | | 2, 423, 189 | 543, 034 | |
| 53. 00 05300 ANESTHESI OLOGY | | | 0.0513 | | 0 | 0 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | | 0. 1533 | 20 | 1, 998, 964 | 306, 481 | 54.00 |
| 60. 00 06000 LABORATORY | | | 0. 1996 | | 3, 029, 297 | 604, 878 | 60.00 |
| 65. 00 06500 RESPI RATORY THERAPY | | | 0. 3218 | | 1, 276, 599 | 410, 854 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | | 0. 4571 | | 303, 025 | 138, 517 | 66.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY | | | 0. 2077 | | 270, 406 | 56, 168 | |
| 68.00 06800 SPEECH PATHOLOGY | | | 0. 3349 | | 77, 919 | 26, 096 | |
| 69. 00 06900 ELECTROCARDI OLOGY | | | 0. 2276 | 37 | 735, 504 | 167, 428 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | | | 0. 5906 | 50 | 0 | 0 | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | | 0. 4049 | | 2, 085, 282 | 844, 527 | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | | 0. 3788 | | 0 | 0 | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | | 0. 3821 | | 2, 039, 471 | 779, 298 | |
| 76. 00 03020 ONCOLOGY | | | 2.8869 | | 0 | 0 | |
| 76. 97 07697 CARDIAC REHABILITATION | | | 0. 5730 | 99 | 0 | 0 | 76.97 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 90. 00 09000 CLINIC | | | 0. 3439 | 57 | 49, 271 | 16, 947 | 90.00 |
| 91.00 09100 EMERGENCY | | | 0. 2304 | 05 | 1, 322, 801 | 304, 780 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | 0. 9477 | 02 | 127, 315 | 120, 657 | |
| 200.00 Total (sum of lines 50 through 94 and 9 | | | | | 15, 739, 043 | 4, 319, 665 | 200. 00 |
| 201.00 Less PBP Clinic Laboratory Services-Pro | ogram only charges | (line 61) | | | 0 | | 201.00 |
| 202.00 Net charges (line 200 minus line 201) | | | | | 15, 739, 043 | | 202.00 |
| | | | | | | | |

| 31.00 03100 INTENSI VE CARE UNI T 0 31. 41.00 04100 SUBPROVI DER - IRF 799,824 41. 43.00 OVATOS SUBPROVI DER - IRF 43. ANCI LLARY SERVICE COST CENTERS 0.224099 9,057 2,030 50. 50.00 05000 OPERATI NG ROOM 0.051369 2,020 104 53. 54.00 05400 RADI DLOGY - DI AGNOSTI C 0.153320 21,772 3.38 54. 60.00 06000 LABORATORY 0.321835 102,880 33.10 65. 65.00 06500 RESPI RATORY THERAPY 0.321835 102,880 33.110 65. 66.00 06000 LECTROCARDI OLGY - DI ANL THERAPY 0.207719 328,712 68,280 67. 67.00 06700 OCUPATI ONAL THERAPY 0.227637 8,252 1,878 69. 0.0 07000 ELECTROCARDI OLGGY 0.3382108 53,752 1,878 69. 0.0 07000 ELECTROCARDI OLGAY DI PATI ENTS 0.342951 0 0 71. 0.0 | Health Financial Systems JO | HNSON MEMORIAL HOSPI | TAL | | | In Lie | u of Form CMS- | 2552-10 |
|--|--|-----------------------|--------|-------------|----|--------------|----------------|---------|
| Component CCN: 15-T001 To 12/31/2016 Date:Time Prepare (16/2018 3: 01 pm (16/2018 3: 01 pm (17/2018 | INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi | der CC | CN: 15-0001 | | | Worksheet D-3 | |
| Cost Center Description Title XVIII Subprovider - IRF Inpatient Program Charges Inpatient Program Charges< | | Compo | nont (| CN: 15 TOO1 | | | Dato/Timo Pro | narod |
| Title XVIII Subprovider - IRF PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs 2) 0.000 0000 AdDucts & PEDIATRICS 0 0 30.00 30.00 30.00 31.000 04000 SUBPROVIDER - IRF 0.224099 9.057 2.030 50.0 50.0 53.000 0500 AdDucts BC Cost Centres 0.224099 9.057 2.030 50.0 53.000 0500 OB FEDIATIONE THERAPY 0.31360 | | Compe | ment (| CN. 15-1001 | 10 | 12/31/2010 | | |
| Cost Center Description Ratio of Cost To Charges Inpatient Program (Charges) Inpatient Program (Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 30.00 03000 INTENSIVE CARE UNIT 0 30.00 3.00 41.00 04100 SUBPROVIDER - IRF 799, 824 41. 43.00 04300 MURSERV 0 30.30 ANCILLARY SERVICE COST CENTERS 0.224099 9.057 2.030 50.00 05000 OPENATING ROOM 0.224099 9.057 2.030 51.00 05000 LABORATORY 0.051369 2.020 10.44 60.00 06000 LABORATORY 0.153320 21,772 3.38 54.00 06600 LABORATORY 0.321835 102.880 33,110 65.00 06600 RESPI RATORY THERAPY 0.321835 102.880 33,116 66.00 06500 RESPI RATORY THERAPY 0.3243916 120,775 40,433 69.00 06600 PHYSI CAL THERAPY 0.334916 120,775 40,433 69.00 06500 ELECTROCARDI OLOGY | | | Title | XVIII | Su | ubprovider - | | |
| Import Note To Charges Program Charges Program (col. 1 x col. 2) 1.00 2.00 3.00 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 30.00 3.00 3.00 41.00 04100 SUBPROVI DER - IRF 0 31. | | | | | | | | |
| INPATI ENT ROUTINE SERVICE COST CENTERS (col. 1 x col. 2) 1.00 2.00 3.00 03000 ADULTS & PEDIATRICS 0 30.0 31.00 03100 INTENSIVE CARE UNIT 0 30.0 41.00 04100 SUBPROVIDER - IRF 799, 824 41. ANCILLARY SERVICE COST CENTERS 799, 824 43. ANCILLARY SERVICE COST CENTERS 0 0.51369 2.020 104 53. 50.00 05300 ANESTHESI OLOGY 0.051369 2.020 104 53. 54.00 05400 RADIOLGGY-DIAGNOSTIC 0.153320 21, 772 3.38 54. 0.00 06500 OLBARTARY 0.321835 102.880 33.110 65. 65.00 06500 RESPI RATORY THERAPY 0.321835 102.880 33.110 65. 66.00 06000 PHYSI CAL THERAPY 0.227719 328, 712 68.280 67. 71.00 07000 ELECTROEARDIOLOGY 0.334916 120, 725 40, 433 68. 69.00 06700 ELECTROEARD TO PATIENTS 0.490494 13.382 | Cost Center Description | | | | | | | |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 0 31.00 3 | | | | To Charges | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS 0.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 41.00 04100 SUBPROVIDER - IRF 0 31.00 32000 0000 OPERATING ROM 0.224099 9.057 2.030 32000 053000 OPERATING ROM 0.51369 2.002 104 33.00 05300 ARSTHESI DLOGY 0.51369 2.020 104 53.00 05300 ARSTHESI OLOGY 0.51369 2.020 104 54.00 05400 RADI OLOGY DI AGNOSTI C 0.153320 21,772 3.338 54.00 065000 RESPI RATORY THERAPY 0.321835 102,880 33.110 65.00 06500 RESPI RATORY THERAPY 0.321835 102,880 33.110 64.00 06600 PHYSI CAL THERAPY 0.321835 120,725 40,433 67.00 06700 OCUCUPATI INT ONAL THERAPY 0.27637 8,252 1,878 69.00 066000 SPECH PATHOLOGY 0.27637 8,252 1,878 69.00 | | | | | | Charges | | |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS 0 30. 00 03000 ADULTS & PEDIATRI CS 0 30. < | | | | 1 00 | | 2.00 | | |
| 30.00 03000 ADULTS & PEDIATRICS 0 30.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 41.00 SUBROVIDER - IRF 0 31.00 ANCILLARY SERVICE COST CENTERS 799,824 41. 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 0.051369 2,020 10.4 53.00 05300 ANESTHESI OLOGY 0.153320 21,772 3.38 54.00 05400 RADIOLOGV-DIAGNOSTIC 0.321835 102,880 33.110 65.00 06500 RESPIRATORY THERAPY 0.321835 102,880 33.110 65. 66.00 06600 PHYSI CAL THERAPY 0.334916 120,725 40,433 68. 67. 67.00 06700 CCUPATIONAL THERAPY 0.324037 0 70. 70. 72.53 40,433 68. 67. 68.00 06800 SPECH PATHOLOGY 0.334916 120,725 40,433 68. 67. 68.00 0000 70.00 70.00 70.00 70.00 70.00 70.< | INPATIENT ROUTINE SERVICE COST CENTERS | | | 1.00 | | 2.00 | 3.00 | |
| 31.00 03100 INTENSI VE CARE UNI T 0 31. 41.00 04100 SUBPROVI DER - IRF 799, 824 41. 43.00 04300 NURSERY 799, 824 43. ANCI LLARY SERVICE COST CENTERS 0.024099 9.057 2.030 50. 50.00 05000 PRESTRESI OLOGY 0.051369 2.020 104 53. 54.00 05400 RABI OLOGY - DI AGNOSTI C 0.153320 21, 772 3.38 54. 60.00 06000 LABORATORY 0.321835 102, 880 33. 106. 65.00 06500 RESPI RATORY THERAPY 0.321835 102, 880 33. 116. 67.00 06700 OCUPATI ONAL THERAPY 0.227719 328, 712 68, 280 67. 68.00 06800 SPEECH PATHOLOGY 0.227637 8, 252 1, 878 69. 00.0700 ELECTROBUCACHALDERAPHY 0.3382108 53, 752 1, 878 69. 00.07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.404994 13, 382 5, 420 71. 73.00 07 | | | | | | 0 | | 30.00 |
| 41.00 04100 SUBPROVI DER - I RF 799, 824 41. 43.00 04300 NURSERY 43. ANCILLARY SERVICE COST CENTERS 0.5224099 9, 057 2, 030 50. 53.00 05300 OPERATI NG ROOM 0.1224099 9, 057 2, 030 50. 53.00 05300 ANESTHESI OLOGY 0.151369 2, 020 104 53. 54.00 05400 RADIOLOGY-DI AGNOSTI C 0.153320 21, 772 3, 338 54. 60.00 06000 LABORATORY 0.199676 165, 413 33, 029 60. 65.00 06500 RESPI RATORY THERAPY 0.321835 102, 880 33, 110 65. 66.00 06600 PHYSI CAL THERAPY 0.207719 328, 712 68, 826 67. 70.00 06700 0CUPATI ONAL THERAPY 0.530650 0 0 70. 70.00 07000 ELECTROCARDI OLOGY 0.334916 120, 725 40, 433 68. 69.00 0FO00 ELECTROCARDI OLOGY 0.590650 0 0 70. <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td><td>31.00</td></t<> | | | | | | 0 | | 31.00 |
| 43. 00 04300 NURSERY 43. ANCI LLARY SERVI CE COST CENTERS 50. 00 OPERATI NG ROOM 0. 224099 9, 057 2, 030 50. 50. 00 05000 OPERATI NG ROOM 0. 051369 2, 020 104 53. 51. 00 05300 ANESTHESI OLOGY 0. 051369 2, 020 104 53. 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 153320 21, 772 3, 338 54. 60. 00 06000 LABORATORY 0. 321835 102, 880 33, 110 65. 65. 00 06500 RESPI RATORY THERAPY 0. 457113 313, 221 143, 177 66. 66. 00 06000 CUPATI ONAL THERAPY 0. 227637 8, 252 1, 878 69. 67. 00 06700 0CUPATI ONAL THERAPY 0. 334916 120, 725 40, 433 68. 69. 00 06800 SPEECH PATHOLOGY 0. 227637 8, 252 1, 878 69. 0 70. 70. 00 07000 ELECTROCARDI OLOGY 0. 334916 13, 382 54.20 71. 72. 72. | | | | | | 799, 824 | | 41.00 |
| 50.00 05000 0PERATI NG R00M 0.224099 9,057 2,030 50. 53.00 05300 ANESTHESI OLOGY 0.051369 2,020 104 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.153320 21,772 3,338 54. 60.00 06600 LABORATORY 0.199676 165.413 33,029 60. 65.00 06600 PHYSI CAL THERAPY 0.321835 102,880 33,110 65. 66.00 06600 PHYSI CAL THERAPY 0.457113 313,221 143,177 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.207719 328,712 68,280 67. 68.00 06800 PEECH PATHOLOGY 0.334916 120,725 40,433 68. 69.00 06900 ELECTROCARDI OLOGY 0.590650 0 0 70. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.382108 53,752 20,539 73. 72.00 07200 I MPL. DEV. CHARGE | | | | | | | | 43.00 |
| 53.00 05300 ANESTHESI OLOGY 0.051369 2,020 104 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.153320 21,772 3,338 54. 60.00 06000 LABORATORY 0.199676 165,413 33,029 60. 65.00 06500 RESPI RATORY THERAPY 0.321835 102,880 33,110 65. 66.00 06600 PHYSI CAL THERAPY 0.457113 313,221 143,177 68,280 67. 67.00 06700 OCCUPATI ONAL THERAPY 0.207719 328,712 68,280 67. 68.00 06800 SPEECH PATHOLOGY 0.334916 120,725 40,433 68. 69.00 OF900 ELECTROCARDI OLOGY 0.590650 0 0 70. 70.00 07000 ELECTROENCEPHALOGRAPHY 0.590650 0 0 70. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.404994 13,382 5,420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.378880 0 0 72. <t< td=""><td>ANCI LLARY SERVICE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<> | ANCI LLARY SERVICE COST CENTERS | | | | | | | |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.153320 21,772 3,338 54. 60.00 06000 LABORATORY 0.199676 165,413 33,029 60. 65.00 06500 RESPI RATORY THERAPY 0.321835 102,880 33,110 65. 66.00 06600 PHYSI CAL THERAPY 0.457113 313,221 143,177 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.207719 328,712 68,280 67. 68.00 06800 SPEECH PATHOLOGY 0.334916 120,725 40,433 68. 69.00 06900 ELECTROCARDI OLOGRAPHY 0.590650 0 0 70. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.340494 13,382 5,420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.378880 0 0 72. 73.00 073000 DRUGS CHARGED TO PATI ENTS 0.382108 53,752 20,539 73. 76.00 03020 NCOLOGY 2.886911 0 0 76. 00170 | 50.00 05000 OPERATI NG ROOM | | | 0. 2240 | 99 | 9, 057 | 2, 030 | 50.00 |
| 60.00 06000 LABORATORY 0.199676 165, 413 33, 029 60. 65.00 06500 RESPI RATORY THERAPY 0.321835 102, 880 33, 110 65. 66.00 06600 PHYSI CAL THERAPY 0.457113 313, 221 143, 177 66. 67.00 06700 OCUPATI ONAL THERAPY 0.207719 328, 712 68, 280 67. 68.00 06800 SPEECH PATHOLOGY 0.227637 8, 252 1, 878 69. 70.00 07000 ELECTROCARDI OLOGY 0.590650 0 0 70. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.404994 13, 382 5, 420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.382108 53, 752 20, 539 73. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.534911 0 0 76. 76.97 07697 CARDI AC REHABI LI TATI ON 0.573099 0 0 76. 0017PATI ENT SERVICE COST CENTERS 0.343957 0 0 90. 91.00 94.94 <t< td=""><td>53. 00 05300 ANESTHESI OLOGY</td><td></td><td></td><td>0. 0513</td><td>69</td><td>2, 020</td><td>104</td><td>53.00</td></t<> | 53. 00 05300 ANESTHESI OLOGY | | | 0. 0513 | 69 | 2, 020 | 104 | 53.00 |
| 65.00 06500 RESPI RATORY THERAPY 0. 321835 102, 880 33, 110 65. 66.00 06600 PHYSI CAL THERAPY 0. 457113 313, 221 143, 177 66. 67.00 06700 OCCUPATI ONAL THERAPY 0. 207719 328, 712 68, 280 67. 68.00 06800 SPEECH PATHOLOGY 0. 334916 120, 725 40, 433 68. 69.00 06900 ELECTROCARDI OLOGY 0. 227637 8, 252 1, 878 69. 70.00 07000 ELECTROCARDI OLOGY 0. 590650 0 0 70. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 404994 13, 382 5, 420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 378880 0 0 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 382108 53, 752 20, 539 73. 76.00 03020 ONCOLOGY 2. 886911 0 0 76. 70.7697 CARDI AC REHABI LI TATI ON 0. 573099 0 0 76. <tr< td=""><td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td><td></td><td></td><td>0. 1533</td><td>20</td><td>21, 772</td><td>3, 338</td><td>54.00</td></tr<> | 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | | 0. 1533 | 20 | 21, 772 | 3, 338 | 54.00 |
| 66.00 06600 PHYSI CAL THERAPY 0.457113 313, 221 143, 177 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.207719 328, 712 68, 280 67. 68.00 06800 SPEECH PATHOLOGY 0.334916 120, 725 40, 433 68. 69.00 06900 ELECTROCARDI OLOGY 0.227637 8, 252 1, 878 69. 70.00 07000 ELECTROENCEPHALOGRAPHY 0.590650 0 0 70. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.404994 13, 382 5, 420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.378880 0 0 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.382108 53, 752 20, 539 73. 76.00 03020 ONCOLOGY 2.886911 0 0 76. 01.00 07407 CARDI AC REHABI LI TATI ON 0.573099 0 0 76. 01.00 09000 CLI NI C 0.343957 0 0 91. 01.00 | 60. 00 06000 LABORATORY | | | 0. 1996 | 76 | 165, 413 | 33, 029 | 60.00 |
| 67.00 06700 0CCUPATI ONAL THERAPY 0.207719 328,712 68,280 67. 68.00 06800 SPEECH PATHOLOGY 0.334916 120,725 40,433 68. 69.00 06900 ELECTROCARDI OLOGY 0.227637 8,252 1,878 69. 70.00 07000 ELECTROCARDI OLOGY 0.227637 8,252 1,878 69. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.404994 13,382 5,420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.37880 0 0 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.382108 53,752 20,539 73. 76.00 03020 ONCOLOGY 2.886911 0 0 76. 76.97 07697 CARDI AC REHABI LI TATI ON 0.573099 0 0 76. 00100 UTPATI ENT SERVI CE COST CENTERS 0.343957 0 0 90. 90.00 09100 EMERGENCY 0.230405 2,148 495 91. 92.00 09200 | 65. 00 06500 RESPI RATORY THERAPY | | | 0. 3218 | 35 | 102, 880 | 33, 110 | 65.00 |
| 68.00 06800 SPEECH PATHOLOGY 0.334916 120,725 40,433 68. 69.00 06900 ELECTROCARDIOLOGY 0.227637 8,252 1,878 69. 70.00 07000 ELECTROENCEPHALOGRAPHY 0.590650 0 0 70. 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.404994 13,382 5,420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.382108 53,752 20,539 73. 76.00 03020 ONCOLOGY 2.886911 0 0 76. 76.97 07697 CARDIAC REHABILITATION 0.573099 0 0 76. 90.00 09000 CLINIC 0.343957 0 0 90. 91.00 09100 EMERGENCY 0.343957 0 0 90. 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.230405 2,148 495 91. 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 1,155,526 365,283 200. | 66. 00 06600 PHYSI CAL THERAPY | | | | | 313, 221 | 143, 177 | 66.00 |
| 69.00 06900 ELECTROCARDI OLOGY 0.227637 8,252 1,878 69. 70.00 07000 ELECTROENCEPHALOGRAPHY 0.590650 0 0 70. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.404994 13,382 5,420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.37880 0 0 73. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.382108 53,752 20,539 73. 76.00 03020 ONCOLOGY 2.886911 0 0 76. 76.97 07697 CARDI AC REHABI LI TATI ON 0.573099 0 0 76. 90.00 09000 CLI NI C 0.343957 0 0 90. 91.00 09100 EMERGENCY 0.9200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.947702 14, 192 13, 450 92. 200.00 Total (sum of Lines 50 through 94 and 96 through 98) 1, 155, 526 365, 283 200. | | | | | | | | |
| 70.00 07000 ELECTROENCEPHALOGRAPHY 0.590650 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.404994 13,382 5,420 71.72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.378880 0 0 72.73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.382108 53,752 20,539 73.75.75 76.00 03020 ONCOLOGY 2.886911 0 0 76.75.75 76.07 07697 CARDIA C REHABILITATION 0.573099 0 0 76.75.75 90.00 09000 CLINIC 0.343957 0 0 90.07.90 91.00 09100 EMERGENCY 0.230405 2,148 495 91.92.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.947702 14,192 13,450 92.00.00 90.00 DISERVATION BEDS (NON-DI STINCT PART) 0.947702 14,192 13,450 92.00.00 1,155,526 365,283 200.00 1,1 | | | | | | | | |
| 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.404994 13,382 5,420 71. 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.378880 0 0 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 0.382108 53,752 20,539 73. 76.00 03020 ONCOLOGY 2.886911 0 0 76. 76.00 07697 CARDIA C REHABILITATION 0.573099 0 0 76. 0010000 CLINIC 0 0.343957 0 0 90. 91.00 90.00 91.00 90.00 0 90. 91.00 9200 08SERVATION BEDS (NON-DI STINCT PART) 0.230405 2,148 495 91. 92.00 09200 0BSERVATION BEDS (NON-DI STINCT PART) 0.947702 14,192 13,450 92. 92.00 1,155,526 365,283 200. 200.00 1,155,526 365,283 200. | | | | | | 8, 252 | | |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.378880 0 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 0.382108 53,752 20,539 73. 76.00 03020 ONCOLOGY 2.886911 0 0 76. 76.07 07677 CARDI AC REHABILITATION 0.573099 0 0 76. 000 04077 CARDI AC REHABILITATION 0.343957 0 0 76. 90.00 09000 CLINIC 0.343957 0 0 90. 91.00 09100 EMERGENCY 0.230405 2,148 495 91. 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.947702 14,192 13,450 92. 200.00 Total (sum of lines 50 through 94 and 96 through 98) 1,155,526 365,283 200. | | | | | | 0 | - | |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0.382108 53,752 20,539 73. 76.00 03020 ONCOLOGY 2.886911 0 0 76. 76.97 07697 CARDI AC REHABILITATION 0.573099 0 0 76. 000 0407 CARDI AC REHABILITATION 0.343957 0 0 76. 90.00 09000 CLINIC 0.343957 0 0 90. 91.00 09100 EMERGENCY 0.230405 2,148 495 91. 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.947702 14,192 13,450 92. 200.00 Total (sum of lines 50 through 94 and 96 through 98) 1,155,526 365,283 200. | | | | | | 13, 382 | | |
| 76. 00 03020 ONCOLOGY 2.886911 0 0 76. 76. 97 07697 CARDI AC_REHABILITATION 0.573099 0 0 76. 00TPATI ENT_SERVICE_COST_CENTERS 0 0.343957 0 0 90. 91. 09100 EMERGENCY 0.230405 2,148 495 91. 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 20.947702 14, 192 13, 450 92. 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 1, 155, 526 365, 283 200. | | | | | | 0 | - | |
| 76. 97 07697 CARDI AC REHABILITATION 0.573099 0 76. 97 0UTPATI ENT SERVICE COST CENTERS 00000 CLINIC 0.343957 0 00 90. 91. 00 09100 EMERGENCY 0.230405 2, 148 495 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.947702 14, 192 13, 450 92. 200. 00 Total (sum of Lines 50 through 94 and 96 through 98) 1, 155, 526 365, 283 200. | | | | | | - | | |
| OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.343957 0 0 90. 91. 00 09100 EMERGENCY 0.230405 2, 148 495 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.947702 14, 192 13, 450 92. 200. 00 Total (sum of Lines 50 through 94 and 96 through 98) 1, 155, 526 365, 283 200. | | | | | | - | | |
| 90.00 09000 CLINIC 0.343957 0 0 90. 91.00 09100 EMERGENCY 0.230405 2,148 495 91. 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.947702 14,192 13,450 92. 200.00 Total (sum of lines 50 through 94 and 96 through 98) 1,155,526 365,283 200. | | | | 0.5730 | 99 | 0 | 0 | 76.97 |
| 91. 00 09100 EMERGENCY 0. 230405 2, 148 495 91. 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 947702 14, 192 13, 450 92. 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 1, 155, 526 365, 283 200. | | | | 0.0400 | | | | |
| 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 947702 14, 192 13, 450 92. 200. 00 Total (sum of Lines 50 through 94 and 96 through 98) 1, 155, 526 365, 283 200. | | | | | | Ű | - | |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) 1, 155, 526 365, 283 200. | | | | | | | | |
| | | brough 09) | | 0.9477 | 02 | | | |
| | | | 61) | | | 1, 155, 526 | 300, 283 | 200.00 |
| | | in only charges (TTHE | : 01) | | | 1 155 524 | | 201.00 |
| | 202.00 priet charges (The 200 minus The 201) | | I | l | | 1, 155, 520 | | 1202.00 |

| INPATLENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-0001 Period: To 12/31/2016 Period: To 12/31/2016 Worksheet D-3 Cost Center Description Title XIX Hospital Cost Inpatient Program Costs (col 1 x col 2) District of Cost Program Costs (col 1 x col 2) Inpatient Program Costs (col 1 x col 2) Inpatient Progra | Health Financial Systems | JOHNSON MEMORIAL | HOSPI TAL | | In Lie | u of Form CMS-: | 2552-10 |
|---|--|--------------------|------------|--------------|---------------|-----------------|---------|
| Image: construction To 12/31/2016 Date/Time Propared: 1/16/2018 Date/Time Propared: 1/16/2018 Cost Center Description Title XIX Hospital Cost Inpatient Program | INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | | Provider C | CN: 15-0001 | | Worksheet D-3 | |
| Intervent Intervent <t< td=""><td></td><td></td><td></td><td></td><td></td><td>Data /Tima Dra</td><td>norod.</td></t<> | | | | | | Data /Tima Dra | norod. |
| Title XIX Hospital Cost Cost Center Description Ratio of Cost To Charges Inpati ent Program Charges Inpati ent Program Charges Inpati ent Program Charges Program Charges Cost 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03100 (INTENSIVE CARE UNIT 187.329 30.00 41.00 04100 SUBPROVIDER - IRF 187.329 30.00 43.00 06000 (NURSERY 53.378 43.00 ANCI LLARY SERVICE COST CENTERS 0.51369 12.628 649 53.00 50.00 05000 (DFEATING ROOM 0.224099 81.399 18.241 50.00 50.00 05000 (DSCOST CENTERS 0.51369 12.628 649 53.00 50.00 05000 (DAGRATING ROOM 0.224099 81.399 18.241 50.00 50.00 05000 (DSCORTORY 0.51369 12.628 649 53.00 50.00 05000 (DAGRATORY 0.321835 22.792 7.335 65.00 66.00 06600 PHYSICAL THERAPY 0.324916< | | | | | 10 12/31/2016 | | |
| INPATI ENT ROUTI NE SERVICE COST CENTERS Program Costs (col 1 x col. 2) Program Costs (col 1 x col. 2) 30.00 03000 ADULTS & PEDI ATRICS 30.00 31.00 03100 INTENSIVE CARE UNI T 10.08 44 31.00 41.00 04100 SUBPROVI DER - 1 RF 0 10.08 64 31.00 43.00 04300 NURSERV 0 0.224099 81.399 18.241 50.00 55.00 050300 ARSERV 0.013320 18.528 2.841 54.00 0 0 0.321835 22.792 7.335 65.00 0 0.6000 0.6000 ARDIOLOGY DIAL THERAPY 0.2270719 4.138 860 67.00 66.00 0 65.00 0.6500 RESPI RATORY THERAPY 0.321835 22.792 7.335 | | | Titl | e XIX | Hospi tal | Cost | |
| INPATI ENT ROUTINE SERVICE COST CENTERS Charges (col. 1 x col. 2) 1.00 2.00 3.00 31.00 03000 ADULTS & PEDIATRICS 187, 329 30.00 31.00 03100 INTENSIVE CARE UNIT 10, 864 31.00 41.00 41.00 53, 378 43.00 ANCILLARY SERVICE COST CENTERS 53, 378 43.00 ANCILLARY SERVICE COST CENTERS 53, 378 43.00 ANCILLARY SERVICE COST CENTERS 53, 378 43.00 0.00 05000 (OPERATING ROOM 0.224099 81, 399 18, 241 50.00 50.00 05000 (OPERATING ROOM 0.224099 81, 399 18, 241 50.00 50.00 05000 (OPERATING ROOM 0.224099 81, 399 18, 241 50.00 50.00 05000 (OPERATING ROOM 0.224099 81, 399 18, 241 50.00 60.00 06000 (ABOLGAVIDA ROADSTIC 0.513320 18, 528 2, 841 54.00 66.00 06500 (RESPI RATORY THERAPY 0.321835 22, 792 7, 335 66.00 | Cost Center Description | | | Ratio of Cos | t Inpatient | I npati ent | |
| Impart ENT_ROUTINE_SERVICE_COST_CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 187,329 30.00 41.00 04100 SUBPROVIDER - IRF 10,664 31.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 43.00 05000 OPERATING ROOM 53,378 43.00 60.00 05000 OPERATING ROOM 0.224009 81,399 18,241 50.00 05000 OPERATING ROOM 0.051369 12,628 644 53.00 05300 ANESTHESIOLOGY 0.153320 18,528 2,841 50.00 54.00 05600 RSPI RATORY THERAPY 0.199676 51,491 10,222 60.00 65.00 06500 RSPI RATORY THERAPY 0.3321835 22,792 7,335 68.00 60.00 06800 SPEECH PATHORY THERAPY 0.227637 3,514 800 69.00 60.00 06800 SPECH PATHOLOGY 0.227637 3,514 800 69.00 60.00 06800 SPECH PATHOLOGY 0.332181 50,521 19,304 70.00 | | | | To Charges | | | |
| INPATI ENT_ROUTI NE_SERVI CE_COST_CENTERS 0.00 03000 ADULTS & PEDI ATRI CS 30.00 31.00 03100 INTENSI VE CARE_UNI T 10,864 31.00 41.00 04100 SUBPROVI DER - I RF 0 43.00 41.00 ANCILLARY_SERVI CE_COST_CENTERS 0 0 43.00 ANCILLARY_SERVI CE_COST_CENTERS 0 0.53.03 18.241 50.00 50.00 05000 OPERATI NG ROM 0.224099 81.399 18.241 50.00 53.00 05300 ANESTHESI OLOGY 0.153320 18.528 2.841 54.00 64.00 0.0000 (DABATTORY 0.19676 51.491 10.282 66.00 65.00 06500 RESPI RATORY THERAPY 0.321835 22.792 7.335 65.00 66.00 06600 OPERATIONAL THERAPY 0.227719 4.138 860 67.00 67.00 06700 OCLARDATIONAL THERAPY 0.227719 4.138 860 67.00 68.00 06600 SPEECH PATHOLOGY 0.334916 1.068 388 68.07 0.00 | | | | | Charges | | |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 187,329 30.00 41.00 04100 SUBPROVIDER - I RF 0 41.00 43.00 04000 NURSERY 0 41.00 ANCILLARY SERVICE COST CENTERS 53.378 43.00 50.00 05000 OPERATING ROOM 0.224099 81.399 18.241 50.00 05000 ADESTHESI OLOCY 0.051369 12.628 649 53.00 05500 ANESTHESI OLOCY 0.153320 18.528 2.841 54.00 05400 RADI OLOGY - DI AGNOSTI C 0.139676 51.491 10.282 60.00 65.00 06500 RESPI RATORY THERAPY 0.321835 22.792 7.335 65.00 66.00 06600 PHYSI CAL THERAPY 0.207719 4.138 860 67.00 67.00 0CENTIONAL THERAPY 0.334916 1.068 358 68.00 68.00 06800 SPEECH PATHOLOGY 0.334916 1.068 358 68.00 69.00 0700 CUELECTROCARDI OLOCY 0.37880 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<> | | | | | | | |
| 30.00 03000 ADULTS & PEDI ATRICS 187, 329 30.00 31.00 03100 INTENSI VE CARE UNI T 10, 864 31.00 41.00 GUADOS UBPROVI DER - IRF 0 0 43.00 ANDIO SUBPROVI DER - IRF 0 53, 378 43.00 ANDI LLARY SERVICE COST CENTERS 0.5000 0PERATING ROOM 0.224099 81, 399 18, 241 50.00 50.00 05000 0PERATING ROOM 0.15320 18, 528 2, 841 54.00 60.00 06000 LABORATORY 0.153320 18, 528 2, 841 54.00 60.00 06000 LABORATORY 0.153320 18, 528 2, 841 54.00 61.00 06000 LABORATORY 0.321835 22, 792 7, 335 65.00 65.00 06500 OCQUPATI ONAL THERAPY 0.227637 3, 514 860 67.00 68.00 06800 SPEECH PATHOLOGY 0.334916 1, 068 358 68.00 72.00 71.00 07100 MEDCAL SUPPLIES CHARGED TO PATI ENTS 0.342965 338 200 70.00 | | | | 1.00 | 2.00 | 3.00 | |
| 31.00 03100 INTENSIVE CARE UNIT 10,864 31.00 41.00 04100 SUBPROVIDER - IRF 0 43.00 43.00 04100 SUBPROVIDER - IRF 0.33.378 43.00 43.00 00 05000 DPERATING ROM 0.224099 81,399 18,241 50.00 50.00 05000 DPERATING ROM 0.051369 12,628 649 53.00 54.00 05400 RADIOLOGY 0.051369 12,628 649 53.00 54.00 05400 RADIOLOGY 0.199676 51.491 10.282 60.00 65.00 05600 RSPI RATORY THERAPY 0.321835 22,792 7.335 65.00 06000 CCUPATI ONAL THERAPY 0.457113 4,214 1,926 66.00 67.00 06700 0C207719 4,138 860 67.00 0.027719 4,138 860 67.00 69.00 06600 ELECTROCARDIOLOGY 0.227637 3,514 800 69.00 70.00 00000 12,648 9,981 11.00 71.00 MDIAL SCHARGED TO PA | | | | | 107.000 | | 0.00 |
| 41.00 04100 SUBPROVI DER - IRF 0 41.00 43.00 04300 NURSERY 53.378 41.00 43.00 04300 NURSERY 53.378 43.00 43.00 05000 OPERATI NG ROOM 0.224099 81,399 18,241 50.00 53.00 05300 ANESTHESI OLOGY 0.051369 12,628 649 53.00 54.00 05400 RAD IOGY-DI AGNOSTI C 0.153320 18,528 2,841 50.00 60.00 66000 PKPI RATRY THERAPY 0.19676 51,491 10,282 60.00 65.00 06500 RESPI RATORY THERAPY 0.321835 22,792 7,335 65.00 64.00 064000 CUPATI ONAL THERAPY 0.207719 4,138 860 67.00 67.00 06700 DCUPATI ONAL THERAPY 0.227637 3,514 800 69.00 68.00 06800 SPECH PATHOLOGY 0.227637 3,514 800 69.00 70.00 70.00 OTOOD ELECTROCARDI DLOGY 0.384916 1.006 72.00 73.00 | | | | | | | |
| 43.00 04300 NURSERY 53,378 43.00 ANCI LLARY SERVICE COST CENTERS 5000 0PERATING ROOM 0.224099 81,399 18,241 50.00 53.00 05300 ANESTHESI OLOGY 0.051369 12,628 649 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.153320 18,528 2,841 54.00 60.00 0600 LABORATORY 0.19676 51,491 10,282 60.00 65.00 06500 RESPI RATORY THERAPY 0.321835 22,792 7,335 65.00 66.00 06600 PHYSI CAL THERAPY 0.457113 4,214 1,926 66.00 67.00 0CCUPATI ONAL THERAPY 0.334916 1,068 358 68.00 69.00 0.06800 SPECH PATHOLOGY 0.227637 3,514 800 69.00 70.00 0.0100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.404994 24,688 9.998 71.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.382108 50,521 19,304 73.00 74.00 | | | | | | | |
| ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROM 0.224099 81,399 18,241 50. 00 53. 00 05300 ANESTHESI OLOGY 0.051369 12,628 649 53. 00 54. 00 06400 RADI OLOGY-DI AGNOSTI C 0.153320 18,528 2,841 54. 00 60. 00 06000 LABORATORY 0.199676 51,491 10,282 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.321835 22,792 7,335 65. 00 66. 00 06000 LHERAPY 0.457113 4,214 1,926 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.207719 4,138 860 67. 00 68. 00 68000 SPEECH PATHOLOGY 0.3247637 3,514 800 69. 00 0 07000 ELECTROCARDI OLOGY 0.590650 338 200 70. 00 70. 00 O7200 IMELCTRENECED TO PATI ENTS 0.404994 24,688 9,998 71. 00 | | | | | - | | |
| 50.00 05000 OPERATI NG ROOM 0.224099 81,399 18,241 50.00 53.00 05300 ANESTHESI OLOGY 0.051369 12,628 649 53.00 64.00 05400 RADI LOGY-DI AGNOSTI C 0.153320 18,528 2,841 54.00 60.00 06000 LABORATORY 0.199676 51.491 10,228 60.00 65.00 06500 RESPI RATORY THERAPY 0.321835 22,792 7,335 65.00 66.00 06600 PHYSI CAL THERAPY 0.457113 4,214 1,926 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.334916 1,068 358 68.00 67.00 0 05000 ELECTROCARDI OLOGY 0.334916 1,068 358 68.00 69.00 07000 ELECTROCARDI OLOGY 0.33818 200 70.00 71.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 <t< td=""><td></td><td></td><td></td><td></td><td>53, 378</td><td></td><td>43.00</td></t<> | | | | | 53, 378 | | 43.00 |
| 53.00 05300 ANESTHESI OLOGY 0.051369 12,628 649 53.00 54.00 05400 RADI OLOCY-DI AGNOSTI C 0.153320 18,528 2,841 54.00 60.00 06000 LABORATORY 0.199676 51,491 10,282 60.00 65.00 06500 RESPI RATORY THERAPY 0.321835 22,792 7,335 65.00 66.00 06600 PHYSI CAL THERAPY 0.457113 4,214 1,926 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.457113 4,214 1,926 66.00 68.00 SPEECH PATHOLOGY 0.227637 3,514 800 67.00 69.00 OF000 ELECTROCARDI OLOGY 0.227637 3,514 800 69.00 70.00 O7000 ELECTROCARDED TO PATI ENTS 0.404994 24,688 9,998 71.00 73.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0.382108 50,521 19,304 74.00 O7300 DRUGS CHARGED TO PATI ENTS 0.382108 50,521 19,304 73.00 75.00 | | | | 0.2240 | 0 01 200 | 10 2/1 | 50.00 |
| 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.153320 19, 528 2, 841 54.00 60.00 06000 LABORATORY 0.199676 51, 491 10, 282 60.00 65.00 06500 RESPI RATORY THERAPY 0.321835 22, 792 7, 33 65.00 66.00 06600 PHYSI CAL THERAPY 0.457113 4, 214 1, 926 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.207719 4, 138 860 67.00 68.00 06800 SPEECH PATHOLOGY 0.334916 1, 068 358 68.00 69.00 06900 ELECTROCARDI OLOGA 0.227637 3, 514 800 69.00 70.00 OT000 ELECTROCARDI OLOGAPHY 0.334916 1, 068 358 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.404994 24, 688 9, 998 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.382108 50, 521 19, 304 73.00 76.00 03020 ONCOLOGY 2.866911 0 0 76.00 | | | | | | | |
| 60.00 06000 LABORATORY 0.199676 51,491 10,282 60.00 65.00 06500 RESPIRATORY THERAPY 0.321835 22,792 7,335 65.00 66.00 06600 PHYSI CAL THERAPY 0.457113 4,214 1,926 66.00 67.00 06700 0C20PATI ONAL THERAPY 0.207719 4,138 860 67.00 68.00 06800 SPEECH PATHOLOGY 0.334916 1,068 358 68.00 69.00 06900 ELECTROCARDI OLOGY 0.227637 3,514 800 69.00 70.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.404994 24,688 9,998 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.382108 50,521 19,304 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.343957 0 0 76.00 76.97 CARDI AC REHABI LI TATI ON 0.573099 0 0 70.00 76.00 71.00 09000 CLI NI C 0.343957 0 0 90.00 76.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | | | | | |
| 65.00 06500 RESPI RATORY THERAPY 0.321835 22,792 7,335 65.00 66.00 06600 PHYSI CAL THERAPY 0.457113 4,214 1,926 66.00 67.00 0CCUPATI ONAL THERAPY 0.207719 4,138 860 67.00 68.00 06800 SPEECH PATHOLOGY 0.334916 1,068 358 68.00 69.00 06900 ELECTROCARDI OLOGY 0.227637 3,514 800 69.00 70.00 0700 ELECTROENCEPHALOGRAPHY 0.590650 338 200 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.404994 24,688 9,998 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.382108 50,521 19,304 73.00 76.00 03020 ONCOLOGY 2.866911 0 0 76.97 76.97 0.017PATI ENT SERVICE COST CENTERS 0.343957 0 0 76.97 90.00 90.00 90.00 92.00 90.00 09000 CLINI C 0.343957 0 | | | | | | | |
| 66.00 06600 PHYSI CAL THERAPY 0.457113 4,214 1,926 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.207719 4,138 860 67.00 68.00 06800 SPEECH PATHOLOGY 0.334916 1,068 358 68.00 69.00 06900 ELECTROCARDI OLOGY 0.227637 3,514 800 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.590650 338 200 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.404994 24,688 9,998 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.378880 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.382108 50,521 19,304 73.00 76.00 03020 ONCOLOGY 2.886911 0 0 76.97 0.01741 ENT SERVICE COST CENTERS 0.343957 0 0 90.00 90.00 76.97 90.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.343957 0 0 90.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | | | | | |
| 67.00 06700 OCCUPATIONAL THERAPY 0.207719 4,138 860 67.00 68.00 06800 SPEECH PATHOLOGY 0.334916 1,068 358 68.00 69.00 06900 ELECTROCARDIOLOGY 0.227637 3,514 800 69.00 70.00 07000 ELECTROCARDIOLOGY 0.227637 3,514 800 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.404994 24,688 9,98 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.37880 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.382108 50,521 19,304 73.00 76.00 03020 ONCOLOGY 2.886911 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 0.573099 0 0 76.97 001700 EMERGENCY 0.343957 0 0 90.00 91.00 09100 EMERGENCY 0.230405 15,089 3,477 91.00 92.00 092200 OBSERVATION BEDS (NON-DISTINCT PAR | | | | | | | |
| 68.00 06800 SPEECH PATHOLOGY 0.334916 1,068 358 68.00 69.00 06900 ELECTROCARDI OLOGY 0.227637 3,514 800 69.00 70.00 07000 ELECTRONCEPHALOGRAPHY 0.590650 338 200 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.404994 24,688 9,998 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.378880 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.382108 50,521 19,304 73.00 76.00 03020 ONCOLOGY 2.886911 0 0 76.00 76.97 OR697 CARDI AC REHABI LI TATI ON 0.573099 0 0 76.97 001704 D9100 EMERGENCY 0.343957 0 0 90.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.343957 0 0 92.00 09200 DSERVATI ON BEDS (NON-DI STINCT PART) 0.947702 0 0 92.00 | | | | | | | |
| 69.00 06900 ELECTROCARDI OLOGY 0.227637 3,514 800 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.590650 338 200 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.404994 24,688 9,998 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.378880 0 0 72.00 73.00 07300 RUGS CHARGED TO PATIENTS 0.382108 50,521 19,304 73.00 76.00 03020 ONCOLOGY 2.886911 0 0 76.00 76.70 07697 CARDI AC REHABILITATION 0.573099 0 0 76.97 001PATIENT SERVICE COST CENTERS 0.343957 0 0 90.00 | | | | | | | 1 |
| 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.404994 24,688 9,998 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.378880 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.382108 50,521 19,304 73.00 76.00 03020 ONCOLOGY 2.886911 0 0 76.00 76.97 ORADI AC REHABILITATION 0.573099 0 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0.343957 0 0 90.00 90.00 09000 CLINIC 0.343957 0 90.00 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.230405 15,089 3,477 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 92.00 0 0 92.00 0 0 92.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 200.00 201.00 201.00 | 69. 00 06900 ELECTROCARDI OLOGY | | | 0. 2276 | 37 3, 514 | 800 | 69.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.378880 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.382108 50,521 19,304 73.00 76.00 03020 ONCOLOGY 2.886911 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 0.573099 0 0 76.97 0000 09000 CLINIC 0.343957 0 0 90.00 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.343957 0 0 92.00 200.00 D9200 OBSERVATION BEDS (NON-DISTINCT PART) 0.947702 0 0 92.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00 201.00 | 70.00 07000 ELECTROENCEPHALOGRAPHY | | | 0. 5906 | 50 338 | 200 | 70.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS 0.382108 50, 521 19, 304 73.00 76.00 03020 ONCOLOGY 2.886911 0 0 76.00 76.97 07697 CARDI AC_REHABILITATION 0.573099 0 0 76.97 0000 CLI NI C 0.343957 0 0 90.00 90.00 90.00 09100 EMERGENCY 0.343957 0 0 92.00 0 92.00 0 92.00 0 0.947702 0 0 92.00 0 20.00 200.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 201.00 201.00 201.00 201.00 201.00 0 201.00 0 201.00 | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | | 0. 4049 | 24, 688 | 9, 998 | 71.00 |
| 76.00 03020 ONCOLOGY 2.886911 0 0 76.00 76.97 07697 CARDI AC_REHABILITATION 0.573099 0 0 76.97 OUTPATI ENT SERVICE COST CENTERS 0 0.343957 0 0 90.00 90.00 09100 CLINIC 0.343957 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.947702 0 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 290,408 76,271 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | 72.00 07200 IMPL. DEV. CHARGED TO PATIENT | | | 0. 3788 | 30 0 | 0 | 72.00 |
| 76. 97 O7697 CARDI AC REHABILITATION 0.573099 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0 0.343957 0 0 90.00 90.00 09100 EMERGENCY 0.343957 0 0 90.00 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART) 0.947702 0 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 290,408 76,271 200.00 201.00 201.00 201.00 0 201.00 0 201.00 0 201.00 0 0 201.00 0 0 201.00 0 201.00 0 201.00 0 0 201.00 0 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 0 201.00 0 201.00 0 201.00 0 201.00 201.00 0 201.00 0 201.00 201.00 201.00 201.00 <t< td=""><td></td><td></td><td></td><td>0. 38210</td><td>50, 521</td><td>19, 304</td><td>73.00</td></t<> | | | | 0. 38210 | 50, 521 | 19, 304 | 73.00 |
| OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.343957 0 0 90.00 91.00 09100 EMERGENCY 0.230405 15,089 3,477 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.947702 0 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 290,408 76,271 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | | | 0 | |
| 90. 00 09000 CLINIC 0.343957 0 0 90. 00 91. 00 09100 EMERGENCY 0.230405 15, 089 3, 477 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0. 947702 0 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 290, 408 76, 271 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 | | | | 0. 5730 | 99 0 | 0 | 76.97 |
| 91.00 09100 EMERGENCY 0.230405 15,089 3,477 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.947702 0 0 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 290,408 76,271 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | | | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.947702 0 92.00 92.00 200.00 Total (sum of lines 50 through 94 and 96 through 98) 290,408 76,271 200.00 201.00 201.00 0 201.00 20 | | | | | | - | |
| 200.00 Total (sum of lines 50 through 94 and 96 through 98) 290,408 76,271 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | | | | |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00 | | | | 0. 94770 | | - | |
| | | | | | 290, 408 | 76, 271 | 1 |
| 202.00 Net charges (line 200 minus line 201) 290,408 202.00 | | ogram only charges | (line 61) | | 0 | | |
| | 202.00 Net charges (line 200 minus line 201) | | | I | 290, 408 | | 202.00 |

| Health Financial Sys | stems | JOHNSON MEMORIAL | HOSPI TAL | | | In Lie | u of Form CMS-2 | 2552-10 |
|-----------------------|---------------------------------|------------------|-------------|--------------|----|---------------|--------------------------------|---------------|
| INPATIENT ANCILLARY | SERVICE COST APPORTIONMENT | | Provider C | CN: 15-0001 | | i od: | Worksheet D-3 | |
| | | | | | | m 01/01/2016 | | |
| | | | Component (| CCN: 15-T001 | To | 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pared: |
| | | | Ti †I | e XIX | SI | ibprovi der - | Cost | <u>i pili</u> |
| | | | | e xix | | IRF | 0031 | |
| Cost Ce | nter Description | | | Ratio of Cos | | Inpati ent | Inpati ent | |
| | | | | To Charges | | | Program Costs | |
| | | | | | | Charges | (col. 1 x col. | |
| | | | | | | | 2) | |
| | | | | 1.00 | | 2.00 | 3.00 | |
| | ITINE SERVICE COST CENTERS | | | | | | | |
| 30.00 03000 ADULTS | | | | | | 0 | | 30.00 |
| 31.00 03100 I NTENSI | | | | | | 0 | | 31.00 |
| 41.00 04100 SUBPROV | | | | | | 9, 277 | | 41.00 |
| 43.00 04300 NURSERY | | | | | | 0 | | 43.00 |
| | RVICE COST CENTERS | | | | | | | |
| 50.00 05000 OPERATI | | | | 0. 2240 | | 0 | 0 | 50.00 |
| 53.00 05300 ANESTHE | | | | 0.0513 | | 0 | 0 | 53.00 |
| | GY-DI AGNOSTI C | | | 0. 1533 | | 0 | 0 | 54.00 |
| 60.00 06000 LABORAT | | | | 0. 1996 | | 282 | 56 | 60.00 |
| 65. 00 06500 RESPI RA | | | | 0. 3218 | | 604 | 194 | 65.00 |
| 66. 00 06600 PHYSI CA | | | | 0. 4571 | | 3, 859 | 1, 764 | 66.00 |
| | IONAL THERAPY | | | 0. 2077 | 19 | 3, 819 | 793 | 67.00 |
| 68.00 06800 SPEECH | PATHOLOGY | | | 0. 3349 | 16 | 709 | 237 | 68.00 |
| 69.00 06900 ELECTRO | | | | 0. 2276 | - | 0 | 0 | 69.00 |
| | ENCEPHALOGRAPHY | | | 0. 5906 | | 0 | 0 | 70.00 |
| 71.00 07100 MEDI CAL | SUPPLIES CHARGED TO PATIENTS | | | 0. 4049 | 94 | 12 | 5 | 71.00 |
| 72.00 07200 IMPL. D | EV. CHARGED TO PATIENT | | | 0. 3788 | 80 | 0 | 0 | 72.00 |
| 73.00 07300 DRUGS C | HARGED TO PATIENTS | | | 0. 3821 | 80 | 0 | 0 | 73.00 |
| 76.00 03020 ONCOLOG | Y | | | 2.8869 | 11 | 0 | 0 | 76.00 |
| 76. 97 07697 CARDI AC | REHABI LI TATI ON | | | 0. 5730 | 99 | 0 | 0 | 76.97 |
| | RVICE COST CENTERS | | | _ | | | | |
| 90.00 09000 CLINIC | | | | 0. 3439 | 57 | 0 | 0 | 90.00 |
| 91.00 09100 EMERGEN | | | | 0. 2304 | | 0 | 0 | 91.00 |
| | TION BEDS (NON-DISTINCT PART) | | | 0. 9477 | 02 | 0 | 0 | 92.00 |
| | sum of lines 50 through 94 and | | | | | 9, 285 | 3, 049 | 200. 00 |
| | P Clinic Laboratory Services-Pr | | (line 61) | | | 0 | | 201.00 |
| 202.00 Net cha | rges (line 200 minus line 201) | | | | | 9, 285 | | 202.00 |
| | | | | | | | | |

| | Financial Systems JOHNSON MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Peri od: From 01/01/2016 To 12/31/2016 | u of Form CMS-2 Worksheet E Part A Date/Time Pre 1/16/2018 3:0 | pared: | |
|----------------|---|--------------------------|--|--|----------------|--|
| | | Title XVIII | Hospi tal | PPS | | |
| | | | | 1.00 | | |
| | PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS | | | 1.00 | | |
| . 00 . 01 | DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions) | ing prior to October 1 | see | 0 4, 372, 932 | 1. 00 1. 01 | |
| . 02 | DRG amounts other than outlier payments for discharges occurr instructions) | ing on or after October | 1 (see | 1, 305, 742 | 1. 02 | |
| . 03 | DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions) | or discharges occurring | prior to October | 0 | 1.03 | |
| . 04 | DRG for federal specific operating payment for Model 4 BPCl f October 1 (see instructions) | or discharges occurring | on or after | 0 | 1. 04 | |
| 2. 00 2. 01 | Outlier payments for discharges. (see instructions) Outlier reconciliation amount | | | 45, 325 0 | 2. 00 2. 01 | |
| 2. 02 5. 00 | Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments | i ons) | | 0 1, 276, 352 | 2.02 3.00 | |
| . 00 | Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment | rting period (see instru | uctions) | 82.59 | | |
| . 00 | FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions) | t recent cost reporting | period ending on | 0.00 | 5.00 | |
| . 00 | FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e) | the criteria for an add | on to the cap | 0.00 | 6. 00 | |
| . 00 . 01 | MMA Section 422 reduction amount to the IME cap as specified ACA Section 5503 reduction amount to the IME cap as specified | under 42 CFR §412.105(1 | | 0.00 0.00 | 7. 00 7. 01 | |
| 8. 00 | <pre>If the cost report straddles July 1, 2011 then see instructio Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).</pre> | 0.00 | 8.00 | | | |
| 8. 01 | The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. | | | | | |
| 8. 02 | | | | | | |
| 0. 00 | Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions) | (see | 0.00 | 9.00 | | |
| 0. 00 1. 00 | FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs. | ent year from your recou | ds | 0.00 0.00 | 10.00 11.00 | |
| 2.00 | Current year allowable FTE (see instructions) | | | | 12.00 | |
| 3.00 4.00 | Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye | ar ended on or after Sep | otember 30, 1997, | | 13.00 14.00 | |
| 5.00 | otherwise enter zero. Sum of lines 12 through 14 divided by 3. | | | 0.00 | 15.00 | |
| | Adjustment for residents in initial years of the program | | | | 16.00 | |
| | Adjustment for residents displaced by program or hospital clo | sure | | | 17.00 | |
| | Adjusted rolling average FTE count | | | | 18.00 | |
| 9.00 | Current year resident to bed ratio (line 18 divided by line 4 | .). | | 0.000000 | | |
| | Prior year resident to bed ratio (see instructions) | | | 0. 000000 0. 000000 | | |
| | IME payment adjustment (see instructions) | | | 0.000000 | 1 | |
| | IME payment adjustment - Managed Care (see instructions) | | | 0 | | |
| | Indirect Medical Education Adjustment for the Add-on for Sect Number of additional allopathic and osteopathic IME FTE resid | | Sec. 412.105 | | 23.00 | |
| 4. 00 | (f)(1)(iv)(C) IME FTE Resident Count Over Cap (see instructions) | | | 0.00 | | |
| | If the amount on line 24 is greater than -0-, then enter the instructions) | lower of line 23 or line | e 24 (see | | 25.00 | |
| 26.00 27.00 | Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions) | | | 0.000000 | | |
| | IME add-on adjustment amount (see instructions) | | | 0.000000 | | |
| 8.00 | IME add-on adjustment amount - Managed Care (see instructions) |) | | 0 | | |
| | Total IME payment (sum of lines 22 and 28) | | | 0 | | |
| 9.00 9.01 | Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment | | 0 | | | |
| 0.00 | Percentage of SSI recipient patient days to Medicare Part A p | atient days (see instru | ctions) | 3. 56 | 30.00 | |
| | Percentage of Medicaid patient days (see instructions) | | <i>,</i> | | 31.00 | |
| | Sum of lines 30 and 31 | | | 25.74 | | |
| 3.00 | Allowable disproportionate share percentage (see instructions |) | | 10.45 | | |
| | Disproportionate share adjustment (see instructions) | | | 148, 356 | | |

| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | | Period: | Worksheet E | |
|----------------|---|--------------------------------|---|----------------------|-------|
| | | | From 01/01/2016 To 12/31/2016 | Date/Time Pre | |
| | | Title XVIII | Hospi tal | 1/16/2018 3:0 PPS | I pm |
| | | | Prior to 10/1 | | |
| | | | 1.00 | 2.00 | |
| | Uncompensated Care Adjustment | | - I | | |
| 35.00 | | | | 5, 977, 483, 147 | |
| 35.01 35.02 | Factor 3 (see instructions) | tor zoro on this line) (coo | 0. 000046850 | 0. 000048129 | |
| 35. UZ | Hospital uncompensated care payment (If line 34 is zero, ent instructions) | tel zelo oli tilis i lie) (see | 300, 126 | 287, 693 | 35.0 |
| 35. 03 | Pro rata share of the hospital uncompensated care payment an | nount (see instructions) | 224, 685 | 72, 514 | 35.0 |
| 36.00 | Total uncompensated care (sum of columns 1 and 2 on line 35. | | 297, 199 | | 36.0 |
| | Additional payment for high percentage of ESRD beneficiary o | | | | |
| 40.00 | Total Medicare discharges on Worksheet S-3, Part I excluding | g discharges for MS-DRGs | 0 | | 40.0 |
| 41 00 | 652, 682, 683, 684 and 685 (see instructions) | | | | 41 0 |
| 41.00 | Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions) | 683, 684 an 685. (See | 0 | | 41.0 |
| 41.01 | Total ESRD Medicare covered and paid discharges excluding MS | S-DRGs 652 682 683 684 | 0 | | 41.0 |
| | an 685. (see instructions) | | , i i i i i i i i i i i i i i i i i i i | | |
| 42.00 | Divide line 41 by line 40 (if less than 10%, you do not qual | ify for adjustment) | 0.00 | | 42.0 |
| 43.00 | Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6 | 682, 683, 684 an 685. (see | 0 | | 43.0 |
| 44 00 | instructions) | | 0,000000 | | |
| 44.00 | Ratio of average length of stay to one week (line 43 divided days) | by The 41 divided by 7 | 0. 000000 | | 44.0 |
| 45.00 | Average weekly cost for dialysis treatments (see instruction | าร) | 0.00 | | 45.0 |
| 46.00 | Total additional payment (line 45 times line 44 times line 4 | | 0 | | 46. (|
| 47.00 | Subtotal (see instructions) | | 6, 169, 554 | | 47. |
| 48.00 | Hospital specific payments (to be completed by SCH and MDH, | small rural hospitals | 0 | | 48. |
| | only. (see instructions) | | | | |
| | | | | Amount 1.00 | |
| 49.00 | Total payment for inpatient operating costs (see instruction | 15) | | 6, 169, 554 | 49.0 |
| 50.00 | Payment for inpatient program capital (from Wkst. L, Pt. I a | | | 460, 715 | |
| 51.00 | Exception payment for inpatient program capital (Wkst. L, Pi | . III, see instructions) | | 0 | |
| 52.00 | Direct graduate medical education payment (from Wkst. E-4, I | ine 49 see instructions). | | 0 | |
| 53.00 | Nursing and Allied Health Managed Care payment | | | 0 | |
| 54.00 54.01 | Special add-on payments for new technologies | | | 0 | |
| 55.00 | Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line | 69) | | 0 | |
| 56.00 | Cost of physicians' services in a teaching hospital (see int | | | 0 | |
| 57.00 | Routine service other pass through costs (from Wkst. D, Pt. | | rough 35). | 0 | |
| 58.00 | Ancillary service other pass through costs from Wkst. D, Pt. | IV, col. 11 line 200) | | 0 | 58. |
| 59.00 | Total (sum of amounts on lines 49 through 58) | | | 6, 630, 269 | |
| 60.00 | Primary payer payments | | | 0 | |
| 51.00 52.00 | Total amount payable for program beneficiaries (line 59 minu Deductibles billed to program beneficiaries | is line 60) | | 6, 630, 269 | |
| 52.00 | Coinsurance billed to program beneficiaries | | | 717, 164 3, 220 | |
| 54. 00 | Allowable bad debts (see instructions) | | | 64, 480 | |
| 55.00 | Adjusted reimbursable bad debts (see instructions) | | | 41, 912 | |
| 66.00 | Allowable bad debts for dual eligible beneficiaries (see ins | structions) | | 15, 473 | |
| 67.00 | Subtotal (line 61 plus line 65 minus lines 62 and 63) | | | 5, 951, 797 | |
| 68.00 | Credits received from manufacturers for replaced devices for | | | 0 | |
| 69.00 | Outlier payments reconciliation (sum of lines 93, 95 and 96) | . (For SCH see instructions) |) | 0 | |
| 70.00 70.50 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT | | | 0 | |
| 70. 30 | SCH or MDH volume decrease adjustment | | | 0 | |
| 70.88 | Pioneer ACO demonstration payment adjustment amount (see ins | structions) | | 0 | |
| 70.90 | HSP bonus payment HVBP adjustment amount (see instructions) | | | 0 | |
| 70. 91 | HSP bonus payment HRR adjustment amount (see instructions) | | | 0 | |
| 70. 92 | Bundled Model 1 discount amount (see instructions) | | | 0 | |
| 70. 93 | HVBP payment adjustment amount (see instructions) | | | -8, 128 | |
| 70.94 | HRR adjustment amount (see instructions) Recovery of accelerated depreciation | | | -5, 247 | 70. |
| 70.95 | | | | | |

| CALCULATION OF REINBURSEMENT SETTLEMENT Provider CON: 15-001 Period: To 12/31/2016 Worksheet E Part A To 12/31/2016 Date: Time Prepared: 1716/2018 3:01 pm Title XVIII Hospital PPS To 2010 FFV (syyy) Amount 0 0 70.96 To volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 0 0 70.97 70.96 Low volume adjustment (see instructions) 0 0 70.97 0 0 70.97 70.97 Volume Payment-3 0 0 70.97 0 0 70.97 70.98 Low Volume Payment-3 0 0 70.97 0 70.97 70.08 Volume Payment-3 0 0 70.97 0 70.97 70.04 Adjustment amount (see instructions) 118.768 71.01 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.0 | Heal th | Financial Systems | JOHNSON MEMORIAL | HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---|----------|---|--|------------|-----|----------------------------------|--|---------|
| FFY (yyyy) Amount 0 1.00 70. 96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) 0 0 70. 96 0.79 Low volume adjustment for federal fiscal year for the period prior to 10/1) 0 0 70. 96 0.79 Low volume adjustment for federal fiscal year for the period ending on or after 10/1) 0 0 70. 98 0.79 Low Volume Payment-3 0 70. 98 0 70. 99 70.0 Maount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 5. 938, 422 71. 00 71.01 Sequestration adjustment for contractor use only) 5. 880, 069 72. 09 73.00 Tentati ve settlement (for contractor use only) 5. 880, 069 73. 00 74.00 Balance due provider (Program) (line 71 minus lines 71. 01, 72, and 73) -60. 415 74. 00 75.00 Protested amounts (nonal lowable cost report items) in accordance with 0 92.00 00 Operating outlier amount from Wkst. E, Pt. A, line 2 0 0 92.00 92.00 Operating outlier amo | CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | | | | From 01/01/2016 To 12/31/2016 | Part A Date/Time Pre 1/16/2018 3:0 | |
| 0 1.00 70. 96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) 0 0 70. 96 10. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 0 0 70. 96 70. 97 Low Volume Agment-3 0 70. 97 0 70. 99 90 Ad adjustment amount (see instructions) 0 70. 99 70. 99 91. 00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 5, 938, 422 71. 00 71. 01 Sequestration adjustment (for contractor use only) 5, 880, 069 72. 00 73. 00 Tentative settlement (for contractor use only) -60, 415 74. 00 75. 00 Operating outlier mount from Wkst. E. Pt. A, line 2 (see instructions) 0 91.00 90. 00 Operating outlier reconciliation adjustment amount (see instructions) 0 92. 00 91. 00 Capital outlier reconciliation adjustment amount (see instructions) 0 92. 00 92. 00 Operating outlier reconciliation adjustment amount (see instructions) | | | | Title | | | PPS | |
| 70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1) 0 0 70.96 70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 0 0 70.97 70.98 Low Volume Payment-3 0 70.98 0 70.98 70.98 Low Volume Adjustment for federal fiscal year (yyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1) 0 0 70.96 70.98 Low Volume Payment-3 0 70.98 0 70.98 71.01 Sequestration adjustment (see instructions) 118,768 71.00 71.00 72.00 Interim payments 5,880.069 72.00 73.00 76.08 73.00 70.00 Potested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 71.06 73.00 70.00 Capital outlier reconciliation adjustment amount (see instructions) 0 90.00 91.00 92.00 91.00 Capital outlier reconciliation adjustment amount (see instructions) 0 92.00 92.00 93.00 94.00 | | | | | FFY | (уууу) | | |
| the corresponding federal year for the period prior to 10/1) 0 0 70.97 10.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0) 0 0 70.97 10.99 HAC adjustment amount (see instructions) 0 0 70.99 10.99 HAC adjustment amount (see instructions) 0 0 70.99 11.00 Sequestration adjustment (see instructions) 0 118.768 71.01 12.00 Interim payments 5.880.069 72.00 118.768 71.01 12.00 Interim payments 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 75.00 99.00 9 | | | | | | 0 | | |
| the corresponding federal year for the period ending on or after 10/1) 70.98 1000000000000000000000000000000000000 | 70. 96 | Low volume adjustment for federal fiscal year the corresponding federal year for the perio | ar (yyyy) (Enter in od prior to 10/1) | n column O | | 0 | 0 | 70. 96 |
| 70.98 Low Volume Payment-3 0 70.98 70.99 HAC adjustment amount (see instructions) 0 70.98 70.09 HAC adjustment amount (see instructions) 0 70.98 71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 5,938,422 71.00 71.01 Sequestration adjustment (see instructions) 118,768 71.01 72.00 Interim payments 0 73.00 73.00 74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) -60,415 74.00 75.00 Potested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1. §115.2 0 70.99 70.02 To BE COMPLETED BY CONTRACTOR (lines 90 through 96) 0 90.00 90.00 Operating outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 94.00 The rate used to calculate the time value of money (see instructions) 0 92.00 95.00 Time value of money for operating expenses (see instructions) 0 92.00 96.00 Time value of | 70. 97 | | | | | 0 | 0 | 70. 97 |
| 70.99 HAC adjustment amount (see instructions) 0 70.99 71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 5,938,422 71.00 71.01 Sequestration adjustment (see instructions) 5,880,069 72.00 72.00 Interim payments 0 73.00 73.00 Tentative settlement (for contractor use only) -60,415 74.00 74.00 Balance due provider (lines 90 through 96) 0 73.00 70.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 0 90.00 70.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 92.00 94.00 The rate used to calculate the time value of money (see instructions) 0 94.00 94.00 Time value of money for capital related expenses (see instructions) 0 95.00 95.00 Time value of money for capital related expenses (see instructions) 0 95.00 96.00 Time value of m | 70. 98 | | J | | | | 0 | 70. 98 |
| 71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 5,938,422 71.00 71.01 Sequestration adjustment (see instructions) 118,768 71.01 72.00 Interim payments 5,880,069 72.00 73.00 Tentative settlement (for contractor use only) 5,880,069 72.00 74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) 6,60,415 74.00 75.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 1,367,147 70.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 0 90.00 90.00 Operating outlier reconciliation adjustment amount (see instructions) 0 91.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 92.00 94.00 The rate used to calculate the time value of money (see instructions) 0 93.00 96.00 Time value of money for operating expenses (see instructions) 0 94.00 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 96.00 Time value of money for operating expense (see instructions) <td< td=""><td>70.99</td><td></td><td></td><td></td><td></td><td></td><td>0</td><td>70, 99</td></td<> | 70.99 | | | | | | 0 | 70, 99 |
| 71.01 Sequestration adjustment (see instructions) 118,768 71.01 72.00 Interim payments 5,880,069 72.00 73.00 Tentative settlement (for contractor use only) 5,880,069 72.00 74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) -60,415 74.00 75.00 Protested amounts (nonal lowable cost report items) in accordance with 1,367,147 75.00 70 BE COMPLETED BY CONTRACTOR (lines 90 through 96) 0 0 90.00 90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 0 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 93.00 94.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 96.00 HSP Bonus Payment Amount 0 0 0 100.00 HSP Bonus amount (see instructions) 0 0 0 96.00 HSP Bonu | 71.00 | | plus/minus lines (| 59 & 70) | | | 5, 938, 422 | 71.00 |
| 72.00 Interim payments 5,880,069 72.00 73.00 Tentative settlement (for contractor use only) 0 73.00 74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) -60,415 74.00 75.00 Protested amounts (nonal lowable cost report items) in accordance with 1,367,147 -60,415 75.00 Decomplete BY CONTRACTOR (lines 90 through 96) 90.00 90.00 90.00 90.00 Operating outlier reconciliation adjustment amount (see instructions) 0 91.00 91.00 91.00 Capital outlier reconciliation adjustment amount (see instructions) 0 92.00 92.00 92.00 92.00 93.00 00 93.00 93.00 94.00 94.00 94.00 95.00 93.00 96.00 95.00 96.00 95.00 96.00 96.00 95.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 100.00 96.00 96.00 100.00 96.00 96.00 100.00 96.00 100.00 96.00 100.00 96.00 100.00 100.00 96.00 100.00 | | | F | | | | | |
| 73.00 Tentative settlement (for contractor use only) 0 73.00 74.00 Bal ance due provider (Program) (line 71 minus lines 71.01, 72, and 73) -60.415 74.00 75.00 Protested amounts (nonal lowable cost report items) in accordance with 1,367,147 75.00 75.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 0 90.00 90.00 Operating outlier reconciliation adjustment amount (see instructions) 0 91.00 91.00 Capital outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 93.00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 HSP Bonus Payment Amount 0 0 96.00 100.00 HSP bonus amount (see instructions) 0 0 0 96.00 HSP Bonus Payment Amount 0 0 0 100.00 HSP Bonus Payment factor (see instructions) 0 0 0 96.00 HSP Adjustment factor (see instructions) 0 0 0 97.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<> | | | | | | | | |
| 74.00 Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73) -60,415 74.00 75.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 1,367,147 75.00 70.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 0 90.00 90.00 Operating outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 92.00 94.00 The rate used to calculate the time value of money (see instructions) 0 93.00 96.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 HSP Bonus Payment Amount 0 0 0 100.00 HSP Bonus Payment Amount 0 0 0 0 101.00 HSP Bonus Payment for HSP Bonus Payment 0 0 0 0 101.00 HSP Bonus Payment for HSP Bonus Payment 0 0 0 0 0 102.00 HRP Adjustment for HSP | | | lv) | | | | | |
| 75.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 0 90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) 0 90.00 91.00 Capital outlier from Wkst. L, Pt. I, line 2 0 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 93.00 94.00 The rate used to calculate the time value of money (see instructions) 0 94.00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 96.00 HSP Bonus Payment Amount 0 0 0 100.00 HSP bonus amount (see instructions) 0 0 0 0 101.00 HVBP adjustment for HSP Bonus Payment 0 0 0 0 0 102.00 HKP Adjustment for HSP Bonus payment (see instructions) 0 0 0 0 0 0 0 | 74.00 | | | and 73) | | | -60, 415 | 74.00 |
| CMS Pub. 15-2, chapter 1, §115.2TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)90.00Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)91.00Capital outlier from Wkst. L, Pt. I, line 292.00Operating outlier reconciliation adjustment amount (see instructions)93.00Capital outlier reconciliation adjustment amount (see instructions)94.00The rate used to calculate the time value of money (see instructions)95.00Time value of money for operating expenses (see instructions)96.00Time value of money for capital related expenses (see instructions)96.00Time value of money for capital related expenses (see instructions)96.00HSP Bonus Payment Amount100.00HSP bonus amount (see instructions)97.00098.00099.00090.00090.00091.00092.00092.00093.00094.00100.0095.00100.0095.00100.0096.00090.00090.00090.00090.00090.00090.00090.00090.00090.00090.00090.00090.00090.00090.00090.00090.00090.000< | 75.00 | | | | | | | |
| 90.00Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2 0 perating outlier reconciliation adjustment amount (see instructions) 93.00090.0092.00Operating outlier reconciliation adjustment amount (see instructions) 0 93.00092.0093.00Capital outlier reconciliation adjustment amount (see instructions) 0 93.00092.0094.00The rate used to calculate the time value of money (see instructions) 0 95.000093.0096.00Time value of money for operating expenses (see instructions) 0 96.0000096.00Time value of money for capital related expenses (see instructions) 0 96.0000096.00HSP Bonus Payment Amount 100.000000101.00HVBP Adjustment for HSP Bonus Payment 101.0000000102.00HVBP adjustment for HSP Bonus payment (see instructions) 000000102.00HVBP adjustment for HSP Bonus Payment 103.00000000103.00HRR Adjustment for tor (see instructions)000000 | | CMS Pub. 15-2, chapter 1, §115.2 | , | | | | | |
| 91.00Capital outlier from Wkst. L, Pt. I, line 2091.0092.00Operating outlier reconciliation adjustment amount (see instructions)092.0093.00Capital outlier reconciliation adjustment amount (see instructions)092.0094.00The rate used to calculate the time value of money (see instructions)093.0095.00Time value of money for operating expenses (see instructions)096.0096.00Time value of money for capital related expenses (see instructions)096.0096.00Time value of money for capital related expenses (see instructions)0096.00Time value of money for capital related expenses (see instructions)0097.00Up of to 10/100098.00HSP Bonus Payment Amount000100.00HVBP Adjustment for HSP Bonus Payment000101.00HVBP adjustment for HSP Bonus payment (see instructions)000102.00HVBP adjustment for HSP Bonus payment (see instructions)000103.00HRR adjustment factor (see instructions)0.00000.0000103.00 | | | | | | | - | |
| 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 93.00 94.00 The rate used to calculate the time value of money (see instructions) 0 93.00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 97.00 HSP Bonus Payment Amount 0 0 0 100.00 HSP bonus amount (see instructions) 0 0 0 101.00 HVBP adjustment for HSP Bonus Payment 0 0 0 0 101.00 HVBP adjustment for HSP bonus payment (see instructions) 0 0 0 0 102.00 HVBP adjustment for HSP Bonus Payment 0 0 0 0 0 102.00 HVBP adjustment for HSP Bonus Payment 0 0 0 0 0 0 0 0 0 0 0 | | | | tructions) | | | - | |
| 93.00 Capital outlier reconciliation adjustment amount (see instructions) 0 93.00 94.00 The rate used to calculate the time value of money (see instructions) 0.00 94.00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 97.00 Time value of money for capital related expenses (see instructions) 0 96.00 97.00 Time value of money for capital related expenses (see instructions) 0 96.00 97.00 Time value of money for capital related expenses (see instructions) 0 0 96.00 97.00 HSP Bonus Payment Amount 0 0 0 0 0 97.00 HSP Adjustment for HSP Bonus Payment 0 < | | | | | | | - | |
| 94.00 The rate used to calculate the time value of money (see instructions) 0.00 94.00 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 0 95.00 96.00 Prior to 10/1 0n/After 10/1 0 96.00 HSP Bonus Payment Amount 100.00 HSP bonus amount (see instructions) 0 0 100.00 HVBP Adjustment for HSP Bonus Payment 0 0 0 100.00 101.00 HVBP adjustment for HSP Bonus payment (see instructions) 0 0 0 102.00 102.00 HVBP adjustment for HSP Bonus payment (see instructions) 0 0 0 102.00 103.00 HRR adjustment factor (see instructions) 0.00000 0.00000 103.00 | | | | | | | - | |
| 95.00 Time value of money for operating expenses (see instructions) 0 95.00 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 96.00 Prior to 10/1 0n/After 10/1 0 100.00 HSP Bonus Payment Amount 0 0 0 100.00 HSP bonus amount (see instructions) 0 0 0 101.00 HVBP Adjustment for HSP Bonus Payment 0 0 0 100.00 102.00 HVBP adjustment for HSP Bonus payment (see instructions) 0 0 0 102.00 103.00 HRR adjustment factor (see instructions) 0 0 0 0 0 | | | • | , | | | 0 | |
| 96.00 Time value of money for capital related expenses (see instructions) 0 96.00 Prior to 10/1 On/After 10/1 Intervalue of money for capital related expenses (see instructions) Prior to 10/1 On/After 10/1 Intervalue of money for capital related expenses (see instructions) Intervalue of money for capital related expenses (see instructions) HSP Bonus Payment Amount 0 0 0 0 100.00 HSP bonus amount (see instructions) 0 <td></td> <td></td> <td></td> <td>uctions)</td> <td></td> <td></td> <td></td> <td></td> | | | | uctions) | | | | |
| HSP Bonus Payment Amount Pri or to 10/1 On/After 10/1 100.00 HSP bonus amount (see instructions) 0 0 HVBP Adj ustment for HSP Bonus Payment 0 0 0 101.00 HVBP adj ustment factor (see instructions) 0.000000000 0.000000000 101.00 102.00 HVBP adj ustment for HSP bonus payment (see instructions) 0 0 0 102.00 HRR Adj ustment for HSP Bonus Payment 0 0 0 102.00 0 102.00 HRR Adj ustment for HSP Bonus Payment 0 0 0 0 102.00 | | | | | | | - | |
| Image: Non-Structure Image: Non-Structure HSP Bonus Payment Amount 0 100.00 HSP bonus amount (see instructions) 0 HVBP Adjustment for HSP Bonus Payment 0 0 101.00 HVBP adjustment factor (see instructions) 0 0 102.00 HVBP adjustment for HSP bonus payment (see instructions) 0 0 0 102.00 HVBP adjustment for HSP bonus payment (see instructions) 0 0 0 103.00 HRR adjustment factor (see instructions) 0 0 0 | 96.00 | Time value of money for capital related exp | enses (see instruct | tions) | | | 0 | 96.00 |
| HSP Bonus Payment Amount 100.00 HSP bonus amount (see instructions) 0 0 100.00 HVBP Adjustment for HSP Bonus Payment 0 0 0 100.00 101.00 HVBP adjustment factor (see instructions) 0 0 0 101.00 102.00 HVBP adjustment for HSP bonus payment (see instructions) 0 0 0 102.00 HRR Adjustment for HSP Bonus Payment 0 0 0 102.00 HRR Adjustment for HSP Bonus Payment 0 0 0 102.00 HRR adjustment for ISP Bonus Payment 0 0 0 103.00 0 0.0000 0.0000 103.00 | | | | | | | | |
| 100.00HSP bonus amount (see instructions)00100.00HVBP Adj ustment for HSP Bonus Payment101.00HVBP adj ustment factor (see instructions)0.000000000.00000000101.00102.00HVBP adj ustment for HSP bonus payment (see instructions)000102.00HRR Adj ustment for HSP Bonus Payment000102.00HRR Adj ustment for HSP Bonus Payment00102.00103.00HRR adj ustment factor (see instructions)0.00000.0000103.00 | | | | | | 1.00 | 2.00 | |
| HVBP Adj ustment for HSP Bonus Payment101.00HVBP adj ustment factor (see instructions)0.000000000101.00102.00HVBP adj ustment amount for HSP bonus payment (see instructions)00102.00HRR Adj ustment for HSP Bonus Payment00102.00HRR adj ustment for HSP bonus payment00103.00 | 100.00 | | | | | | | 100.00 |
| 101.00HVBP adjustment factor (see instructions)0.000000000101.00102.00HVBP adjustment amount for HSP bonus payment (see instructions)00HRR Adjustment for HSP Bonus Payment00103.00HRR adjustment factor (see instructions)0.0000103.00 | 100.00 | | | | | 0 | 0 | 100.00 |
| 102.00HVBP adjustment amount for HSP bonus payment (see instructions)00HRR Adjustment for HSP Bonus Payment103.00HRR adjustment factor (see instructions)0.0000103.00 | 4.04 0.0 | | | | | | 0.000000000 | 101 00 |
| HRR Adjustment for HSP Bonus Payment 103.00 HRR adjustment factor (see instructions) 0.0000 103.00 | | | | ` | | | | |
| 103.00 HRR adjustment factor (see instructions) 0.0000 0.0000 103.00 | 102.00 | | t (see instructions | 5) | | 0 | 0 | 102.00 |
| | 103.00 | | | | | 0, 0000 | 0,0000 | 103.00 |
| | | | (see instructions) |) | | | | |

| | Financial Systems DLUME CALCULATION EXHIBIT 4 | | JOHNSON MEMORI | Provider CC | | eri od: | u of Form CMS-2 Worksheet E | |
|----------|---|-------------------------|----------------------------|------------------|------------------|--------------------------------|--------------------------------|------|
| | | | | | | rom 01/01/2016 o 12/31/2016 | | pare |
| | | | | Title | XVIII | Hospi tal | PPS | трш |
| | | 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) | |
| 00 | DRG amounts other than outlier | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 1 |
| DD D1 | payments DRG amounts other than outlier | 1.00 | 4, 372, 932 | 0 | 4, 372, 932 | _ | 4, 372, 932 | |
| | payments for discharges occurring prior to October 1 | 1.01 | 1, 012, 702 | 0 | 1, 012, 702 | | 1,072,702 | |
| 02 | DRG amounts other than outlier payments for discharges occurring on or after October 1 | 1. 02 | 1, 305, 742 | 0 | | 1, 305, 742 | 1, 305, 742 | 1 |
| 3 | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 | 1. 03 | 0 | 0 | С | | 0 | |
| 4 | DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 | 1. 04 | 0 | 0 | | 0 | 0 | 1 |
| 0 | Outlier payments for discharges (see instructions) | 2.00 | 45, 325 | 0 | 29, 953 | 15, 372 | 45, 325 | 2 |
|)1 | Outlier payments for discharges for Model 4 BPCI | 2. 02 | 0 | 0 | C | 0 | 0 | 2 |
| 0 | Operating outlier reconciliation | 2.01 | 0 | 0 | C | 0 | 0 | 3 |
| 00 | Managed care simulated payments Indirect Medical Education Adju | 3. 00 | 1, 276, 352 | 0 | C | 0 | 0 | 4 |
| 00 | Amount from Worksheet E, Part A, line 21 (see instructions) | 21.00 | 0. 000000 | 0. 000000 | 0. 000000 | 0. 000000 | | Ę |
| 0 | IME payment adjustment (see instructions) | 22.00 | 0 | 0 | C | 0 | 0 | ė |
| 1 | IME payment adjustment for managed care (see instructions) Indirect Medical Education Adju | 22.01 | 0 | 0 | C | 0 | 0 | e |
| 0 | IME payment adjustment factor | 27.00 | 0. 000000 | 0.000000 | | 0. 000000 | | - |
| 0 | (see instructions) IME adjustment (see | 28.00 | 0 | 0 | C | 0 | 0 | 8 |
| 1 | instructions) IME payment adjustment add on for managed care (see | 28.01 | 0 | 0 | C | 0 | 0 | 8 |
| 0 | instructions) Total IME payment (sum of | 29.00 | 0 | 0 | C | 0 | 0 | q |
| 1 | lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and | 29.01 | 0 | 0 | C | 0 | 0 | ç |
| | 8.01) Disproportionate Share Adjustme | nt | | | | | | |
| 00 | Allowable disproportionate share percentage (see | 33.00 | 0. 1045 | 0. 1045 | 0. 1045 | 0. 1045 | | 1(|
| 00 | instructions) Disproportionate share adjustment (see instructions) | 34.00 | 148, 356 | 0 | 114, 243 | 34, 113 | 148, 356 | 1' |
| 01 | Additional payment for high per | 36.00 centage of ESF | 297, 199 RD beneficiary | 0 di scharges | 297, 199 | 0 | 297, 199 | 11 |
| 00 | Total ESRD additional payment | 46.00 | 0 | 0 | C | 0 | 0 | 12 |
| 00 | (see instructions) Subtotal (see instructions) | 17 00 | 6 140 FE4 | ~ | 1 01 / 207 | 1 255 227 | 4 140 FF4 | 1- |
| 00 | Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) | 47.00 48.00 | 6, 169, 554 0 | 0 0 | 4, 814, 327 C | 1, 355, 227 0 0 | 6, 169, 554 0 | |
| 00 | (see instructions) Total payment for inpatient operating costs (see instructions) | 49.00 | 6, 169, 554 | 0 | 4, 814, 327 | 1, 355, 227 | 6, 169, 554 | 15 |
| 00 | Payment for inpatient program capital | 50.00 | 460, 715 | 0 | 353, 466 | 107, 249 | 460, 715 | |
| 00 | Special add-on payments for new technologies | 54.00 | 0 | 0 | C | 0 | 0 | 17 |
| 01 02 | Net organ aquisition cost Credits received from manufacturers for replaced | 68.00 | О | 0 | С | 0 | 0 | 17 |
| 00 | devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions) | | 0 | 0 | С | 0 | 0 | 18 |

| Health Financial Systems | | JOHNSON MEMORI | AL HOSPITAL | | In Lie | eu of Form CMS-: | 2552-10 |
|--|---------------|---------------------|-------------|--------------|---|--------------------------------|---------|
| LOW VOLUME CALCULATION EXHIBIT 4 | | | Provider C | | Period: From 01/01/2016 To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pared: |
| | | | Title | XVIII | Hospi tal | PPS | |
| | W/S E, Part A | Amounts (from | Pre/Post | Period Prior | Peri od | Total (Col 2 | |
| | line | E, Part A) | Entitlement | to 10/01 | On/After 10/01 | through 4) | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 19.00 SUBTOTAL | | | 0 | 5, 167, 79 | 3 1, 462, 476 | 6, 630, 269 | 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 | 456, 408 | 0 | 350, 66 | 2 105, 746 | 456, 408 | 20.00 |
| 20.01 Model 4 BPCI Capital DRG other than outlier | 1. 01 | 0 | 0 | | 0 0 | 0 | 20. 01 |
| 21.00 Capital DRG outlier payments | 2.00 | 4, 307 | 0 | 2, 80 | 4 1, 503 | 4, 307 | 21.00 |
| 21.01 Model 4 BPCI Capital DRG | 2.01 | 0 | 0 | | 0 0 | 0 | 21.01 |
| outlier payments | | | | | | | |
| 22.00 Indirect medical education percentage (see instructions) | 5.00 | 0. 0000 | 0.0000 | 0.000 | 0 0.0000 | | 22.00 |
| 23.00 Indirect medical education adjustment (see instructions) | 6.00 | 0 | 0 | | 0 0 | 0 | 23.00 |
| 24.00 Allowable disproportionate share percentage (see instructions) | 10.00 | 0. 0000 | 0.0000 | 0.000 | 0 0.0000 | | 24.00 |
| 25.00 Disproportionate share adjustment (see instructions) | 11.00 | 0 | 0 | | 0 0 | 0 | 25.00 |
| 26.00 Total prospective capital payments (see instructions) | 12.00 | 460, 715 | 0 | 353, 46 | 6 107, 249 | 460, 715 | 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. 08767 | 9 0. 092143 | | 27.00 |
| 28.00 Low volume adjustment (transfer amount to Wkst. E, | 70. 96 | | | 453, 10 | 7 | 453, 107 | 28.00 |
| Pt. A, line) 29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line) | 70. 97 | | | | 134, 757 | 134, 757 | 29. 00 |
| 100.00 Transfer low volume adjustments to Wkst. E, Pt. A. | | Ν | | | | | 100. 00 |

| HOSPI 1 | AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | TION EXHIBIT 5 | Provider CC | | Period: From 01/01/2016 To 12/31/2016 | Date/Time Prep 1/16/2018 3:0 | pared: |
|--------------------------------------|---|-------------------------|---------------------------------|--------------------|---|---------------------------------|----------------|
| | | | | XVIII | Hospi tal | PPS | |
| | | Wkst. E, Pt. A, line | Amt. from Wkst. E, Pt. A) | Period to 10/01 | Period on after 10/01 | Total (cols. 2 and 3) | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| 1.00 | DRG amounts other than outlier payments | 1.00 | | | | | 1.00 |
| 1.01 | DRG amounts other than outlier payments for discharges occurring prior to October 1 | 1.01 | 4, 372, 932 | 4, 372, 93 | | 4, 372, 932 | 1. 01 |
| 1.02 | DRG amounts other than outlier payments for discharges occurring on or after October 1 | 1.02 | 1, 305, 742 | | 1, 305, 742 | 1, 305, 742 | 1. 02 |
| 1.03 | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1 | 1.03 | 0 | | 0 | 0 | 1. 03 |
| 1.04 | DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 | 1.04 | 0 | | 0 | 0 | 1. 04 |
| . 00 | Outlier payments for discharges (see instructions) | 2.00 | 45, 325 | 29, 95 | 3 15, 372 | 45, 325 | 2.00 |
| 2. 01 | Outlier payments for discharges for Model 4 BPCI | 2.02 | 0 | | 0 0 | 0 | 2. 01 |
| 3.00 | Operating outlier reconciliation | 2.01 | 0 | | 0 0 | 0 | 3.00 |
| 4.00 | Managed care simulated payments | 3.00 | 1, 276, 352 | | 0 0 | 0 | 4.00 |
| 5.00 | Indirect Medical Education Adjustment Amount from Worksheet E, Part A, Line 21 | 21.00 | 0. 000000 | 0. 00000 | 0 0. 000000 | | 5.00 |
| | (see instructions) | 00.00 | | | | | / 00 |
| 6. 00 6. 01 | IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions) | 22.00 22.01 | 0 | | 0 0 0 0 | | 6. 00 6. 01 |
| | Indirect Medical Education Adjustment for the | Add-on for Se | ction 422 of th | ne MMA | | | |
| 7.00 | IME payment adjustment factor (see instructions) | 27.00 | 0. 000000 | 0.00000 | 0 0. 000000 | | 7.00 |
| 8.00 | IME adjustment (see instructions) | 28.00 | 0 | | 0 0 | 0 | 8.00 |
| 8. 01 | IME payment adjustment add on for managed care (see instructions) | 28.01 | 0 | | 0 0 | 0 | 8. 01 |
| 9.00 | Total IME payment (sum of lines 6 and 8) | 29.00 | 0 | | 0 0 | 0 | 9.00 |
| 9. 01 | Total IME payment for managed care (sum of lines 6.01 and 8.01) | 29. 01 | 0 | | 0 0 | 0 | 9. 01 |
| | Disproportionate Share Adjustment | | | | | | |
| 10.00 | Allowable disproportionate share percentage (see instructions) | 33.00 | 0. 1045 | 0. 104 | 5 0. 1045 | | 10.00 |
| 11. 00 | Disproportionate share adjustment (see instructions) | 34.00 | 148, 356 | 114, 24 | 3 34, 113 | 148, 356 | 11.00 |
| 11. 01 | Uncompensated care payments | 36.00 | 297, 199 | 224, 68 | 5 72, 514 | 297, 199 | 11. 01 |
| 12. 00 | Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) | 46.00 | o o | | 0 0 | 0 | 12.00 |
| 13 00 | Subtotal (see instructions) | 47.00 | 6, 169, 554 | 4, 741, 81 | 3 1, 427, 741 | 6, 169, 554 | 13 00 |
| | Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) | 48.00 | 0 | | 0 0 | | 14.00 |
| 15.00 | Total payment for inpatient operating costs (see instructions) | 49.00 | 6, 169, 554 | 4, 741, 81 | 3 1, 427, 741 | 6, 169, 554 | 15.00 |
| | Payment for inpatient program capital | 50.00 | 460, 715 | 353, 46 | 6 107, 249 | 460, 715 | 16.00 |
| 16.00 | | 54.00 | 0 | | 0 0 | | |
| | Special add-on payments for new technologies | 34.00 | | | 1 | | 17.01 |
| 17.00 | Special add-on payments for new technologies Net organ acquisition cost | 54.00 | | | | | 17.01 |
| 16. 00 17. 00 17. 01 17. 02 | | 68.00 | 0 | | o o | 0 | |
| 17. 00 17. 01 | Net organ acquisition cost Credits received from manufacturers for | | 0 | | o o o o | | 17. 02 |

| Health Financial Systems | JOHNSON MEMOR | | | | u of Form CMS- | 2552-10 |
|--|-------------------------|----------------------------------|---------|---|-----------------------------|---------|
| HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | TION EXHIBIT 5 | Provider CC | | Period: From 01/01/2016 To 12/31/2016 | | pared: |
| | | Title | XVIII | Hospi tal | PPS | |
| | Wkst. L, line | (Amt. from Wkst. L) | | | | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| 20.00 Capital DRG other than outlier | 1.00 | 456, 408 | 350, 66 | 2 105, 746 | 456, 408 | 20.00 |
| 20.01 Model 4 BPCI Capital DRG other than outlier | 1.01 | 0 | | 0 0 | 0 | 20.01 |
| 21.00 Capital DRG outlier payments | 2.00 | 4, 307 | 2,80 | 1, 503 | 4, 307 | 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 | 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 | 460, 715 | 353, 46 | 6 107, 249 | 460, 715 | 26.00 |
| | Wkst. E, Pt. A, line | (Amt. from Wkst. E, Pt. A) | | | | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | |
| 27.00 | | | | | | 27.00 |
| 28.00 Low volume adjustment prior to October 1 | 70.96 | 0 | | 0 | 0 | 28.00 |
| 29.00 Low volume adjustment on or after October 1 | 70.97 | 0 | | 0 | 0 | 29.00 |
| 30.00 HVBP payment adjustment (see instructions) | 70, 93 | -8, 128 | -13, 84 | 7 5, 719 | -8, 128 | 30.00 |
| 30.01 HVBP payment adjustment for HSP bonus payment (see instructions) | 70.90 | 0 | | 0 0 | 0 | |
| 31.00 HRR adjustment (see instructions) | 70.94 | -5, 247 | -5, 24 | 7 0 | -5, 247 | 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 | |
| 32.00 HAC Reduction Program adjustment (see instructions) | 70.99 | | | 0 0 | 0 | 32.00 |
| 100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A. | | Y | | | | 100. 00 |

| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0001 Period: From 01/01/20 To 12/31/20 | | |
|----------------|--|-------------------------|----------------|
| | Title XVIII Hospital | PPS | |
| | | 1.00 | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | | |
| 1.00 | Medical and other services (see instructions) | 1, 817 | 1.00 |
| 2.00 3.00 | Medical and other services reimbursed under OPPS (see instructions) PPS payments | 7, 188, 663 5, 646, 973 | 2.00 3.00 |
| 3.00 4.00 | Outlier payment (see instructions) | 29, 242 | |
| 5.00 | Enter the hospital specific payment to cost ratio (see instructions) | 0.000 | |
| 6.00 | Line 2 times line 5 | 0 | 6.00 |
| 7.00 | Sum of line 3 plus line 4 divided by line 6 | 0.00 | |
| 8.00 9.00 | Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 | 0 | 8.00 9.00 |
| 10.00 | Organ acquisitions | 0 | 10.00 |
| 11.00 | Total cost (sum of lines 1 and 10) (see instructions) | 1, 817 | |
| | COMPUTATION OF LESSER OF COST OR CHARGES | • | [|
| 10.00 | Reasonable charges | 4 70(| 10.00 |
| 12.00 13.00 | Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) | 4, 796 | 12.00 13.00 |
| 14.00 | Total reasonable charges (sum of lines 12 and 13) | 4, 796 | |
| | Customary charges | | |
| 15.00 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | 0 | 15.00 |
| 16.00 | Amounts that would have been realized from patients liable for payment for services on a chargebasi | s 0 | 16.00 |
| 17.00 | had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) | 0. 000000 | 17 00 |
| | Total customary charges (see instructions) | 4, 796 | |
| 19.00 | Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see | 2, 979 | |
| | instructions) | | |
| 20. 00 | Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see | 0 | 20.00 |
| 21.00 | instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) | 1, 817 | 21.00 |
| 22.00 | Interns and residents (see instructions) | 0 | 22.00 |
| 23.00 | Cost of physicians' services in a teaching hospital (see instructions) | 0 | 23.00 |
| 24.00 | Total prospective payment (sum of lines 3, 4, 8 and 9) | 5, 676, 215 | 24.00 |
| 25.00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions) | 0 | 25.00 |
| | Deductibles and consurance relating to amount on line 24 (for CAH, see instructions) | 1, 185, 635 | |
| 27.00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see | 4, 492, 397 | |
| | instructions) | _ | |
| 28.00 29.00 | Direct graduate medical education payments (from Wkst. E-4, line 50) | 0 | 28.00 29.00 |
| 30.00 | ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29) | 4, 492, 397 | |
| | Primary payer payments | 1, 850 | 1 |
| 32.00 | Subtotal (line 30 minus line 31) | 4, 490, 547 | 32.00 |
| ~~ ~~ | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | |
| | Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) | 0 200, 299 | |
| | Adjusted reimbursable bad debts (see instructions) | 130, 194 | |
| 36.00 | Allowable bad debts for dual eligible beneficiaries (see instructions) | 146, 232 | 36.00 |
| 37.00 | Subtotal (see instructions) | 4, 620, 741 | |
| | MSP-LCC reconciliation amount from PS&R | -98 | |
| 39.00 39.50 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) | 0 | 39.00 39.50 |
| 39.98 | Partial or full credits received from manufacturers for replaced devices (see instructions) | 0 | 39.98 |
| 39.99 | RECOVERY OF ACCELERATED DEPRECIATION | 0 | 39.99 |
| 40.00 | Subtotal (see instructions) | 4, 620, 839 | 40.00 |
| 40.01 | Sequestration adjustment (see instructions) | 92, 417 | |
| 41.00 | Interim payments Tentative settlement (for contractors use only) | 4, 449, 056 | 41.00 42.00 |
| 42.00 | Balance due provider/program (see instructions) | 79, 366 | |
| 44.00 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, | 0 | 44.00 |
| | <u>§115.2</u> | | l |
| 00.00 | TO BE COMPLETED BY CONTRACTOR | | |
| | Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) | 0 | |
| | The rate used to calculate the Time Value of Money | | 91.00 |
| | Time Value of Money (see instructions) | 0 | |
| 94 00 | Total (sum of lines 91 and 93) | 0 | 94.00 |

| Component COX 15-TODI Iffent 11/01/2016 Perform 11/01/2016 Perfo | | Financial Systems JOHNSON MEMORIAL | 1 | | u of Form CMS-2 | 2552-10 |
|---|--------|---|---|---|-----------------|-------------|
| It is support der - PPS Item value Item value Item value Item value 0.00 Well cal and other services (eac instructions) 51 1.00 0.00 Well cal and other services (eac instructions) 51 1.00 0.00 Value cal and other services (cal instructions) 51 1.00 0.00 Value cal and other services (cal instructions) 0.00 0.00 0.01 Ine 3 plus line 4 divided by line 6 0.00 | CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Date/Time Pre | |
| PART B - PENCICAL AND OTHER HEALTH SEMPTES 1.00 1.00 Modical and other services rembursed under OPPS (see instructions) 245 2.00 2.00 PS payments 228 3.00 245 2.00 3.00 Description 0.00 0.01 0.00 <td></td> <td></td> <td>Title XVIII</td> <td></td> <td></td> <td><u>ı pm</u></td> | | | Title XVIII | | | <u>ı pm</u> |
| 100 Well call and other services reinstructions) 51 1.00 0.00 Well call and other services reinstructions) 245 2.00 0.00 PS payments 1.00 0.00 | | | • | · | 1.00 | |
| 2.00 Hedical and other services rimbursed under OPPS (see instructions) 244 2.00 0.00 PPS payments 12.00 0.01 Finter the hespital specific payment to cost ratio (see instructions) 0.00 0.00 Finter the hespital specific payment to cost ratio (see instructions) 0.00 0.00 Finter the hespital specific payment to cost ratio (see instructions) 0.00 0.00 Transitional corridor payment (see instructions) 0.00 0.00 Drog national specific payment (see instructions) 0.00 0.00 Drog national specific payment (see instructions) 0.00 0.00 Drog national specific payment (see instructions) 0.00 1.00 Drog national specific payment (see instructions) 0.00 1.00 Drog national specific payment (see instructions) 134 1.00 Drog national specific payment (see instructions) 134 1.00 Reserval (see instructions) 134 1.00 Resting (see instructions) 1300 | 1 00 | | | | E1 | 1 1 00 |
| 3.00 PPS payments 122 3.00 4.00 Outline payment (see instructions) 0.00 4.00 5.00 Enter the hospital specific payment to cost ruite (see instructions) 0.00 6.00 6.01 Dire 2 these lines 0.00 0.0 | | | tions) | | | 1 |
| 5.00 Enter the face/file payment to cost ratio (see instructions) 0.000 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 5.00 7.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<> | | | | | | |
| 6.00 Line 2 times 1 line 3 divided by line 6 0 6.00 7.00 Sum of line 3 plus line 4 divided by line 6 0 0.00 | | | | | | |
| 7.00 Sam of line 3 plus line 4 divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 0.00 | | | ctions) | | | 1 |
| 8.00 Transitional corridor payment (see instructions) 0 8.00 9.00 Architary service other pass through costs from West. D. Pt. IV. col. 13, line 200 0 0 10.00 Organ acquisitions 0 9.00 10.00 Organ acquisitions 0 9.00 10.00 Organ acquisitions 0 9.00 12.00 Executions 0 9.00 13.00 Organ acquisitions 0 13.00 13.00 Organ acquisition charges (from Wst. 0.4, Pt. 111, col. 4, line 69) 13.00 13.00 Organ acquisition charges (from Wst. 0.4, Pt. 111, col. 4, line 69) 13.00 14.00 Iotal resonable charges 0 15.00 0.01 Restin of line 15 to line 16 (not to exceed 1.00000) 16.00 0 17.00 Ratin of line 15 to line 16 (not to exceed 1.00000) 17.00 18.80 0 10.01 Extension of charges (line 11 minus line 20) (for CAH see instructions) 0 22.00 10.02 Extension of charges (line 11 minus line 20) (for CAH see instructions) 22.00 0 20.00 Extension of charges (line 11 minus line 20) (for CAH see instructions) 22 | | | | | | |
| Dot Operation acquisitions Description 10.00 Order Loss (sum of lines 1 and 10) (see instructions) Description 11.00 Total cost (sum of lines 1 and 10) (see instructions) Description 12.00 Ancillary service charges 134 12.00 Ancillary service charges (sum of lines 12 and 13) 134 15.00 Operation acquisition charges (sum of lines 12 and 13) 134 16.00 Anounts that would have been realized from patients liable for payment for services on a charge basis on a charge basis 0 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see linstructions) 0.000000 19.00 Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 18) (see linstructions) 0.20.00 21.00 Instructions 0.21.00 12.02 12.02 22.00 Data It prospective payment for services on a charge basis (see instructions) 0.22.00 0.00 22.00 Direct of cost or charges (ine 11 minus line 20) (for CAH see instructions) 0.22.00 0.00 23.00 | | | | | | • |
| 11.00 Total cost (cum of lines 1 and 10) (see instructions) 51 11.00 COMPUTATION OF IESER OF COST OR CHARGES 134 12.00 134 12.00 12.00 Ancillary service charges 134 12.00 134 12.00 13.00 Draft reasonable charges (from Wkst. D-4, Pt. 111, col. 4, line 69) 134 12.00 15.00 Destinary charges (from whether call and 13) 134 14.00 15.00 Destinary charges (sum of lines 12 and 13) 0 134 14.00 16.00 Hours that would have been reade in accordance with 42 (FR \$431.13(c)) 0 0.000000 17.00 18.00 Total customary charges cover customary charges (complete only if line 11 exceeds line 11) (see instructions) 0 0.000000 17.00 19.00 Exceeds of customary charges (complete only if line 11 exceeds line 18) (see ol 20.00 0 0.000000 17.00 10.00 Exceeds of customary charges (line 11 minus line 20) (for CAH see instructions) 0 0 0.000000 12.00 12.00 Deductibles and coinsurance (for CAH, see instructions) 0 0 0.00000 0 0.00000 0 0.00000 0 0.00000 | | 5 | IV, col. 13, line 200 | | | |
| Communitation Communitation 12:00 Ancillary service charges 13.00 13:00 Organ acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69) 13.10 14:00 Degrad acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69) 13.00 15:00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 15:00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 16:00 Total customary charges (see instructions) 16.00 19:00 Excess of customary charges over reasonable cost (complete only If line 18 exceeds line 11) (see linstructions) 13.41 ft.00 19:00 Excess of reasonable cost or charges (complete only If line 11 exceeds line 18) (see linstructions) 12.20 20:00 Excess of reasonable cost in a teaching hospital (see instructions) 0.23.00 21:00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0.23.00 23:00 Cost of physicians' services in a teaching hospital (see instructions) 0.23.00 24:00 Total reducting (coamount on line 24 (for CAH, see instructions) 0.24.00 20:00 Defatereducation costs (from W | | o i | | | | |
| Reasonable charges 114 12.00 12.00 Ancillary service charges 134 12.00 13.00 Organ acquisition charges (from West. D-4, Pt. III, col. 4, line 69) 134 14.00 13.00 Organ acquisition charges (from West. D-4, Pt. III, col. 4, line 69) 134 14.00 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 16.00 Anounts that would have been realized from patients liable for payment for services on a chargebasis 0 15.00 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0 0.000000 17.00 18.00 Total conteary charges (see instructions) 0 0.000000 17.00 19.00 Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see 0 20.00 10.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 21.00 10.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 22.00 10.00 Excess of reasonable cost charges (line 11 minus line 20) (for CAH see instruction | 11.00 | | | | 51 | 11.00 |
| 13.00 Organ acquisition charges (from Wkst. D-4, Pt. 111, col. 4, line 69) 0 13.00 14.00 Total reasonable charges (sum of lines 12 and 13) 134 15.00 Aggregate amount actually collected from patients I lable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §431.3(e) 0 0 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 18.00 19.00 Excess of customary charges (see instructions) 0.000000 17.00 20.00 Excess of customary charges (see instructions) 0.20.00 51.21.00 21.00 Lessen of cost or charges (line 11 minus line 20) (for CAH see instructions) 0.23.00 0.23.00 22.00 Detextuality collawares (structions) 0.24.00 0.22.00 0.02.00 0.02.00 24.00 Detextuality and line 11 may the sum of lines 24 (dr CAH, see instructions) 0.22.00 0.22.00 25.00 Detductibles and coinsurance (for CAH, see instructions) 0.25.00 22.00 26.00 Deductibles and coinsurance (for CAH, see instructions) 0.29.00 0.20.00 22.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td> | | | | | | 1 |
| 14. 00 Total reasonable charges (sum of lines 12 and 13) 134 14. 00 15. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0 15. 00 16. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0 0.000000 17. 00 18. 00 Total customary charges (see instructions) 0 0.000000 17. 00 18. 00 Total customary charges over reasonable cost (complete only if line 11 exceeds line 13) (see linstructions) 0 22. 00 19. 00 Excess of reasonable cost over customary charges over reasonable cost (complete only if line 11 exceeds line 13) (see linstructions) 0 22. 00 10 Lasse of castomatic (see linstructions) 0 22. 00 0 22. 00 20. 00 Cost of physici and: services in a tasching hospi tal (see instructions) 122 24. 00 25. 00 22. 00 21. 00 Deductible sand coinsurance (rior CAH, see instructions) 122 24. 00 25. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 | | | | | | |
| Customary charges Collected from patients liable for payment for services on a charge basis 16:00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 15:00 16:00 Macunts that would have been realized from patients liable for payment for services on a charge basis 0 16:00 17:00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17:00 0 0.000000 17:00 18:00 Total customary charges (see instructions) 0 0.000000 17:00 19:00 Excess of customary charges (complete only if line 11 exceeds line 11) (see instructions) 0 20:00 20:00 Excess of cost or charges (line 11 minus line 20) (for CAH see instructions) 0 22:00 21:00 Lesser of Cost or charges (line 11 minus the 2.0) (for CAH see instructions) 0 22:00 20:00 Cost of physicians' services in a teaching hospital (see instructions) 0 22:00 20:00 Deductible s and col nsurance (relating to amount on line 24 (for CAH, see instructions) 12:24:00 20:00 Direct graduate medical education costs (from Wkst, E-4, line 30) 0 28:00 20:00 Direct graduate | | | ine 69) | | | |
| 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 0 15.00 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 0 15.00 17.00 Ratio of line 15 to line 16 (not to exceed line 01.00000) 0 | 14.00 | | | | 134 | 14.00 |
| had such payment been made in accordance with 42 CFR \$413.13(e) 0 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 18.00 Total customary charges (see instructions) 0.00000 19.00 Excess of reasonable cost over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0.0000 10.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0.0000 10.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0.0000 10.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0.2000 10.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0.2100 10.00 Exserved cost or charges (line 11 minus line 20) (for CAH see instructions) 0.22.00 10.00 Exserved cost or charges (line 11 minus line 20) (for CAH, see instructions) 0.23.00 20.00 Extendible sand col nsurance (for CAH, see instructions) 0.22.00 21.00 Exserved col nsurance relating to anount on line 24 (for CAH, see instructions) 0.22.00 22.00 Subtatal (sum of lines 27 through 29) 161 27.00 23.00 Exotral extenses (Exotube BAD DEBTS FOR PROFESSIONAL SERVICES) 0.31.00 31.00 23.00 C | 15.00 | | payment for services on | a charge basis | 0 | 15.00 |
| 17.00 Ratio of line 15 to line 16 (not to exceed 1,00000) 0.000000 17.00 18.00 Total customary charges (see instructions) 134 18.00 18.00 Excess of customary charges (see instructions) 134 18.00 20.00 Excess of cost or charges (line 11 minus line 20) (for CAH see instructions) 0.20.00 21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0.22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.22.00 23.00 Cost of col nsurance (for CAH, see instructions) 0.25.00 25.00 Deductibles and Col nsurance (for CAH, see instructions) 0.25.00 26.00 Deductibles and Col nsurance (for CAH, see instructions) 12 26.00 27.00 SEX of a physician cost (from Wkst. E-4, line 30) 0.28.00 29.00 29.00 18.00 19.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 30) 0.30.00 30.00 30.00 30.00 31.00 31.00 31.00 31.00 Direct graduate medical education payments (from Wkst. E-4, line 30) 0 29.00 19.00 10.11 30.00 31.00 <td< td=""><td>16.00</td><td></td><td></td><td>n a chargebasis</td><td>0</td><td>16.00</td></td<> | 16.00 | | | n a chargebasis | 0 | 16.00 |
| 18.00 Total customary charges (see instructions) 114 18.00 19.00 Excess of customary charges (complete only if line 18 exceeds line 11) (see instructions) 19.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 20.00 21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 21.00 22.00 Interns and residents (see instructions) 0.12.00 23.00 Cast of physicians' services in a teaching hospital (see instructions) 0.23.00 24.00 Total prospective payment (sum of lines 3, 4, 8 and 9) 122 24.00 Deductibles and Coinsurance (FOT CAH, see instructions) 0.25.00 26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 12 27.00 Deductible (see instructions) 0.25.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0.28.00 29.00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0.29.00 20.00 Direct medical education costs (from Wkst. E-4, line 30) 161 30.00 30.00 Ostal (see instructions) 0.31.00 31.00 31.00 3 | 17 00 | 1.5 | e) | | 0,00000 | 17 00 |
| 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 83 19.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 0 20.00 21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 0 22.00 22.00 Cost of physiclans' services in a teaching hospital (see instructions) 0 23.00 23.00 Cost of physiclans' services in a teaching hospital (see instructions) 0 23.00 26.00 Deductibles and coinsurance (for CAH, see instructions) 0 25.00 26.00 Deductibles and coinsurance (for CAH, see instructions) 0 26.00 27.00 Settoral (filenes 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 161 27.00 Settoral (cal education payments (from Wkst. E-4, line 50) 0 28.00 28.00 Deriver graduate medical education payments (from Wkst. E-4, line 50) 0 31.00 30.00 Settoral (Sime FirmeWashele bad debts (see instructions) 0 34.00 31.00 Ophics for and ESN (from Wkst. I-5, line 11) 0 34.00 32.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<> | | | | | | |
| instructions) 20.00 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions) 02.00 21.00 Lesses of cost or charges (line 11 minus line 20) (for CAH see instructions) 51 21.00 22.00 Interns and residents (see instructions) 02.00 22.00 23.00 Cost of physic long's services in a teaching hospital (see instructions) 02.20 23.00 23.00 Cost of physic long's services in a teaching hospital (see instructions) 02.20 24.00 24.00 Deductibles and coinsurance (for CAH, see instructions) 12 24.00 25.00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 12 26.00 27.00 Subtotal (lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 16 12.00 28.00 Direct graduate medical education costs (from Wkst. E-4, line 30) 0 28.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 30) 0 31.00 30.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 31.00 Allowable bad debts (see instructions) 0 34.00 34.00 <td></td> <td></td> <td>lyifline 18 exceeds li</td> <td>ne 11) (see</td> <td></td> <td></td> | | | lyifline 18 exceeds li | ne 11) (see | | |
| instructions) 51.1 1:00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 51.21.00 22:00 Interns and residents (see instructions) 0.22.00 23:00 Cost of physicians' services in a teaching hospital (see instructions) 0.22.00 24:00 Total prospective payment (sum of lines 3, 4, 8 and 9) 122 25:00 Deductibles and coinsurance (for CAH, see instructions) 0 25.00 26:00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 12 26.00 26:00 Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions) 0 28.00 27:00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0 28.00 29:00 Direct graduate medical education payments (from Wkst. E-4, line 30) 0 29.00 30:00 Subtotal (sum 30 minus line 31) 161 30.00 31:00 Deposite rate ESR0 (from Wkst. E-5, line 11) 0 31.00 32:00 Allowable bad debts (see instructions) 0 35.00 33:00 Composite rate ESR0 (from Wkst. E-5, line 11) 0 35.00 | | instructions) | - | | | |
| 21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions) 51 21.00 22.00 Interns and residents (see instructions) 0 23.00 22.01 Conterns and residents (see instructions) 0 23.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00 24.01 Total prospective payment (sum of lines 3, 4, 8 and 9) 122 24.00 COMPUTATION OF RELIMBURSEMENT SETTLEMENT 0 25.00 25.00 26.00 25.00 Deductibles and coinsurance (for CAH, see instructions) 12 26.00 26.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 27.00 Subtotal (sum of lines 27 through 29) 161 30.00 21.00 30.00 Subtotal (sum of lines 27 through 29) 161 30.00 31.00 31.00 Composite rate SEND (from Wkst. I-5, line 11) 161 30.00 33.00 32.00 Composite rate SEND (from Wkst. I-5, line 11) 0 34.00 34.00 33.00 Composite rate SEND (from Wkst. I-5, line 11) 0 36.00 39.00 33.0 | 20.00 | | ly if line 11 exceeds li | ne 18) (see | 0 | 20.00 |
| 22.00Interns and residents (see instructions)022.0023.00Cost of physic ians' services in a teaching hospital (see instructions)023.0024.00Total prospective payment (sum of lines 3, 4, 8 and 9)12224.0025.00Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)025.0026.00Deductibles and coinsurance relating to amount on line 24 and the sum of lines 22 and 23] (see16127.0027.00Subtral [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see16127.0027.00ESRD direct medical education costs (from Wkst. E-4, line 36)028.0029.0028.00Pincet graduate medical education costs (from Wkst. E-4, line 36)029.0029.0020.00Subtral (Sum 30 minus line 31)16130.0031.0031.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)31.0033.00Composite rate ESRD (from Wkst. I-5, line 11)034.0034.00Alusable bad debts (see instructions)036.0035.00Adjusted reimbursable bad debts (see instructions)036.0036.00Alusable bad debts (See Instructions)038.0037.00Subtotal (see instructions)038.0038.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)39.0039.99Partial or full credits received from manufacturers for replaced devices (see instructions)39.9339.99REOVERY OF ACCELERATED DEPRECIATION39.93 | 21 00 | | e instructions) | | 51 | 21 00 |
| 24.00Total prospective payment (sum of lines 3, 4, 8 and 9)12224.000COMPUTATION OF REIMBURSENENT SETTLEMENT025.00Deductibles and coinsurance (for CAH, see instructions)1226.0026.00Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)1226.0027.00Subtral [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see16127.0027.00Direct graduate medical education payments (from Wkst. E-4, line 50)028.0029.00ESRD direct medical education costs (from Wkst. E-4, line 36)029.0020.00Primary payer payments031.0020.00Subtral (Sum 30 minus line 31)16132.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)33.0033.0033.00Composite rate ESRD (from Wkst. 1-5, line 11)034.0035.00Adjusted reimbursable bad debts (see instructions)034.0036.00Subtrali (see instructions)036.0037.00Subtrali (see instructions)038.0038.00OTHER ADJUSTIKITS (SEE INSTRUCTIONS) (SPECIFY)039.0039.99Partial or full credits received from manufacturers for replaced devices (see instructions)39.9339.99Requestration adjustment (see instructions)39.9339.99Recovery of ACCELERATED DEPRECIATION34.0030.00Subtrati (see instructions)39.9039.99Recovery of ACCELERATED DEPRECIATION34.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | | | | |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT025.00Deductibles and coinsurance (for CAH, see instructions)026.00Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)1227.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see16127.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see16128.00Direct graduate medical education costs (from Wkst. E-4, line 36)029.00ESR0 direct medical education costs (from Wkst. E-4, line 36)030.00Subtotal (sum of lines 27 through 29)16131.00Subtotal (line 30 minus line 31)161ALLOWABLE BAD DEBTS FOR PROFESSIONAL SERVICES)33.0033.00Composite rate ESR0 (from Wkst. 1-5, line 11)034.00Allowable bad debts (see instructions)035.00Subtotal (see instructions)036.00Allowable bad debts (see instructions)036.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADUSTMENTS (SEE INSTRUCTIONS) (SEE INSTRUCTIONS)039.99Partial or full credits received from manufacturers for replaced devices (see instructions)39.9339.99Partial or full credits received from manufacturers for replaced devices (see instructions)39.9339.99Partial or full credits received from manufacturers for replaced devices (see instructions)39.9339.99Partial or full credits received from manufacturers for replaced devices (see instructions) | | | ructions) | | | |
| 25.00Deductibles and coinsurance (for CAH, see instructions)025.0026.00Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)1226.0027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)16127.0028.00Direct graduate medical education payments (from Wkst. E-4, line 36)029.0029.00ESRD direct medical education costs (from Wkst. E-4, line 36)029.0030.00Subtotal (sum of lines 27 through 29)16130.0031.00Primary payer payments031.0032.00Composite rate ESRD (from Wkst. I-5, line 11)16133.00Composite rate ESRD (from Wkst. I-5, line 11)033.00Adjusted reimbursable bad debts (see instructions)036.00Micro reconciliation amount from PS&R039.00MSP-LCC reconciliation amount from PS&R039.99Partial or full credits received from manufacturers for replaced devices (see instructions)39.9339.99Partial or full credits received from manufacturers for replaced devices (see instructions)39.9339.99RECOVERV OF ACCELERATED DEPRECIATION030.00Subtotal (see instructions)39.9339.99RECOVERV OF ACCELERATED DEPRECIATION39.9030.90Other estimation adjustment (see instructions)39.9039.90Composite rate estimation (see instructions)40.0141.00Interim payments-54.4042.00 <td>24.00</td> <td></td> <td></td> <td></td> <td>122</td> <td>24.00</td> | 24.00 | | | | 122 | 24.00 |
| 26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 12 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 161 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 30) 0 28.00 28.00 0.00 Subtotal (sum of lines 27 through 29) 161 30.00 29.00 31.00 Primary payer payments 0 31.00 31.00 31.00 31.00 31.00 31.00 32.00 34.00 34.00 34.00 34.00 35.00 34.00 35.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 38.00 < | 25 00 | | | | 0 | 25 00 |
| Instructions)028.00Direct graduate medical education payments (from Wkst. E-4, line 50)028.00Direct graduate medical education costs (from Wkst. E-4, line 36)030.00Subtotal (sum of lines 27 through 29)16131.00Finary payments032.00Subtotal (line 30 minus line 31)161ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)032.00Composite rate ESRD (from Wkst. I-5, line 11)033.00Allowable bad debts (see instructions)035.00Adj usted reimbursable bad debts (see instructions)036.00Allowable bad debts (see instructions)036.00Subtotal (see instructions)037.00Subtotal (see instructions)038.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.90Partial or full credits received from manufacturers for replaced devices (see instructions)39.9839.99RECOVERY OF ACCELERATED DEPRECIATION39.0940.00Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Fortative settlement (for contractors use only)042.0043.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.243.0070.00Orliginal outlier amount (see instructions)099.0090.00Therate used to calculate the Time Value of Money< | | | r CAH, see instructions) | | | |
| 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 Direct medical education costs (from Wkst. E-4, line 36) 0 29.00 0.00 Skbtotal (sum of lines 27 through 29) 161 30.00 30.00 Subtotal (sum of lines 27 through 29) 31.00 31.00 7 31.00 7 31.00 | 27.00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) | | | 161 | 27.00 |
| 29.00ESRD direct medical education costs (from Wkst. E-4, line 36)029.0030.00Subtotal (sum of lines 27 through 29)16130.0031.00Primary payer payments031.0032.00Subtotal (line 30 minus line 31)16132.00ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)33.00Composite rate ESRD (from Wkst. I-5, line 11)033.0034.00Allowable bad debts (see instructions)034.0035.00Adjusted reinbursable bad debts (see instructions)034.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)036.0037.00Subtotal (see instructions)036.0038.00MSP-LCC reconciliation amount from PS&R039.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.01Iterim payments16341.0041.00Interim payments042.0042.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2-570.00Outlier reconciliation adjustment amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)090.0092.00The rate used to calculate the Time Value of Money0.0092. | 20.00 | | | | 0 | 20.00 |
| 30.00Subtotal (sum of lines 27 through 29)16130.0031.00Primary payer payments031.0032.00Subtotal (line 30 minus line 31)161ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)033.0033.00Composite rate ESRD (from Wkst. 1-5, line 11)033.0034.00Allowable bad debts (see instructions)034.0035.00Adj usted reimbursable bad debts (see instructions)035.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)036.0037.00Subtotal (see instructions)036.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.99RECOVERY OF ACCELERANTED DEPRECIATION039.9039.99RECOVERY OF ACCELERANTED DEPRECIATION039.9940.00Subtotal (see instructions)16140.0041.00Interim payments16341.0042.00Tentative settlement (for contractors use only)340.0142.00Tentative settlement (for contractors use only)-543.0043.00Balance due provi der/program (see instructions)-543.0043.00Dialance due provi der/program (see instructions)040.0043.00Balance due provi der/program (see instructions)090.0043.00Dialance due provi der/program (see instructions)044.00 <tr< td=""><td></td><td></td><td>The so)</td><td></td><td></td><td></td></tr<> | | | The so) | | | |
| 31.00 Primary payer payments 0 31.00 32.00 Subtotal (line 30 minus line 31) 161 32.00 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 0 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 0 36.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 38.00 39.90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.90 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.90 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.90 40.01 Sequestration adjustment (see instructions) 0 39.99 40.01 Interim payments 161 41.00 41.00 Sequestration adjustment (see instructions) -5 43.00 42.00 | | | | | | |
| ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)33.00Composite rate ESRD (from Wkst. I-5, line 11)034.00Allowable bad debts (see instructions)035.00Adjusted reimbursable bad debts (see instructions)036.00Allowable bad debts for dual eligible beneficiaries (see instructions)037.00Subtotal (see instructions)038.00MSP-LCC reconciliation amount from PS&R039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.90OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.99RECOVERY OF ACCELERATED DEPRECIATION39.9000Subtotal (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION34.0001Interim payments1610200Interim payments1630301Sequestration adjustment (see instructions)003030044.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 044.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | 31.00 | Primary payer payments | | | 0 | 31.00 |
| 33.00Composite rate ESRD (from Wkst. I-5, line 11)033.0034.00Allowable bad debts (see instructions)034.0035.00Adjusted reimbursable bad debts (see instructions)034.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)036.0037.00Subtotal (see instructions)036.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.5039.99Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9040.00Subtotal (see instructions)16140.0040.01Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.243.0044.00Original outlier amount (see instructions)090.0090.00Original outlier amount (see instructions)090.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)092.0093.00Time Value of Money (see instructions)093.00 | 32.00 | | 250) | | 161 | 32.00 |
| 34.00Allowable bad debts (see instructions)034.0035.00Adjusted reimbursable bad debts (see instructions)035.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)036.0037.00Subtotal (see instructions)16137.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.90Pioneer ACO demonstration payment adjustment (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9040.00Sequestration adjustment (see instructions)16140.0040.01Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Tentative settlement (for contractors use only)34.0043.00Balance due provi der/program (see instructions)-544.00Sti15.2-543.0070.00Original outlier amount (see instructions)090.0090.00Original outlier amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.0093.00Time Value of Money (see instructions)093.00 | 33 00 | | JES) | | 0 | 33 00 |
| 35.00Adjusted reimbursable bad debts (see instructions)035.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)036.0037.00Subtotal (see instructions)16137.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.92Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)034.0040.01Sequestration adjustment (see instructions)16140.0041.00Interim payments16341.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-543.0044.00Protested amounts (nonall owable cost report items) in accordance with CMS Pub. 15-2, chapter 1, TO BE COMPLETED BY CONTRACTOR090.0090.00Original outlier amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money092.0093.00The rate used to calculate the Time Value of Money0.0093.0093.00Time Value of Money (see instructions)093.00 | | • | | | | |
| 37.00Subtotal (see instructions)16137.0038.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Pioneer ACD demonstration payment adjustment (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9839.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)16140.0040.01Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Tentative settlement (for contractors use only)3343.00Balance due provider/program (see instructions)-543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, (\$15.2090.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | 35.00 | Adjusted reimbursable bad debts (see instructions) | | | 0 | 35.00 |
| 38.00MSP-LCC reconciliation amount from PS&R038.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Pioneer ACO demonstration payment adjustment (see instructions)039.0039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9840.00Subtotal (see instructions)16140.0040.01Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 090.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | | 5 | ructions) | | | 1 |
| 39.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.50Pioneer AC0 demonstration payment adjustment (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)16140.0040.01Sequestration adjustment (see instructions)340.0140.01Interim payments16341.0041.00Interim payments16341.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-543.0044.00Stits.2-543.0070De COMPLETED BY CONTRACTOR090.0090.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money093.0093.00Time Value of Money (see instructions)093.00 | | · · · · · · · · · · · · · · · · · · · | | | | |
| 39.50Pioneer ACO demonstration payment adjustment (see instructions)039.5039.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9039.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)16140.0040.01Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-543.0044.00Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2090.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | | | | | | 1 |
| 39.99RECOVERY OF ACCELERATED DEPRECIATION039.9940.00Subtotal (see instructions)16140.0040.01Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2044.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | 39.50 | Pioneer ACO demonstration payment adjustment (see instruction | - | | 0 | 39.50 |
| 40.00Subtotal (see instructions)16140.0040.01Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2-543.0070BE COMPLETED BY CONTRACTOR90.0090.0091.00Outlier amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money092.0093.00Time Value of Money (see instructions)093.00 | | · · · · · · · · · · · · · · · · · · · | ced devices (see instruc | tions) | | 1 |
| 40.01Sequestration adjustment (see instructions)340.0141.00Interim payments16341.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2-543.0090.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | | | | | | 1 |
| 41.00Interim payments16341.0042.00Tentative settlement (for contractors use only)042.0043.00Balance due provider/program (see instructions)-543.0044.00Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115.2-543.0070BE COMPLETED BY CONTRACTOR90.0090.00Original outlier amount (see instructions)091.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | | · · · · · · · · · · · · · · · · · · · | | | | |
| 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Balance due provider/program (see instructions) -5 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 -5 44.00 5115.2 TO BE COMPLETED BY CONTRACTOR 0 90.00 90.00 90.00 90.00 Original outlier amount (see instructions) 0 91.00 91.00 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 0 93.00 | | | | | | |
| 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> <u>TO BE COMPLETED BY CONTRACTOR</u> 90.00 44.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money 0.00 93.00 Time Value of Money (see instructions) 0 | | | | | | 1 |
| §115.2TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)00.010.010.020.030.040.040.050.050.060.070.070.080.00 | | | | | | 1 |
| 90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | 44.00 | §115. 2 | nce with CMS Pub. 15-2, | cnapter 1, | 0 | 44.00 |
| 91.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | | | | | | |
| 92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00 | | | | | | |
| 93.00 Time Value of Money (see instructions) 0 93.00 | | | | | | |
| | | 3 | | | | |
| | 94.00 | | | | 0 | 94.00 |

| IALY: | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CC | CN: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | | pare 1 pm |
|----------------------------|--|--|--------------------------|---|------------------------------|----------------------------|
| | | | XVIII | Hospi tal | PPS | |
| | | Inpati en | 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 amount based on subsequent revision of the interim rate | | 5, 702, 7 | 45 0 | 4, 400, 706 0 | 1. 2. 3. |
| | for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | | | | | |
| | Program to Provider | I | | | | |
| 01 02 03 04 05 | ADJUSTMENTS TO PROVIDER | 07/22/2016 12/31/2016 07/21/2017 | 32, 7 24, 5 120, 0 | 59 12/31/2016 | 0 118, 891 0 0 0 | 3. 3. 3. 3. 3. |
| | Provider to Program | | | | | |
| 50 51 52 53 54 | ADJUSTMENTS TO PROGRAM | | | 0 07/21/2017 0 0 0 | 70, 541 0 0 0 0 | 3 3 3 3 |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | 177, 3 | 24 | 48, 350 | 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, 880, 0 | 69 | 4, 449, 056 | 4 |
| 00 | TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after | | | | | 5 |
| 50 | desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | |
| 01 | TENTATI VE TO PROVI DER | | | 0 | 0 | 5 |
| 02 | | | | 0 | 0 | 5 |
| 03 | | | | 0 | 0 | 5 |
| 50 | Provider to Program TENTATIVE TO PROGRAM | | | 0 | 0 | 5 |
| 50 51 | IENTATIVE TO PROGRAM | | | 0 | 0 | 5 |
| 52 | | | | 0 | Ő | 5 |
| 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) | | | 0 | 0 | 5 |
| 00 | Determined net settlement amount (balance due) based on the cost report. (1) | | | | | 6 |
| 01 | SETTLEMENT TO PROVIDER | | | 0 | 79, 366 | 6 |
| 02 | SETTLEMENT TO PROGRAM | | 60, 4 5, 910, 6 | | 0 4, 528, 422 | 6 |
| 00 | Total Medicare program liability (see instructions) | | 5, 819, 6 | Contractor Number | NPR Date (Mo/Day/Yr) | / |
| | | |) | 1.00 | 2.00 | |
| 00 | Name of Contractor | | | | | 6 |

| NALYS | IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CC Component (| CN: 15-0001 CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | | oared: 1 pm |
|----------------------------|--|----------------------------|-----------------------------|---|-------------------------|---|
| | | Ti tl e | XVIII | Subprovider - IRF | PPS | • |
| | | I npati en | t Part A | | t B | |
| | | mm/dd/yyyy | Amount | | Amount | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | |
| . 00 2. 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 | | 997, 3 | 34 0 | 163 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. 01 |
| . 02 . 03 . 04 | | | | 0 0 0 | 0 0 0 | 3. 02 3. 03 3. 04 |
| . 05 | Provider to Program | | | 0 | 0 | 3.05 |
| . 50 | ADJUSTMENTS TO PROGRAM | 07/21/2017 | 15, 7 | 37 | 0 | 3.50 |
| 51 52 53 54 99 | | 0772172017 | | 0 0 0 0 | | 3. 51 3. 52 3. 53 3. 54 3. 99 |
| 99 00 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) | | -15, 7 | | 163 | 3.9° 4.00 |
| 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) TO BE COMPLETED BY CONTRACTOR | | 981, 5 | 77 | 105 | 4.00 |
| . 00 | List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | 5.00 |
| 01 | TENTATI VE TO PROVI DER | | | 0 | 0 | 5.01 |
| . 02 . 03 | | | | 0 | 0 | 5. 02 5. 03 |
| | Provider to Program | | | | | |
| . 50 . 51 . 52 | TENTATI VE TO PROGRAM | | | 0 0 0 | 0 0 0 | 5.50 5.51 5.52 |
| 99 00 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on | | | 0 | 0 | 5.99 6.00 |
| . 00 | the cost report. (1) SETTLEMENT TO PROVIDER | | | 0 | 0 | 6. 01 |
| . 02 . 00 | SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) | | 981, 5 | 0 | 5 158 | 6. 02 7. 00 |
| 7.00 | | (| | Contractor Number | NPR Date (Mo/Day/Yr) | |

| Heal th | Financial Systems JOHNSON MEMORI | AL HOSPITAL | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|---------------------------|----------------------------|---------------------------------|---------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT | Provider CCN: 15-0001 | Period: From 01/01/2016 | Worksheet E-1 Part II | |
| | | | To 12/31/2016 | Date/Time Prep 1/16/2018 3:0 | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | | | | 1.00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI | | | | |
| 1.00 | Total hospital discharges as defined in AARA §4102 from Wks | | e 14 | 2, 053 | 1.00 |
| 2.00 | Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, | 8-12 | | 2, 944 | 2.00 |
| 3.00 | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 | | | 679 | 3.00 |
| 4.00 | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, | 8-12 | | 6, 494 | 4.00 |
| 5.00 | Total hospital charges from Wkst C, Pt. I, col. 8 line 200 | | | 190, 370, 525 | 5.00 |
| 6.00 | Total hospital charity care charges from Wkst. S-10, col. 3 | line 20 | | 3, 806, 152 | 6.00 |
| 7.00 | CAH only - The reasonable cost incurred for the purchase of line 168 | certified HIT technology | Wkst. S-2, Pt. I | 0 | 7.00 |
| 8.00 | Calculation of the HIT incentive payment (see instructions) | | | 0 | 8.00 |
| 9.00 | Sequestration adjustment amount (see instructions) | | | 0 | 9.00 |
| 10,00 | Calculation of the HIT incentive payment after sequestration | n (see instructions) | | 0 | 10.00 |
| 10100 | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | | | 10100 |
| 30, 00 | Initial/interim HIT payment adjustment (see instructions) | | | 0 | 30.00 |
| 31.00 | Other Adjustment (specify) | | | 0 | 31.00 |
| 32.00 | Balance due provider (line 8 (or line 10) minus line 30 and | line 31) (see instruction | ns) | 0 | 32.00 |
| 02.00 | | | , | °1 | 02.00 |

| | Financial Systems JOHNSON MEMORIAL | | | u of Form CMS-2 | |
|-------|--|---------------------------|----------------------------|--------------------------------|--------|
| ALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 | Period: From 01/01/2016 | Worksheet E-3 Part III | |
| | | Component CCN: 15-T001 | To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | |
| | | Title XVIII | Subprovider - | PPS | i piii |
| | | | | 1.00 | |
| | PART III - MEDICARE PART A SERVICES - IRF PPS | | | 1.00 | |
| . 00 | Net Federal PPS Payment (see instructions) | | | 940, 486 | |
| . 00 | Medicare SSI ratio (IRF PPS only) (see instructions) | | | 0. 0132 | 2. |
| . 00 | Inpatient Rehabilitation LIP Payments (see instructions) | | | 34, 704 | 3. |
| . 00 | Outlier Payments | | | 40, 580 | 4. |
| . 00 | Unweighted intern and resident FTE count in the most recent c | ost reporting period en | ding on or prior | 0.00 | 5. |
| | to November 15, 2004 (see instructions) | | | | |
| . 01 | Cap increases for the unweighted intern and resident FTE coun | | | 0.00 | 5. |
| | program or hospital closure, that would not be counted without | it a temporary cap adjust | ment under 42 | | |
| | CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions) | | | | |
| . 00 | New Teaching program adjustment. (see instructions) | | | 0.00 | 6. |
| . 00 | Current year's unweighted FTE count of I&R excluding FTEs in | the new program growth p | eriod of a "new | 0.00 | 7. |
| | teaching program" (see instructions) | | | | |
| . 00 | Current year's unweighted I&R FTE count for residents within | the new program growth p | eriod of a "new | 0.00 | 8. |
| | teaching program" (see instructions) | | | | |
| . 00 | Intern and resident count for IRF PPS medical education adjus | stment (see instructions) | | 0.00 | |
| 0.00 | Average Daily Census (see instructions) | | | 3.991803 | |
| 1.00 | Teaching Adjustment Factor (see instructions) | | | 0.00000 | |
| 2.00 | Teaching Adjustment (see instructions) | | | 0 | |
| 3.00 | Total PPS Payment (see instructions) | | | 1, 015, 770 | |
| 4.00 | Nursing and Allied Health Managed Care payments (see instruct | i on) | | 0 | |
| 5.00 | Organ acquisition (DO NOT USE THIS LINE) | | | | 15 |
| 5.00 | Cost of physicians' services in a teaching hospital (see inst | ructions) | | 0 | |
| 7.00 | Subtotal (see instructions) | | | 1, 015, 770 | |
| 3. 00 | Primary payer payments | | | 0 | |
| 9.00 | Subtotal (line 17 less line 18). | | | 1, 015, 770 | |
| 0. 00 | Deducti bl es | | | 11, 564 | |
| 1.00 | Subtotal (line 19 minus line 20) | | | 1, 004, 206 | 21. |
| 2.00 | Coinsurance | | | 2, 576 | 22 |
| 3.00 | Subtotal (line 21 minus line 22) | | | 1, 001, 630 | 23 |
| 4.00 | Allowable bad debts (exclude bad debts for professional servi | ces) (see instructions) | | 0 | 24. |
| 5.00 | Adjusted reimbursable bad debts (see instructions) | | | 0 | 25 |
| 6. 00 | Allowable bad debts for dual eligible beneficiaries (see inst | ructions) | | 0 | 26 |
| 1.00 | Subtotal (sum of lines 23 and 25) | | | 1, 001, 630 | 27 |
| 3.00 | Direct graduate medical education payments (from Wkst. E-4, I | ine 49) | | 0 | 28 |
| 9.00 | Other pass through costs (see instructions) | | | 0 | 29 |
| D. 00 | Outlier payments reconciliation | | | 0 | 30. |
| 1.00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | | 0 | 31 |
| 1.50 | Pioneer ACO demonstration payment adjustment (see instruction | is) | | 0 | 31 |
| 1. 99 | Recovery of Accel erated Depreciation | | | 0 | 31 |
| 2.00 | Total amount payable to the provider (see instructions) | | | 1,001,630 | 32 |
| 2. 01 | Sequestration adjustment (see instructions) | | | 20, 033 | 32 |
| 3. 00 | Interim payments | | | 981, 597 | |
| 4.00 | Tentative settlement (for contractor use only) | | | 0 | |
| 5.00 | Balance due provider/program (line 32 minus lines 32.01, 33, | and 34) | | 0 | |
| 6. 00 | Protested amounts (nonallowable cost report items) in accorda | | chapter 1, | 32, 291 | |
| | \$115.2 TO BE COMPLETED BY CONTRACTOR | | | | 1 |
| 0. 00 | Original outlier amount from Wkst. E-3, Pt. III, line 4 | | | 40, 580 | 50. |
| 1.00 | Outlier reconciliation adjustment amount (see instructions) | | | 40, 300 | |
| 2.00 | The rate used to calculate the Time Value of Money | | | 0.00 | |
| | Time Value of Money (see instructions) | | | | 53. |

| | ATION OF REIMBURSEMENT SETTLEMENT P | Provider CCN: 15-0001 | Peri od: | Worksheet E-3 | |
|----------|--|------------------------|----------------------------------|---------------------|----------|
| | | | From 01/01/2016 To 12/31/2016 | | |
| | | | Hocpi tol | 1/16/2018 3:0 | 1 pm |
| | | Title XIX | Hospi tal | Cost Outpati ent | |
| | | | 1.00 | 2.00 | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI | CES FOR TITLES V OR X | | 2.00 | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | 1 |
| 00 | Inpatient hospital/SNF/NF services | | 234, 165 | | 1 1.0 |
| 00 | Medical and other services | | | 0 | 2.0 |
| 00 | Organ acquisition (certified transplant centers only) | | 0 | | 3. (|
| 00 | Subtotal (sum of lines 1, 2 and 3) | | 234, 165 | 0 | |
| 00 | Inpatient primary payer payments | | 0 | | 5.0 |
| 00 | Outpatient primary payer payments | | 004.445 | 0 | |
| 00 | Subtotal (line 4 less sum of lines 5 and 6) | | 234, 165 | 0 | 7.0 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | - |
| 0 | Reasonable Charges | | 240 197 | | |
| 00 00 | Routine service charges Ancillary service charges | | 260, 187 290, 408 | 0 | 8. 9. |
| 00 | Organ acquisition charges, net of revenue | | 290, 408 | 0 | 10. |
| 00 | Incentive from target amount computation | | 0 | | 11. |
| 00 | Total reasonable charges (sum of lines 8 through 11) | | 550, 595 | 0 | 12. |
| 00 | CUSTOMARY CHARGES | | 000,070 | | |
| 00 | Amount actually collected from patients liable for payment for s | services on a charge | 0 | 0 | 13. |
| | basi s | 5 | | | |
| 00 | Amounts that would have been realized from patients liable for p | payment for services o | on O | 0 | 14. |
| | a charge basis had such payment been made in accordance with 42 | CFR §413.13(e) | | | |
| 00 | Ratio of line 13 to line 14 (not to exceed 1.000000) | | 0. 000000 | 0.00000 | |
| | Total customary charges (see instructions) | | 550, 595 | 0 | |
| 00 | Excess of customary charges over reasonable cost (complete only | if line 16 exceeds | 316, 430 | 0 | 17. |
| 00 | line 4) (see instructions) | if line 4 exceeds lin | | 0 | 10 |
| 00 | Excess of reasonable cost over customary charges (complete only 16) (see instructions) | 11 TITLE 4 exceeds TIT | 0 | 0 | 18. |
| 00 | Interns and Residents (see instructions) | | 0 | 0 | 19. |
| 00 | Cost of physicians' services in a teaching hospital (see instruc | ctions) | 0 | 0 | |
| | Cost of covered services (enter the lesser of line 4 or line 16) | | 234, 165 | 0 | |
| | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co | | | - | 1 |
| | Other than outlier payments | - I - I | 0 | 0 | 22. |
| 00 | Outlier payments | | 0 | 0 | 23. |
| 00 | Program capital payments | | 0 | | 24. |
| 00 | Capital exception payments (see instructions) | | 0 | | 25. |
| 00 | Routine and Ancillary service other pass through costs | | 0 | 0 | |
| 00 | Subtotal (sum of lines 22 through 26) | | 0 | 0 | 1 - · · |
| | Customary charges (title V or XIX PPS covered services only) | | 0 | 0 | |
| 00 | Titles V or XIX (sum of lines 21 and 27) | | 234, 165 | 0 | 29. |
| ~~ | COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | 0 | 1 20 |
| 00 | Excess of reasonable cost (from line 18) | | 0 | 0 | |
| 00 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | | 234, 165 | 0 | |
| 00 | Deducti bl es Coi nsurance | | 0 | 0 | |
| | Allowable bad debts (see instructions) | | 0 | - | 34. |
| 00 | Utilization review | | 0 | 0 | 35. |
| 00 | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3 | 33) | 234, 165 | 0 | |
| 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | | 237,103 | 0 | |
| 00 | Subtotal (line 36 ± line 37) | | 234, 165 | 0 | |
| 00 | Direct graduate medical education payments (from Wkst. E-4) | | 201, 100 | 0 | 39. |
| 00 | Total amount payable to the provider (sum of lines 38 and 39) | | 234, 165 | 0 | |
| | Interim payments | | 284, 981 | 0 | |
| 00 | ···· | | | Ũ | |
| 00 00 | Balance due provider/program (line 40 minus line 41) | | -50, 816 | 0 | 42. |

| _CUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0001 Component CCN: 15-T001 | Period: From 01/01/2016 To 12/31/2016 | Worksheet E-3 Part VII Date/Time Pre | |
|----------|---|---|---|--|-----|
| | | | 10 12/31/2016 | 1/16/2018 3:0 | |
| | | Title XIX | Subprovider - IRF | Cost | |
| | | | Inpatient 1.00 | Outpatient 2.00 | |
| | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF | RVICES FOR TITLES V OR X | | 2.00 | |
| | COMPUTATION OF NET COST OF COVERED SERVICES | | | | 1 |
| 00 | Inpatient hospital/SNF/NF services | | 18, 756 | |] · |
| 00 | Medical and other services | | | 0 | |
| 00 | Organ acquisition (certified transplant centers only) | | 0 | | |
| 00 | Subtotal (sum of lines 1, 2 and 3) | | 18, 756 | 0 | |
| 00 | Inpatient primary payer payments | | 0 | _ | 1 |
| 00 | Outpatient primary payer payments | | | 0 | |
| 00 | Subtotal (line 4 less sum of lines 5 and 6) | | 18, 756 | 0 | 1 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | 4 |
| 0 | Reasonable Charges | | 0.077 | | Η. |
| 00 00 | Routine service charges Ancillary service charges | | 9, 277 9, 285 | 0 | |
| 00 | Organ acquisition charges, net of revenue | | 9, 203 | 0 | 1 |
| 00 | Incentive from target amount computation | | 0 | | 1 |
| 00 | Total reasonable charges (sum of lines 8 through 11) | | 18, 562 | 0 | |
| 00 | CUSTOMARY CHARGES | | 10,002 | | 1 |
| 00 | Amount actually collected from patients liable for payment for | r services on a charge | 0 | 0 | 1: |
| | basi s | 5 | | | |
| 00 | Amounts that would have been realized from patients liable for | r payment for services o | n 0 | 0 | 14 |
| | a charge basis had such payment been made in accordance with ${\mbox{\sc 4}}$ | | | | |
| | Ratio of line 13 to line 14 (not to exceed 1.000000) | | 0.000000 | 0.00000 | |
| | Total customary charges (see instructions) | | 18, 562 | 0 | |
| 00 | Excess of customary charges over reasonable cost (complete onl | y if line 16 exceeds | 0 | 0 | 1 |
| ~~ | line 4) (see instructions) | | - 104 | 0 | |
| 00 | Excess of reasonable cost over customary charges (complete onl 16) (see instructions) | y II IIne 4 exceeds IIn | e 194 | 0 | 1 |
| 00 | Interns and Residents (see instructions) | | 0 | 0 | 1 |
| | Cost of physicians' services in a teaching hospital (see instr | ructions) | 0 | 0 | |
| 00 | Cost of covered services (enter the lesser of line 4 or line 1 | | 18, 562 | 0 | |
| | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be | | | | |
| 00 | Other than outlier payments | · · | 0 | 0 | 2 |
| 00 | Outlier payments | | 0 | 0 | 2 |
| 00 | Program capital payments | | 0 | | 2 |
| 00 | Capital exception payments (see instructions) | | 0 | | 2 |
| 00 | Routine and Ancillary service other pass through costs | | 0 | 0 | |
| | Subtotal (sum of lines 22 through 26) | | 0 | 0 | |
| | Customary charges (title V or XIX PPS covered services only) | | 0 | 0 | |
| 00 | Titles V or XIX (sum of lines 21 and 27) | | 18, 562 | 0 | 2 |
| 00 | COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18) | | 194 | 0 | 3 |
| | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | | 194 18, 562 | 0 | |
| | Deductibles | , | 10, 502 | 0 | |
| 00 | Coi nsurance | | 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 | d 33) | 18, 562 | 0 | |
| 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 0 | 0 | 3 | |
| 00 | Subtotal (line 36 ± line 37) | 18, 562 | 0 | | |
| 00 | Direct graduate medical education payments (from Wkst. E-4) | 0 | | 3 | |
| 00 | Total amount payable to the provider (sum of lines 38 and 39) | | 18, 562 | 0 | |
| 00 | Interim payments | | 8, 994 | 0 | |
| | Balance due provider/program (line 40 minus line 41) | | 9, 568 | 0 | |
| 00 | Protested amounts (nonallowable cost report items) in accordar | nce with CMS Pub 15-2, | 0 | 0 | 43 |

| LANCE | inancial Systems JOHNSON MEMORI SHEET (If you are nonproprietary and do not maintain | Provider C | | eriod: | u of Form CMS-2 Worksheet G | |
|-----------------|---|-----------------------------|--------------------------|--------------------------------|--------------------------------|------|
| ınd-typ ıly) | e accounting records, complete the General Fund column | | | rom 01/01/2016 o 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | |
| | | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
| 0 | | 1.00 | 2.00 | 3.00 | 4.00 | |
| | JRRENT ASSETS ash on hand in banks | 44, 512, 427 | 0 | 0 | 0 | 1 1 |
| | emporary investments | 14, 312, 42, | 0 | 0 | 0 | 2 |
| | otes receivable | 0 | 0 | 0 | 0 | 3 |
| 00 A | ccounts receivable | 17, 292, 322 | 0 | 0 | 0 | 4 |
| | ther receivable | 49, 091 | 0 | 0 | 0 | |
| | llowances for uncollectible notes and accounts receivable | 0 | 0 | 0 | 0 | 6 |
| | nventory repaid expenses | 1, 533, 137 | 0 | 0 | 0 | 7 |
| | ther current assets | 1, 210, 440 32, 814, 313 | | 0 | 0 | 9 |
| | ue from other funds | 02,014,019 | 0 | 0 | 0 | 10 |
| | otal current assets (sum of lines 1-10) | 97, 411, 730 | 0 | 0 | 0 | 11 |
| FI | I XED ASSETS | | | | | |
| | and | 4, 743, 329 | | | 0 | 12 |
| | and improvements | 2, 746, 206 | | 0 | 0 | |
| | ccumulated depreciation | -1, 021, 645 | | 0 | 0 | 14 |
| | uildings | 68, 972, 645 | | 0 | 0 | 15 |
| | ccumulated depreciation easehold improvements | -32, 261, 668 | | 0 | 0 | 17 |
| | ccumul ated depreciation | 0 | 0 | 0 | 0 | 18 |
| | i xed equipment | 12, 930, 439 | 0 | 0 | 0 | 19 |
| | ccumulated depreciation | -9, 995, 647 | 0 | 0 | 0 | 20 |
| 00 A | utomobiles and trucks | 0 | 0 | 0 | 0 | 21 |
| | ccumulated depreciation | 0 | 0 | 0 | 0 | 22 |
| | ajor movable equipment | 50, 480, 013 | 0 | 0 | 0 | 23 |
| | ccumulated depreciation | -31, 656, 264 | 0 | 0 | 0 | 24 |
| | inor equipment depreciable ccumulated depreciation | 0 | | 0 | 0 | 25 |
| | IT designated Assets | 0 | | 0 | 0 | 27 |
| | ccumul ated depreciation | 0 | | 0 | 0 | 28 |
| | i nor equi pment-nondepreci abl e | 0 | 0 | 0 | 0 | 29 |
| | otal fixed assets (sum of lines 12-29) | 64, 937, 408 | | | 0 | 30 |
| 0 | THER ASSETS | | | | | |
| | nvestments | 0 | 0 | - | 0 | 31 |
| | eposits on Leases | 0 | 0 | 0 | 0 | 32 |
| | ue from owners/officers ther assets | 0 | 0 | 0 | 0 | 33 |
| | otal other assets (sum of lines 31-34) | 2, 424, 783 2, 424, 783 | | 0 | 0 | 34 |
| | otal assets (sum of lines 11, 30, and 35) | 164, 773, 921 | 0 | - | 0 | |
| | URRENT LI ABI LI TI ES | 104, 113, 721 | 0 | 9 | 0 | 1 30 |
| | ccounts payable | 3, 622, 786 | 0 | 0 | 0 | 37 |
| 00 S | al ari es, wages, and fees payable | 5, 134, 595 | 0 | 0 | 0 | 38 |
| | ayroll taxes payable | 0 | 0 | 0 | 0 | |
| | otes and loans payable (short term) | 0 | 0 | 0 | 0 | |
| | eferred income | 0 | 0 | 0 | 0 | |
| | ccelerated payments | 0 | 0 | 0 | 0 | 42 |
| | ue to other funds ther current liabilities | 488 22, 493 | | 0 | 0 | |
| | otal current liabilities (sum of lines 37 thru 44) | 8, 780, 362 | | | 0 | |
| | ONG TERM LIABILITIES | 0,700,302 | 0 | 9 | 0 | 1 7. |
| | ortgage payable | 0 | 0 | 0 | 0 | 46 |
| 00 N | otes payable | 0 | 0 | 0 | 0 | 47 |
| 00 U | nsecured Loans | 0 | 0 | 0 | 0 | 48 |
| | ther long term liabilities | 0 | 0 | 0 | 0 | 49 |
| | otal long term liabilities (sum of lines 46 thru 49) | 0 | 0 | 0 | 0 | |
| | otal liabilities (sum of lines 45 and 50) APITAL ACCOUNTS | 8, 780, 362 | 0 | 0 | 0 | 51 |
| | eneral fund balance | 155, 993, 559 | | | | 52 |
| | pecific purpose fund | 100, 770, 007 | o | | | 53 |
| | onor created - endowment fund balance - restricted | | | о | | 54 |
| | onor created - endowment fund balance - unrestricted | | | o | | 55 |
| | overning body created - endowment fund balance | | | 0 | | 56 |
| | lant fund balance - invested in plant | | | | 0 | |
| | lant fund balance - reserve for plant improvement, | | | | 0 | 58 |
| | eplacement, and expansion | 455 000 5 | _ | _ | - | |
| | otal fund balances (sum of lines 52 thru 58) | 155, 993, 559 | | 0 | 0 | 59 |
| | otal liabilities and fund balances (sum of lines 51 and | 164, 773, 921 | | | 0 | 60 |

| Heal th | Financial Systems | JOHNSON MEMORIA | AL HOSPITAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|--|--|--|--|----------|---|--------------------------------|--|
| STATEN | IENT OF CHANGES IN FUND BALANCES | | Provider CC | | Period: From 01/01/2016 To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pared: 1 pm |
| | | General | Fund | Speci al | Purpose Fund | Endowment Fund | |
| | | 1.00 | 2.00 | 2.00 | 4.00 | F 00 | |
| 1.00 | Fund balances at beginning of period | 1.00 | 2.00 138,670,754 | 3.00 | 4.00 | 5.00 | 1.00 |
| $\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$ | Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TRANSFER FROM OTHER FUNDS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) | 19, 669, 892 0 0 0 0 0 0 0 0 0 0 0 0 | -2, 347, 087 136, 323, 667 19, 669, 892 155, 993, 559 | | | | 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 |
| 18.00 | Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) | | 0 155, 993, 559 | | | | 18. 00 19. 00 |
| | | Endowment Fund | PI ant | Fund | | | |
| | | 6.00 | 7.00 | 8.00 | | | |
| 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 | Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TRANSFER FROM OTHER FUNDS | 0 | 0 0 0 0 0 | | 0 | | 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 |
| 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 | Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18) | 0 0 0 | 0 0 0 0 0 0 | | 0 0 0 0 | | 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 |

| STATEN | IENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CC | N: 15-0001 | Period: From 01/01/2016 To 12/31/2016 | | pared: |
|----------------|--|---------------|-------------|---|-----------------|--------|
| | Cost Center Description | | Inpati ent | Outpati ent | Total | |
| | | | 1.00 | 2.00 | 3.00 | |
| | PART I - PATIENT REVENUES | • | | | | |
| | General Inpatient Routine Services | | | | | 1 |
| 1.00 | Hospi tal | | 11, 775, 7 | 13 | 11, 775, 713 | 1.00 |
| 2.00 | SUBPROVIDER - IPF | | | | | 2.00 |
| 3.00 | SUBPROVIDER - IRF | | 1, 856, 63 | 36 | 1, 856, 636 | 3.00 |
| 4.00 | SUBPROVI DER | | | | | 4.00 |
| 5.00 | Swing bed - SNF | | | 0 | 0 | 5.00 |
| 5.00 | Swing bed - NF | | | 0 | 0 | 6.00 |
| 7.00 | SKILLED NURSING FACILITY | | | | | 7.00 |
| 3.00 | NURSING FACILITY | | | | | 8.00 |
| 9.00 | OTHER LONG TERM CARE | | | | | 9.00 |
| 10.00 | Total general inpatient care services (sum of lines 1-9) | | 13, 632, 34 | 49 | 13, 632, 349 | 10.00 |
| | Intensive Care Type Inpatient Hospital Services | | | | т | |
| 11.00 | I NTENSI VE CARE UNI T | | 1, 995, 91 | 11 | 1, 995, 911 | 11.00 |
| 12.00 | CORONARY CARE UNIT | | | | | 12.00 |
| 13.00 | BURN INTENSIVE CARE UNIT | | | | | 13.00 |
| 14.00 | SURGI CAL INTENSI 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 11-15) | lines | 1, 995, 91 | 11 | 1, 995, 911 | 16.00 |
| 17.00 | Total inpatient routine care services (sum of lines 10 and 16) | | 15, 628, 26 | 60 | 15, 628, 260 | 17.00 |
| 18.00 | Ancillary services | | 31, 967, 56 | 61 108, 595, 779 | 140, 563, 340 | 18.00 |
| 19.00 | Outpatient services | | 3, 093, 51 | 12 29, 445, 469 | 32, 538, 981 | 19.00 |
| 20.00 | RURAL HEALTH CLINIC | | | 0 0 | 0 0 | 20.00 |
| 21.00 | FEDERALLY QUALIFIED HEALTH CENTER | | | 0 0 | 0 0 | 21.00 |
| 22.00 | HOME HEALTH AGENCY | | | 1, 574, 485 | 5 1, 574, 485 | 22.00 |
| 23.00 | AMBULANCE SERVICES | | | | | 23.00 |
| 24.00 | СМНС | | | | | 24.00 |
| 25.00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | | 25.00 |
| 26.00 | HOSPICE | | | | | 26.00 |
| 27.00 | PHYSI CI AN | | | 0 11, 002, 018 | | |
| 27.01 | DI ETARY | | | 0 632 | | |
| 27.02 | PRO FEES | | 54, 62 | | | |
| 28.00 | Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1) | to Wkst. | 50, 743, 96 | 61 151, 106, 518 | 3 201, 850, 479 | 28.00 |
| | PART II - OPERATING EXPENSES | | | | 1 | |
| 29.00 | Operating expenses (per Wkst. A, column 3, line 200) | | | 82, 973, 583 | 3 | 29.00 |
| 30.00 | ADD (SPECIFY) | | | 0 | | 30.00 |
| 31.00 | | | | 0 | | 31.00 |
| 32.00 | | | | 0 | | 32.0 |
| 33.00 | | | | 0 | | 33.00 |
| 34.00 | | | | 0 | | 34.0 |
| 35.00 | | | | 0 | | 35.00 |
| 36.00 | Total additions (sum of lines 30-35) | | | | 2 | 36.00 |
| 37.00 | DEDUCT (SPECI FY) | | | 0 | | 37.00 |
| 38.00 | | | | 0 | | 38.00 |
| 39.00 | | | | - | | 39.00 |
| 10.00 | | | | 0 | | 40.0 |
| 11.00 | Total doductions (sum of lines 27 41) | | | , | | 41.00 |
| 12.00 13.00 | Total deductions (sum of lines 37-41) |) (transfor | | | | 42.0 |
| +3.00 | Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4) | J (Li anster | | 82, 973, 583 | ין | 43.00 |

| Heal th | Financial Systems | JOHNSON MEMORIAL | HOSPI TAL | In Lie | u of Form CMS-2 | 2552-10 |
|---------|--|----------------------|-----------------------|-----------------|---------------------------------|---------------|
| STATE | MENT OF REVENUES AND EXPENSES | | Provider CCN: 15-0001 | Peri od: | Worksheet G-3 | |
| | | | | From 01/01/2016 | | |
| | | | | To 12/31/2016 | Date/Time Prep 1/16/2018 3:0 | |
| | | | | | 1710/2010 3.0 | <u>i piii</u> |
| | | | | | 1.00 | |
| 1.00 | Total patient revenues (from Wkst. G-2, Par | tl, column 3, line | e 28) | | 201, 850, 479 | 1.00 |
| 2.00 | Less contractual allowances and discounts of | on patients' account | ts | | 125, 142, 578 | 2.00 |
| 3.00 | Net patient revenues (line 1 minus line 2) | | | | 76, 707, 901 | 3.00 |
| 4.00 | Less total operating expenses (from Wkst. G | | 43) | | 82, 973, 583 | 4.00 |
| 5.00 | Net income from service to patients (line 3 | 8 minus line 4) | | | -6, 265, 682 | 5.00 |
| | OTHER I NCOME | | | | | |
| 6.00 | Contributions, donations, bequests, etc | | | | 0 | 6.00 |
| 7.00 | Income from investments | | | | 0 | 7.00 |
| 8.00 | Revenues from telephone and other miscellar | neous communication | servi ces | | 0 | 8.00 |
| 9.00 | Revenue from television and radio service | | | | 0 | 9.00 |
| 10.00 | Purchase di scounts | | | | 0 | 10.00 |
| 11.00 | | | | | 0 | 11.00 |
| | Parking lot receipts | | | | 0 | 12.00 |
| 13.00 | | | | | 0 | 13.00 |
| 14.00 | 1 5 5 | lests | | | 0 | 14.00 |
| 15.00 | J | | | | 0 | 15.00 |
| 16.00 | | | nan patients | | 0 | 16.00 |
| | Revenue from sale of drugs to other than pa | | | | 0 | 17.00 |
| | Revenue from sale of medical records and ab | | | | 0 | 18.00 |
| | Tuition (fees, sale of textbooks, uniforms, | | | | 0 | 19.00 |
| 20.00 | | and canteen | | | 0 | 20.00 |
| 21.00 | | | | | 0 | 21.00 |
| 22.00 | | | | | 0 | 22.00 |
| 23.00 | and the second sec | | | | 0 | 23.00 |
| 24.00 | | | | | 2, 682, 999 | |
| 24.01 | NON OP | | | | 1, 235, 658 | |
| 24.02 | MI SC | | | | -51 | 24.02 |
| 24.03 | | | | | 0 | 24.03 |
| | Total other income (sum of lines 6-24) | | | | 3, 918, 606 | |
| | Total (line 5 plus line 25) | | | | -2, 347, 076 | |
| 27.00 | | | | | 11 | 27.00 |
| 28.00 | | | | | 11 | 28.00 |
| 29.00 | Net income (or loss) for the period (line 2 | to minus line 28) | | | -2, 347, 087 | 29.00 |
| | | | | | | |

| | Financial Systems | | JOHNSON MEMORI | | | In Lie | u of Form CMS- | 2552-10 |
|------------------|---|---------------------|----------------------------|-----------------------|---------------------------------|----------------------------|--------------------------------|----------------|
| ANALYS | IS OF HOSPITAL-BASED HOME HEALT | TH AGENCY COSTS | | | CN: 15-0001 | Period: From 01/01/2016 | Worksheet H | |
| | | | | HHA CCN: | 15-7510 | To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pared: 1 pm |
| | | | | | | Home Health | PPS | |
| | | Sal ari es | Employee | Transportati on | Contracted/P | Agency I ur Other Costs | Total (sum of | |
| | | | Benefits | (see instructions) | chased Servi ces | | cols. 1 thru 5) | |
| | | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | 6.00 | |
| 1 00 | GENERAL SERVICE COST CENTERS Capital Related - Bldg. & | 1 | | C | | 0 | 0 | 1 00 |
| 1.00 | Fixtures | | | | | 0 | 0 | 1.00 |
| 2.00 | Capital Related - Movable | | | C | D | 0 | 0 | 2.00 |
| 3.00 | Equipment Plant Operation & Maintenance | 0 | 0 | C | þ | 0 0 | 0 | 3.00 |
| 4.00 | Transportation | 0 | 0 | | þ | 0 0 | 0 | 4.00 |
| 5.00 | Administrative and General HHA REIMBURSABLE SERVICES | 193, 059 | 0 | 47, 569 | / | 0 103, 379 | 344, 007 | 5.00 |
| 6.00 | Skilled Nursing Care | 252, 558 | | | | 0 0 | | • |
| 7.00 8.00 | Physical Therapy Occupational Therapy | 166, 272 65, 248 | | | | 0 0 | 166, 272 65, 248 | • |
| 9.00 | Speech Pathol ogy | 2, 488 | | | | 0 0 | 2, 488 | • |
| 10.00 | Medical Social Services | 498 | | C | D | 0 0 | 498 | • |
| 11.00 12.00 | Home Health Aide Supplies (see instructions) | 0 | 0 | | | 0 0 0 7,974 | 0 7, 974 | |
| 13.00 | Drugs | 0 | - | | | 0 0 | 0 | |
| 14.00 | DME HHA NONREI MBURSABLE SERVI CES | 0 | 0 | C | | 0 0 | 0 | 14.00 |
| 15.00 | Home Dialysis Aide Services | 0 | 0 | C | þ | 0 0 | 0 | 15.00 |
| 16.00 | Respiratory Therapy | 0 | - | C | | 0 0 | 0 | |
| 17.00 18.00 | Private Duty Nursing Clinic | 0 | 0 | | | 0 0 | 0 | |
| 19.00 | Health Promotion Activities | 0 | 0 | C | | 0 0 | 0 | |
| 20.00 | Day Care Program | 0 | 0 | C | þ | 0 0 | 0 | |
| 21.00 22.00 | Home Delivered Meals Program Homemaker Service | | 0 | | | | 0 | |
| 23.00 | All Others (specify) | 0 | 0 | C | | 0 0 | 0 | 23.00 |
| 23.50 | Telemedicine Total (sum of lines 1–23) | 0 680, 123 | 0 | C 47, 569 | | 0 0 0 111, 353 | 0 839, 045 | 23.50 |
| 24.00 | | Recl assi fi cati | | Adjustments | Net Expenses | | 037, 043 | 24.00 |
| | | on | Trial Balance (col. 6 + | | for Allocation (col. 8 + col | | | |
| | | | col.7) | | 9) | | | |
| | GENERAL SERVICE COST CENTERS | 7.00 | 8.00 | 9.00 | 10.00 | | | |
| 1.00 | Capital Related - Bldg. & | 0 | 0 | C | D | 0 | | 1.00 |
| 2.00 | Fixtures | | | | | | | 2 00 |
| 2.00 | Capital Related – Movable Equipment | 0 | 0 | Ĺ |) | 0 | | 2.00 |
| 3.00 | Plant Operation & Maintenance | 0 | - | - | | 0 | | 3.00 |
| 4.00 5.00 | Transportation Administrative and General | 0 38, 244 | | | | 0 51 | | 4.00 5.00 |
| 0.00 | HHA REI MBURSABLE SERVI CES | | 002,201 | | | | | 0.00 |
| 6.00 | Skilled Nursing Care Physical Therapy | 0 | | | | | | 6.00 7.00 |
| 7.00 8.00 | Occupational Therapy | 0 | | |) 166, 2) 65, 2 | | | 8.00 |
| 9.00 | Speech Pathology | 0 | 2, 488 | C | 2, 4 | 38 | | 9.00 |
| 10. 00 11. 00 | Medical Social Services Home Health Aide | 0 | 498 0 | C | 4 | 98 | | 10.00 11.00 |
| 12.00 | Supplies (see instructions) | 0 | 7, 974 | | 7,9 | 74 | | 12.00 |
| 13.00 | Drugs | 0 | | C | | 0 | | 13.00 |
| 14.00 | DME HHA NONREI MBURSABLE SERVI CES | 0 | 0 | C |) | 0 | | 14.00 |
| 15.00 | Home Dialysis Aide Services | 0 | | | | 0 | | 15.00 |
| 16. 00 17. 00 | Respiratory Therapy Private Duty Nursing | 0 | 0 | C | | 0 | | 16.00 17.00 |
| 17.00 | Clinic | 0 | 0 | | | 0 | | 17.00 |
| 19.00 | Health Promotion Activities | 0 | 0 | C | | 0 | | 19.00 |
| 20. 00 21. 00 | Day Care Program Home Delivered Meals Program | 0 | 0 | | | 0 | | 20.00 21.00 |
| 22.00 | Homemaker Service | 0 | 0 | C | þ | Õ | | 22.00 |
| 23.00 | All Others (specify) | 0 | - | | | 0 | | 23.00 |
| 23. 50 24. 00 | Telemedicine Total (sum of lines 1–23) | 38, 244 | 0 877, 289 | | | B9 | | 23.50 24.00 |
| | | | | | | 1 | | |

| Heal th | Financial Systems | | JOHNSON MEMORIA | AL_HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--------------------------------------|---|------------------------|------------------------|-------------|----------------------------|----------------------------|-------------------------|----------------|
| COST A | LLOCATION - HHA GENERAL SERVICE | COST | | Provider C | | Period: From 01/01/2016 | Worksheet H-1 Part I | |
| | | | | HHA CCN: | | To 12/31/2016 | | pared: |
| | | | | | | Home Health | PPS | i piii |
| | | | | | | Agency I | | |
| | | | Capital Rela | ited Costs | | | | |
| | | Net Expenses | BIdgs & | Movabl e | Plant | Transportati on | | 1 |
| | | for Cost Allocation | Fixtures | Equi pment | Operation & Maintenance | | (col s. 0-4) | |
| | | (from Wkst. H, | | | Marintenance | | | |
| | | col. 10) | | | | | | |
| | GENERAL SERVICE COST CENTERS | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 4A. 00 | |
| 1.00 | Capital Related - Bldg. & | 0 | 0 | | | | 0 | 1.00 |
| | Fixtures | | | | | | 0 | 0.00 |
| 2.00 | Capital Related – Movable Equipment | 0 | | 0 | | | 0 | 2.00 |
| 3.00 | Plant Operation & Maintenance | 0 | 0 | 0 | | 0 | 0 | 3.00 |
| 4.00 | Transportation | 0 | 0 | 0 | | 0 0 | 202 251 | 4.00 |
| 5.00 | Administrative and General HHA REIMBURSABLE SERVICES | 382, 251 | 0 | 0 | | 0 0 | 382, 251 | 5.00 |
| 6.00 | Skilled Nursing Care | 252, 558 | 0 | 0 | | 0 0 | 252, 558 | |
| 7.00 | Physical Therapy | 166, 272 | 0 | 0 | | 0 0 | 166, 272 | |
| 8.00 9.00 | Occupational Therapy Speech Pathology | 65, 248 2, 488 | | 0 | | | 65, 248 2, 488 | |
| 10.00 | Medical Social Services | 498 | 0 | 0 | | 0 0 | 498 | 10.00 |
| 11.00 | Home Health Aide | 0 | 0 | 0 | | 0 0 | 0 | |
| 12.00 13.00 | Supplies (see instructions) Drugs | 7, 974 | 0 | 0 | | 0 0 | 7, 974 0 | 1 |
| 14.00 | DME | 0 | 0 | 0 | | 0 0 | 0 | • |
| | HHA NONREI MBURSABLE SERVI CES | | | | 1 | | | 1.5 00 |
| 15.00 16.00 | Home Dialysis Aide Services Respiratory Therapy | 0 | 0 | 0 | | 0 0 0 0 | 0 | |
| | Private Duty Nursing | 0 | 0 | 0 | | 0 0 | 0 | |
| 18.00 | Clinic | 0 | 0 | 0 | | 0 0 | 0 | |
| | Health Promotion Activities Day Care Program | 0 | 0 | 0 | | 0 0 | 0 | |
| | Home Delivered Meals Program | 0 | 0 | 0 | | 0 0 | 0 | |
| 22.00 | Homemaker Service | 0 | 0 | 0 | | 0 0 | 0 | |
| | All Others (specify) Telemedicine | 0 | 0 | 0 | | 0 0 | 0 | |
| | Total (sum of lines 1-23) | 877, 289 | 0 | 0 | | 0 0 0 0 | 877, 289 | |
| | | Admi ni strati ve | | | | | | |
| | | & General 5.00 | <u>4A + 5)</u> 6.00 | | | | | - |
| | GENERAL SERVICE COST CENTERS | 3.00 | 0.00 | | - | | | |
| 1.00 | Capital Related - Bldg. & | | | | | | | 1.00 |
| 2.00 | Fixtures Capital Related - Movable | | | | | | | 2.00 |
| 2.00 | Equi pment | | | | | | | 2.00 |
| 3.00 4.00 | Plant Operation & Maintenance | | | | | | | 3.00 |
| 4.00 5.00 | Transportation Administrative and General | 382, 251 | | | | | | 4.00 5.00 |
| | HHA REIMBURSABLE SERVICES | | <u>_</u> | | | | | |
| 6.00 7.00 | Skilled Nursing Care Physical Therapy | 195, 017 128, 389 | 447, 575 294, 661 | | | | | 6.00 7.00 |
| 8.00 | Occupational Therapy | 50, 382 | 115, 630 | | | | | 8.00 |
| 9.00 | Speech Pathology | 1, 921 | 4, 409 | | | | | 9.00 |
| 10.00 | Medical Social Services | 385 | 883 | | | | | 10.00 |
| 11.00 12.00 | Home Health Aide Supplies (see instructions) | 0 6, 157 | 0 14, 131 | | | | | 11.00 12.00 |
| | Drugs | 0 | 0 | | | | | 13.00 |
| 14.00 | | 0 | 0 | | | | | 14.00 |
| 15.00 | HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services | 0 | 0 | | | | | 15.00 |
| 16.00 | Respiratory Therapy | 0 | 0 | | | | | 16.00 |
| | Private Duty Nursing | 0 | 0 | | | | | 17.00 |
| | Clinic Health Promotion Activities | 0 | 0 | | | | | 18.00 19.00 |
| | Day Care Program | 0 | 0 | | | | | 20.00 |
| | | 1 | | | | | | 21.00 |
| 20. 00 21. 00 | Home Delivered Meals Program | 0 | 0 | | | | | • |
| 20.00 21.00 22.00 | Homemaker Service | 0 | 0 | | | | | 22.00 |
| 20. 00 21. 00 22. 00 23. 00 | | 0 0 0 | - | | | | | • |

| Heal th | Financial Systems | | JOHNSON MEMORI | AL HOSPITAL | | In Lie | u of Form CMS-2 | 2552-10 |
|---------|---|---------------------------------------|--|---|-----------------------------|---|--|---------|
| COST AI | LLOCATION - HHA STATISTICAL BAS | il S | | Provider C HHA CCN: | CN: 15-0001 15-7510 | Period: From 01/01/2016 To 12/31/2016 | | pared: |
| | | | | | | Home Health Agency I | PPS | |
| | | Capital Rel | ated Costs | | | | | |
| | | BI dgs & Fixtures (SQUARE FEET) | Movable Equipment (DOLLAR VALUE) | Pl ant Operation & Maintenance (SQUARE FEET) | Transportatio (MI LEAGE) | onReconciliation | Administrative & 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 |
| | Transportation (see | 0 | 0 | C |) | 0 | | 4.00 |
| | instructions) | | | | | | | |
| • | Administrative and General | 0 | 0 | C | | 0 -382, 251 | 495, 038 | 5.00 |
| | HHA REIMBURSABLE SERVICES | | | | 1 | | | |
| | Skilled Nursing Care | 0 | 0 | 0 | | 0 0 | 252, 558 | |
| | Physical Therapy | 0 | 0 | 0 | | 0 0 | 166, 272 | 7.00 |
| | Occupational Therapy | 0 | 0 | 0 | | 0 0 | 65, 248 | |
| | Speech Pathology Medical Social Services | 0 | 0 | 0 | | 0 0 | 2, 488 498 | |
| | Home Health Aide | 0 | 0 | 0 | | 0 0 | 498 | |
| | Supplies (see instructions) | | 0 | | | | 7, 974 | |
| | Drugs | | 0 | 0 | | 0 0 | 0 | |
| | DME | | 0 | 0 | | 0 0 | 0 | • |
| | HHA NONREI MBURSABLE SERVI CES | <u> </u> | U | | | 0 0 | 0 | 11.00 |
| | Home Dialysis Aide Services | 0 | 0 | C |) | 0 0 | 0 | 15.00 |
| 16.00 | Respiratory Therapy | 0 | 0 | C |) | 0 0 | 0 | 16.00 |
| 17.00 | Private Duty Nursing | 0 | 0 | C |) | 0 0 | 0 | 17.00 |
| 18.00 | Clinic | 0 | 0 | C | | 0 0 | 0 | 18.00 |
| 19.00 | Health Promotion Activities | 0 | 0 | C | | 0 0 | 0 | 19.00 |
| | Day Care Program | 0 | 0 | 0 | | 0 0 | 0 | 20.00 |
| | Home Delivered Meals Program | 0 | 0 | C | | 0 0 | 0 | 21.00 |
| | Homemaker Service | 0 | 0 | 0 | | 0 0 | 0 | 22.00 |
| | All Others (specify) | 0 | 0 | 0 | 1 | 0 0 | 0 | |
| | Telemedicine | 0 | 0 | 0 | | | 0 | 23.50 |
| | Total (sum of lines 1-23) | 0 | 0 | 0 | | 0 -382, 251 | 495, 038 | |
| | Cost To Be Allocated (per Worksheet H-1, Part I) | 0 | 0 | C | | U | 382, 251 | |
| 26.00 | Unit Cost Multiplier | 0. 000000 | 0. 000000 | 0.00000 | 0.0000 | 00 | 0. 772165 | 26.00 |

| LLOCAT | ION OF GENERAL SERVICE COSTS T | O HHA COST CENT | TERS | Provider C | | Period: From 01/01/2016 | Worksheet H-2 Part I | |
|--------|--|--------------------------|----------------------|------------------------|----------------|----------------------------|--------------------------------|--------------|
| | | | | HHA CCN: | | To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pare 1 pm |
| | | | | | | Home Health Agency I | PPS | |
| | | | CAPI | TAL RELATED CO | DSTS | | | |
| | Cost Center Description | HHA Trial Balance (1) | NEW BLDG & I FIXT | BLDG & FIXT - TOWER | MVBLE EQUIP | BENEFI TS | COMMUNI CATI ONS | |
| | | 0 | 1.00 | 1.01 | 2.00 | DEPARTMENT 4.00 | 4. 01 | |
| | Administrative and General | 0 | 9, 519 | 0 | | | 9, 570 | |
| | Skilled Nursing Care | 447, 575 | 0 | 0 | | - | 0 | |
| | Physical Therapy Occupational Therapy | 294, 661 115, 630 | 0 | 0 | | | 0 | |
| | Speech Pathol ogy | 4, 409 | 0 | 0 | | | 0 | |
| | Medical Social Services | 883 | 0 | 0 | | 0 | 0 | |
| | Home Health Aide | 0 | 0 | 0 | (| 0 0 | 0 | |
| | Supplies (see instructions) | 14, 131 | 0 | 0 | (| 0 0 | 0 | 8 |
| | Drugs | 0 | 0 | 0 | (| 0 | 0 | |
| | DME Hama Dialucia Aida Samuiaan | 0 | 0 | 0 | | 0 | 0 | |
| | Home Dialysis Aide Services Respiratory Therapy | 0 | 0 | 0 | | | 0 | |
| | Private Duty Nursing | 0 | | 0 | | | 0 | |
| | Clinic | 0 | o | 0 | | | 0 | |
| | Health Promotion Activities | 0 | 0 | 0 | (| 0 0 | 0 | |
| | Day Care Program | 0 | 0 | 0 | | 0 0 | 0 | 10 |
| | Home Delivered Meals Program | 0 | 0 | 0 | 0 | 0 0 | 0 | |
| | Homemaker Service | 0 | 0 | 0 | (| 0 | 0 | |
| | All Others (specify) Telemedicine | 0 | 0 | 0 | | 0 | 0 | |
| | Total (sum of lines 1-19) (2) | 877, 289 | 9, 519 | 0 | 56 | - | 9, 570 | |
| | Unit Cost Multiplier: column | 077,207 | 2, 512 | 0 | | 104,001 | 9, 370 | 21 |
| | 26, line 1 divided by the sum | | | | | | | - |
| | of column 26, line 20 minus | | | | | | | |
| | column 26, line 1, rounded to | | | | | | | |
| | 6 decimal places. Cost Center Description | DATA | MATERI ALS | ADMI TTI NG | PATI ENT | Subtotal | ADMI NI STRATI VE | |
| | | PROCESSI NG | MANAGEMENT | | ACCOUNTI NG | | & GENERAL | |
| 00 | Administrative and General | 4.02 57,590 | 4.03 | 4.04 | 4.05 18,410 | 4A. 05 268, 094 | 5.00 | 1 |
| | Skilled Nursing Care | 57, 590 | 000 | 7,400 | 10,410 | 447, 575 | 17, 133 28, 603 | |
| | Physical Therapy | 0 | 0 | 0 | | 294,661 | 18, 830 | |
| | Occupational Therapy | 0 | 0 | 0 | (| 115, 630 | | |
| 0 | Speech Pathology | 0 | 0 | 0 | (| 4, 409 | 282 | 1 |
| | Medical Social Services | 0 | 0 | 0 | 0 | 883 | 56 | |
| | Home Health Aide | 0 | 0 | 0 | (| 0 0 | 0 | |
| | Supplies (see instructions) | 0 | 0 | 0 | | 14, 131 | 903 | |
| 00 | Drugs DMF | 0 | | 0 | | | 0 | |
| | Home Dialysis Aide Services | 0 | 0 | 0 | | | 0 | |
| | Respiratory Therapy | 0 | o | 0 | | 0 | 0 | |
| | Private Duty Nursing | 0 | О | 0 | | 0 0 | 0 | |
| | Clinic | 0 | 0 | 0 | (| 0 0 | 0 | |
| | Health Promotion Activities | 0 | 0 | 0 | (| 0 | 0 | |
| | Day Care Program | 0 | 0 | 0 | | | 0 | |
| | Home Delivered Meals Program Homemaker Service | 0 | 0 | 0 | | | 0 | |
| | All Others (specify) | 0 | | 0 | | | 0 | |
| | Tel emedi ci ne | 0 | 0 | 0 | | | 0 | |
| | Total (sum of lines 1-19) (2) | 57, 590 | 688 | 7, 460 | 18, 410 | 1, 145, 383 | 73, 196 | |
| | Unit Cost Multiplier: column | | | | | 0.000000 | | 21 |
| | 26, line 1 divided by the sum | | | | | | | |
| | ot column 34 line 30 minue | | | | 1 | 1 | | 1 |
| | of column 26, line 20 minus column 26, line 1, rounded to | | | | | | | |

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

| LLOCATI | ON OF GENERAL SERVICE COSTS | O HHA COST CEN | TERS | Provider CC | CN: 15-0001 | Period: From 01/01/2016 | Worksheet H-2 Part I | |
|---------|--|----------------------|-----------------------|-----------------------|--|----------------------------|-------------------------|---------------|
| | | | | HHA CCN: | 15-7510 | To 12/31/2016 | | pared 1 pm |
| | | | | | | Home Health Agency I | PPS | |
| | Cost Center Description | OPERATION OF | LAUNDRY & | HOUSEKEEPING | DI ETARY | CAFETERIA | NURSI NG | |
| | | PLANT 7.00 | LINEN SERVICE 8.00 | 9.00 | 10.00 | 11.00 | ADMI NI STRATI ON | |
| .00 A | Administrative and General | 19, 718 | | | 10.00 | 0 11.00 0 17,828 | 13.00 0 | 1.0 |
| .00 S | Skilled Nursing Care | 0 | | 0 | | 0 0 | 0 | |
| | Physical Therapy | 0 | 0 | 0 | | 0 0 | | |
| | Occupational Therapy Speech Pathology | | 0 | 0 | | | 0 | |
| | ledical Social Services | 0 | 0 | 0 | | 0 0 | | |
| 00 H | lome Health Aide | 0 | 0 | 0 | | 0 0 | 0 | 7.0 |
| | Supplies (see instructions) | 0 | 0 | 0 | | 0 0 | 0 | |
| |)rugs ME | | 0 | 0 | | | - | |
| | lome Dialysis Aide Services | 0 | 0 | 0 | | 0 0 | | |
| 2.00 R | Respiratory Therapy | 0 | 0 | 0 | | 0 0 | - | |
| | Private Duty Nursing | 0 | 0 | 0 | | | - | |
| | Clinic Health Promotion Activities | 0 | 0 | 0 | | | , s | |
| | Day Care Program | 0 | 0 | 0 | | 0 0 | | |
| | lome Delivered Meals Program | 0 | 0 | 0 | | 0 0 | 0 | |
| | lomemaker Service | 0 | 0 | 0 | | 0 0 | u u | |
| | NII Others (specify) Telemedicine | | 0 | 0 | | | u u | |
| | otal (sum of lines 1-19) (2) | 19, 718 | 0 | 6, 870 | | 0 17,828 | - | |
| | Init Cost Multiplier: column | | | | | | | 21. |
| | 26, line 1 divided by the sum | | | | | | | |
| | of column 26, line 20 minus column 26, line 1, rounded to | | | | | | | |
| | decimal places. | | | | | | | |
| | Cost Center Description | CENTRAL | PHARMACY | MEDI CAL RECORDS & | Subtotal | Intern & | Subtotal | |
| | | SERVICES & SUPPLY | | LIBRARY | | Residents Cost & Post | | |
| | | | | | | Stepdown | | |
| | | 14.00 | 15.00 | 16.00 | 24.00 | Adjustments 25.00 | 26.00 | |
| 00 A | Administrative and General | 0 | 15.00 | | | | | 1. |
| 00 S | Skilled Nursing Care | 0 | 0 | 0 | | 78 C | | 2. |
| | Physical Therapy | 0 | 0 | 0 | 313, 49 | | | |
| | Occupational Therapy Speech Pathology | 0 | 0 | 0 | 123, 0 ⁻ 4, 6 ⁰ | | | |
| | ledical Social Services | 0 | 0 | 0 | 9: | | | |
| | lome Health Aide | 0 | 0 | 0 | | 0 0 | 0 | |
| | Supplies (see instructions) | 0 | 0 | 0 | 15, 03 | | | |
| 00 D |)rugs ME | 0 | 0 | 0 | | | - | |
| | lome Dialysis Aide Services | 0 | 0 | 0 | | 0 0 | 0 | |
| 00 R | Respiratory Therapy | 0 | 0 | 0 | | 0 0 | 0 | |
| | Private Duty Nursing | 0 | 0 | 0 | | 0 0 | 0 | |
| | Clinic Health Promotion Activities | | 0 | 0 | | | 0 | |
| | Day Care Program | 0 | 0 | 0 | | 0 0 | 0 | |
| . 00 H | lome Delivered Meals Program | 0 | 0 | 0 | | 0 0 | | |
| | lomemaker Service | 0 | 0 | 0 | | 0 0 | 0 | |
| | All Others (specify) Telemedicine | | 0 | 0 | | | 0 | |
| | otal (sum of lines 1-19) (2) | 0 | 0 | 10, 650 | 1, 273, 64 | - | | |
| . 00 U | Init Cost Multiplier: column | | | | | | | 21. |
| | 26, line 1 divided by the sum | | | | | | | |
| | of column 26, line 20 minus column 26, line 1, rounded to | | | | | | | |
| | | | | | | | | |

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

| Heal th | Financial Systems | | JOHNSON MEMORIAL | HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|--------------|-------------------------------|-----------------|------------------|--------------------------|-----------------------|---|-----------------|--------------|
| ALLOCA | TION OF GENERAL SERVICE COSTS | TO HHA COST CEN | TERS | Provider CCN HHA CCN: | N: 15-0001 15-7510 | Period: From 01/01/2016 To 12/31/2016 | | pared: |
| | | | | | | | 1/16/2018 3:0 | 1 pm |
| | | | | | | Home Health | PPS | |
| | Cast Caster Description | | | | | Agency I | | |
| | Cost Center Description | Allocated HHA | Total HHA | | | | | |
| | | A&G (see Part | Costs | | | | | |
| | | 27.00 | 28.00 | | | - | | |
| 1.00 | Administrative and General | 27.00 | 20.00 | | | | | 1.00 |
| 2.00 | Skilled Nursing Care | 173, 612 | 649, 790 | | | | | 2.00 |
| 3.00 | Physical Therapy | 114, 296 | 427, 787 | | | | | 3.00 |
| 4.00 | Occupational Therapy | 44, 852 | 167, 871 | | | | | 4.00 |
| 4.00 5.00 | Speech Pathol ogy | 1, 710 | 6, 401 | | | | | 4.00 5.00 |
| 6.00 | Medical Social Services | 342 | 1, 281 | | | | | 6.00 |
| 7.00 | Home Heal th Aide | 0 | 1, 201 | | | | | 7.00 |
| 8.00 | Supplies (see instructions) | 5, 481 | 20, 515 | | | | | 8.00 |
| 9,00 | Drugs | 0,401 | 20, 515 | | | | | 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 |
| 19.50 | Tel emedi ci ne | 0 | 0 | | | | | 19.50 |
| 20,00 | Total (sum of lines 1-19) (2) | 340, 293 | 1, 273, 645 | | | | | 20,00 |
| 21.00 | Unit Cost Multiplier: column | 0. 364592 | , , , , , , , | | | | | 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.

| | Financial Systems | | JOHNSON MEMORIA | | N 45 0004 | | u of Form CMS- | |
|------------------|---|--------------------|-----------------|-------------------------------|------------------------------------|---|---|-------------|
| ALLOCA BASI S | TION OF GENERAL SERVICE COSTS T | O HHA COST CEN | TERS STATISTICA | L Provider CO | F | Period: From 01/01/2016 Fo 12/31/2016 | Worksheet H-2 Part II Date/Time Pre | pared: |
| | | | | | | Home Health | 1/16/2018 3:0 PPS | <u>1 pm</u> |
| | | | | | | Agency I | FF3 | |
| | | CAPI | TAL RELATED COS | STS | | | | |
| | Cost Center Description | NEW BLDG & FIXT | | MVBLE EQUIP (DOLLAR VALUE) | EMPLOYEE BENEFITS | COMMUNI CATI ONS | PROCESSI NG | |
| | | (TOTAL FEET) | (SQUARE FEET) | | DEPARTMENT (GROSS SALARI ES) | (# NON PT PHONES) | (WORK ORDERS) | |
| 1.00 | | 1.00 | 1.01 | 2.00 | 4.00 | 4.01 | 4. 02 | 1.00 |
| 1.00 2.00 | Administrative and General Skilled Nursing Care | 1, 305 0 | 0 | 56 0 | | | 45 0 | |
| 3.00 | Physical Therapy | 0 | 0 | 0 | | - | 0 | 1 |
| 4.00 | Occupational Therapy | 0 | 0 | 0 | | 0 0 | 0 | 4.00 |
| 5.00 | Speech Pathology | 0 | 0 | 0 | (| 0 | 0 | |
| 6.00 7.00 | Medical Social Services Home Health Aide | 0 | 0 | 0 | | | 0 | |
| 8.00 | Supplies (see instructions) | 0 | 0 | 0 | | | 0 | |
| 9.00 | Drugs | 0 | 0 | 0 | (| 0 | 0 | 1 |
| 10.00 | DME | 0 | 0 | 0 | 0 | 0 0 | 0 | |
| 11.00 12.00 | Home Dialysis Aide Services | 0 | 0 | 0 | | | 0 | |
| 12.00 | Respiratory Therapy Private Duty Nursing | 0 | 0 | 0 | | | 0 | 1 |
| 14.00 | Clinic | 0 | 0 | 0 | | 0 0 | 0 | 1 |
| 15.00 | Health Promotion Activities | 0 | 0 | 0 | | 0 0 | 0 | |
| 16.00 | Day Care Program | 0 | 0 | 0 | (| 0 | 0 | |
| 17.00 18.00 | Home Delivered Meals Program Homemaker Service | 0 | 0 | 0 | | | 0 | |
| 19.00 | All Others (specify) | 0 | 0 | 0 | | 0 0 | 0 | 1 |
| 19. 50 | Tel emedi ci ne | 0 | 0 | 0 | (| 0 0 | 0 | |
| 20. 00 21. 00 | Total (sum of lines 1-19) Total cost to be allocated | 1, 305 9, 519 | 0 | 56 56 | | | 45 57, 590 | 1 |
| | Unit cost multiplier | 7. 294253 | 0. 000000 | 1.000000 | | | 1, 279. 777778 | |
| | Cost Center Description | MATERI ALS | ADMI TTI NG | | Reconci I i ati or | ADMI NI STRATI VE | OPERATION OF | |
| | | MANAGEMENT | (GROSS | ACCOUNTI NG | | & GENERAL | PLANT | |
| | | (SUPPLY USAGE) | REVENUE) | (GROSS REVENUE) | | (ACCUM. COST) | (TOTAL FEET) | |
| | | 4.03 | 4.04 | 4.05 | 5A | 5.00 | 7.00 | |
| 1.00 | Administrative and General | 11, 913 | 1, 574, 485 | 1, 574, 485 | (| | 1, 305 | |
| 2.00 3.00 | Skilled Nursing Care Physical Therapy | 0 | 0 | 0 | | 0 447, 575 294, 661 | 0 | |
| 4.00 | Occupational Therapy | 0 | 0 | 0 | | 115, 630 | 0 | |
| 5.00 | Speech Pathology | 0 | 0 | 0 | | 4, 409 | 0 | 5.00 |
| 6.00 | Medical Social Services | 0 | 0 | 0 | (| 883 | 0 | |
| 7.00 8.00 | Home Health Aide Supplies (see instructions) | 0 | 0 | 0 | | 0 0 0 14,131 | 0 | 1 1.00 |
| 9.00 | Drugs | 0 | 0 | 0 | | 0 0 | 0 | |
| 10.00 | DME | 0 | 0 | 0 | (| 0 | 0 | 10.00 |
| 11.00 | Home Dialysis Aide Services | 0 | 0 | 0 | (| 0 0 | 0 | 1 |
| 12.00 | Respiratory Therapy | 0 | 0 | 0 | | 0 | 0 | |
| 13.00 14.00 | Private Duty Nursing Clinic | | 0 | 0 | | | 0 | 1 |
| 15.00 | Health Promotion Activities | 0 | 0 | 0 | | 0 0 | 0 | 1 |
| 16.00 | Day Care Program | 0 | 0 | 0 | 0 | 0 0 | 0 | 16.00 |
| 17.00 | Home Delivered Meals Program | 0 | 0 | 0 | (| 0 | 0 | |
| 18.00 19.00 | Homemaker Service All Others (specify) | 0 | 0 | 0 | | | 0 | |
| 19.00 19.50 | Telemedicine | 0 | 0 | 0 | | | 0 | 1 |
| 20.00 | Total (sum of lines 1-19) | 11, 913 | | 1, 574, 485 | | 1, 145, 383 | 1, 305 | 20.00 |
| 21.00 | Total cost to be allocated | 688 | | 18, 410 | | 73, 196 | | 21.00 |
| 22.00 | Unit cost multiplier | 0. 057752 | 0. 004738 | 0. 011693 | I | 0.063905 | 15. 109579 | y 22.00 |

| Heal th | Financial Systems | | JOHNSON MEMORIAL | L HOSPI TAL | | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|---|-----------------------------|------------------------|-------------------|------------------|----------------------------|--------------------------------|----------------|
| ALLOCA BASI S | TION OF GENERAL SERVICE COSTS | TO HHA COST CEN | TERS STATISTICAL | Provider CC | CN: 15-0001 | Period: From 01/01/2016 | Worksheet H-2 Part II | |
| DASI 5 | | | | HHA CCN: | 15-7510 | To 12/31/2016 | Date/Time Pre 1/16/2018 3:0 | pared: 1 pm |
| | | | | | | Home Health Agency I | PPS | |
| | Cost Center Description | LAUNDRY & | HOUSEKEEPI NG | DIETARY | CAFETERI A | NURSI NG | CENTRAL | |
| | | LINEN SERVICE (POUNDS OF | (TOTAL FEET) | (MEALS SERVED) | (HOURS PAI D) | ADMI NI STRATI ON | SERVI CES & SUPPLY | |
| | | LAUNDRY) | | | | (DI RECT NRSI NG HRS) | (COSTED REQUIS.) | |
| | | 8.00 | 9.00 | 10.00 | 11.00 | 13.00 | 14.00 | |
| 1.00 2.00 | Administrative and General Skilled Nursing Care | 0 | 1, 305 0 | 0 | 19, 9 | 47 0 0 0 | 0 | |
| 3.00 | Physical Therapy | 0 | 0 | 0 | | 0 0 | 0 | |
| 4.00 | Occupational Therapy | 0 | 0 | 0 | | 0 0 | 0 | |
| 5.00 6.00 | Speech Pathology Medical Social Services | 0 | 0 | 0 | | 0 0 | 0 | |
| 7.00 | Home Heal th Ai de | 0 | Ō | 0 | | 0 0 | 0 | |
| 8.00 9.00 | Supplies (see instructions) | 0 | 0 | 0 | | 0 0 0 0 | 0 | |
| 9.00 10.00 | Drugs DME | 0 | o | 0 | | 0 0 | 0 | 9.00 10.00 |
| 11.00 | Home Dialysis Aide Services | 0 | 0 | 0 | | 0 0 | 0 | |
| 12.00 | Respiratory Therapy Private Duty Nursing | 0 | 0 | 0 | | 0 0 0 0 | 0 | |
| 13.00 14.00 | Clinic | 0 | o | 0 | | 0 0 | 0 | |
| 15.00 | Health Promotion Activities | 0 | 0 | 0 | | 0 0 | 0 | 15.00 |
| 16.00 17.00 | Day Care Program Home Delivered Meals Program | 0 | 0 | 0 | | 0 0 | 0 | 16.00 17.00 |
| 17.00 | Homemaker Service | 0 | o | 0 | | 0 0 | 0 | |
| 19.00 | All Others (specify) | 0 | 0 | 0 | | 0 0 | 0 | 19.00 |
| 19. 50 20. 00 | Telemedicine Total (sum of lines 1–19) | 0 | 0 1, 305 | 0 | 19, 9 | 0 0 | 0 | 19.50 20.00 |
| 20.00 | Total cost to be allocated | 0 | 6, 870 | 0 | 17, 8 | | 0 | 20.00 |
| 22.00 | Unit cost multiplier | 0. 000000 | 5. 264368 | 0. 000000 | 0. 8937 | 68 0. 000000 | 0. 000000 | 22.00 |
| | Cost Center Description | PHARMACY (COSTED | MEDI CAL RECORDS & | | | | | |
| | | REQUIS.) | LI BRARY | | | | | |
| | | | (GROSS | | | | | |
| | | 15.00 | REVENUE) 16.00 | | | | | |
| 1.00 | Administrative and General | 0 | 1, 574, 485 | | | | | 1.00 |
| 2.00 3.00 | Skilled Nursing Care Physical Therapy | 0 | 0 | | | | | 2.00 3.00 |
| 4.00 | Occupational Therapy | 0 | 0 | | | | | 4.00 |
| 5.00 | Speech Pathol ogy | 0 | 0 | | | | | 5.00 |
| 6.00 7.00 | Medical Social Services Home Health Aide | 0 | 0 | | | | | 6.00 7.00 |
| 8.00 | Supplies (see instructions) | 0 | Ö | | | | | 8.00 |
| 9.00 | Drugs DME | 0 | 0 | | | | | 9.00 |
| 10. 00 11. 00 | Home Dialysis Aide Services | 0 | 0 | | | | | 10.00 11.00 |
| 12.00 | Respiratory Therapy | 0 | 0 | | | | | 12.00 |
| 13.00 14.00 | Private Duty Nursing Clinic | 0 | 0 | | | | | 13.00 14.00 |
| 14.00 | Health Promotion Activities | 0 | 0 | | | | | 15.00 |
| 16.00 | Day Care Program | 0 | 0 | | | | | 16.00 |
| 17.00 18.00 | Home Delivered Meals Program Homemaker Service | 0 | 0 | | | | | 17.00 18.00 |
| 19.00 | All Others (specify) | 0 | 0 | | | | | 19.00 |
| 19.50 | Tel emedi ci ne | 0 | O | | | | | 19. 50 |
| 20.00 21.00 | Total (sum of lines 1-19) Total cost to be allocated | 0 | 1, 574, 485 10, 650 | | | | | 20.00 21.00 |
| | Unit cost multiplier | 0. 000000 | 0. 006764 | | | | | 21.00 |
| | • | | I | | | | | |

| | Financial Systems | | JOHNSON MEMORI | | 01 45 0004 | | u of Form CMS-2 | 2552-1 |
|---------|---|--|---|------------------------------------|---|--|---|------------------------------|
| APPORTI | ONMENT OF PATIENT SERVICE COST | S | | HHA CCN: | CN: 15-0001 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Date/Time Pres | pared: |
| | | | | Title | e XVIII | Home Health | 1/16/2018 3:0 PPS | 1 pm |
| | Cost Center Description | From, Wkst. H-2, Part I, col. 28, line | Facility Costs (from Wkst. H-2, Part I) | Shared Ancillary Costs (from | Total HHA Costs (cols. + 2) | Agency I Total Visits | Average Cost Per Visit (col. 3 ÷ col. | |
| | | | 1.00 | Part II) | 2.00 | 4.00 | 4) | |
| E | PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION | OF AGGREGATE F | 1.00 PROGRAM COST, A | 2.00 GGREGATE OF TH | 3.00 IE PROGRAM LIN | 4.00 IITATION COST, OF | 5.00 | |
| | Cost Per Visit Computation Skilled Nursing Care | 2.00 | 649, 790 | | 649, 79 | 3, 018 | 215. 30 | 1.00 |
| | Physical Therapy | 3.00 | | C | | | | 2.00 |
| | Occupational Therapy | 4.00 | | C | | | | |
| | Speech Pathol ogy | 5.00 | | C | | | 200. 03 | |
| | Medical Social Services | 6.00 | | | 1, 28 | | | |
| - | Home Health Aide Total (sum of lines 1-6) | 7.00 | 0 1, 253, 130 | 0 | 1, 253, 13 | | 0.00 | 6.00 7.00 |
| 7.00 | | | 1,200,100 | 0 | Program Visit | | | 7.00 |
| | | | | | | art B | | |
| | Cost Center Description | Cost Limits | CBSA No. (1) | Part A | Not Subject 1 Deductibles Coinsurance | & Deductibles | | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | Limitation Cost Computation | I | | | 1 | | | |
| | Skilled Nursing Care Skilled Nursing Care | | 18020 26900 | 0 | | | | 8. 00 8. 01 |
| | Skilled Nursing Care | | 20900 50032 | 0 | | 0 | | 8.02 |
| | Physical Therapy | | 18020 | C | | | | 9.00 |
| 9.01 | Physical Therapy | | 26900 | C | 1, 22 | 27 | | 9.0 |
| | Physical Therapy | | 50032 | C | | 0 | | 9.02 |
| | Occupational Therapy | | 18020 | 0 | | ⁷ 9 | | 10.00 |
| | Occupational Therapy Occupational Therapy | | 26900 50032 | 0 | | | | 10. 0 ² 10. 02 |
| | Speech Pathol ogy | | 18020 | C | | | | 11.00 |
| | Speech Pathology | | 26900 | C | 1 | | | 11.01 |
| | Speech Pathology | | 50032 | C | | 0 | | 11.02 |
| | Medical Social Services | | 18020 | 0 | | | | 12.00 |
| | Medical Social Services | | 26900 | 0 | | | | 12.01 |
| | Medical Social Services Home Health Aide | | 50032 18020 | 0 | | - | | 12.02 13.00 |
| | Home Heal th Aide | | 26900 | 0 | | | | 13.0 |
| | Home Health Aide | | 50032 | 0 | | 0 | | 13.02 |
| 14.00 | Total (sum of lines 8-13) | | | 0 | | | | 14.00 |
| | Cost Center Description | | Facility Costs | Shared | Total HHA | | 32 200.03 2 640.50 0 0.00 6,443 | |
| | | Part I, col. 28. line | (from Wkst. H-2, Part I) | Ancillary Costs (from | Costs (cols. + 2) | 11 0 0 2 0 0 4,153 HHA Is. 1 (from HHA ÷ col. 4) | | |
| | | 20, 1110 | 11 2, 101 (1) | Part II) | . 2) | 1(0001 03) | | |
| | | 0 | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| | Supplies and Drugs Cost Computa Cost of Medical Supplies | ations 8.00 | 20, 515 | C | 20, 51 | 5 0 | 0,00000 | 15.00 |
| | Cost of Drugs | 9.00 | | 0 | | | | |
| | | | Program Visits | - | Cost of | | | |
| | | | - | - | Servi ces | | | |
| | Cost Conton Deparintian | Part A | Par Nat Subi aat ta | | Dent A | Part B Not Subject to | Subject to | |
| | Cost Center Description | Part A | Not Subject to Deductibles & | | Part A | Deductibles & | | |
| | | | Coi nsurance | Coi nsurance | | Coi nsurance | | |
| | | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | | |
| E | PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation | OF AGGREGATE F | PROGRAM COSI, A | GGREGATE OF TH | IE PROGRAM LIN | ITATION COST, OF | { | |
| | Skilled Nursing Care | 0 | 1, 936 | | | 0 416, 821 | | 1.00 |
| 2.00 | Physical Therapy | 0 | 1, 350 | | | 0 269, 987 | | 2.00 |
| | Occupational Therapy | 0 | 848 | | | 0 113, 700 | | 3.00 |
| | Speech Pathology | 0 | 17 | | | 0 3, 401 | | 4.00 |
| | Medical Social Services Home Health Aide | 0 | 2 | | | 0 1, 281 0 0 | | 5.00 6.00 |
| | Total (sum of lines 1-6) | 0 | - | | | 0 805, 190 | | 7.00 |
| | (| . 0 | | | 1 | | . I | |

| Heal th | Financial Systems | | JOHNSON MEMORI | AL HOSPITAL | | In Lie | u of Form CMS- | 2552-10 |
|----------------------------|---|-------------------------------|---------------------|-------------------------|------------------------|---|--|-------------------------|
| APPORT | IONMENT OF PATIENT SERVICE COST | S | | Provider CC HHA CCN: | CN: 15-0001 15-7510 | Period: From 01/01/2016 To 12/31/2016 | Worksheet H-3 Part I Date/Time Pre | epared: |
| | | | | Title | XVIII | Home Health | 1/16/2018 3: C PPS |)1 pm |
| | | | | | | Agency I | | |
| | Cost Center Description | 6.00 | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| | Limitation Cost Computation | 0.00 | 7.00 | 8.00 | 9.00 | 10.00 | 11.00 | |
| 8.00 | Skilled Nursing Care | | | | | | | 8.00 |
| 8.01 | Skilled Nursing Care | | | | | | | 8. 01 |
| 8.02 | Skilled Nursing Care | | | | | | | 8.02 |
| 9.00 | Physical Therapy | | | | | | | 9.00 |
| 9. 01 9. 02 | Physical Therapy Physical Therapy | | | | | | | 9. 01 9. 02 |
| 10.00 | Occupational Therapy | | | | | | | 10.00 |
| 10. 01 | Occupational Therapy | | | | | | | 10. 01 |
| 10. 02 | Occupational Therapy | | | | | | | 10. 02 |
| 11.00 | Speech Pathol ogy | | | | | | | 11.00 |
| 11. 01 11. 02 | Speech Pathology Speech Pathology | | | | | | | 11.01 11.02 |
| 12.00 | Medi cal Soci al Servi ces | | | | | | | 12.00 |
| 12.01 | Medical Social Services | | | | | | | 12.01 |
| 12.02 | Medical Social Services | | | | | | | 12.02 |
| 13. 00 13. 01 | Home Health Aide Home Health Aide | | | | | | | 13.00 13.01 |
| 13.01 | Home Heal th Aide | | | | | | | 13.01 |
| 14.00 | Total (sum of lines 8-13) | | | | | | | 14.00 |
| | | Prog | ram Covered Cha | irges | Cost of | | | |
| | | | | | Servi ces | | | |
| | | | Par | tВ | | Part B | | |
| | Cost Center Description | Part A | Not Subject to | | Part A | Not Subject to | Subject to | |
| | | | Deductibles & | Deductibles & | | Deductibles & | Deductibles & | |
| | | 6.00 | Coinsurance 7.00 | Coi nsurance 8.00 | 9.00 | Coi nsurance 10.00 | Coi nsurance 11.00 | |
| | Supplies and Drugs Cost Computa | | 7.00 | 0.00 | 7.00 | 10.00 | 11.00 | |
| 15.00 | Cost of Medical Supplies | 0 | - | 0 | | 0 0 | C | |
| 16.00 | | T 1 1 5 | 0 | 0 | | 0 | C | 16.00 |
| | Cost Center Description | Total Program Cost (sum of | | | | | | |
| | | col s. 9-10) | | | | | | |
| | | 12.00 | | | | | | |
| | PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION | OF AGGREGATE F | PROGRAM COST, A | GGREGATE OF TH | E PROGRAM LI | MITATION COST, OF | 2 | |
| | Cost Per Visit Computation | | | | | | | - |
| 1.00 | Skilled Nursing Care | 416, 821 | | | | | | 1.00 |
| 2.00 | Physical Therapy | 269, 987 | | | | | | 2.00 |
| 3.00 4.00 | Occupational Therapy | 113,700 | | | | | | 3.00 4.00 |
| 4.00 5.00 | Speech Pathology Medical Social Services | 3, 401 1, 281 | | | | | | 5.00 |
| 6.00 | Home Heal th Aide | 0 | | | | | | 6.00 |
| 7.00 | Total (sum of lines 1-6) | 805, 190 | | | | | | 7.00 |
| | Cost Center Description | 12.00 | | | | | | + |
| | Limitation Cost Computation | 12.00 | | | | | | |
| 8.00 | Skilled Nursing Care | | | | | | | 8.00 |
| 8.01 | Skilled Nursing Care | | | | | | | 8. 01 |
| 8.02 | Skilled Nursing Care | | | | | | | 8.02 |
| 9. 00 9. 01 | Physical Therapy Physical Therapy | | | | | | | 9.00 9.01 |
| 9.01 9.02 | Physical Therapy | | | | | | | 9.01 |
| 10.00 | Occupational Therapy | | | | | | | 10.00 |
| 10.01 | Occupational Therapy | | | | | | | 10. 01 |
| 10.02 | Occupational Therapy | | | | | | | 10.02 |
| 11. 00 11. 01 | Speech Pathology Speech Pathology | | | | | | | 11.00 11.01 |
| 11.01 | Speech Pathology | | | | | | | 11.02 |
| 12.00 | Medical Social Services | | | | | | | 12.00 |
| 12.01 | Medical Social Services | | | | | | | 12.01 |
| | Medical Social Services | | | | | | | 12.02 |
| 12.02 | | | | | | | | |
| 12. 02 13. 00 | Home Health Aide | | | | | | | 13.00 |
| 12.02 | | | | | | | | 13.00 13.01 13.02 |
| 12. 02 13. 00 13. 01 | Home Health Aide Home Health Aide Home Health Aide | | | | | | | 13.01 |

| Health Financial Systems | | JOHNSON MEMORI | AL_HOSPITAL | | In Lie | eu of Form CMS-2 | 2552-10 |
|--------------------------------------|-----------------|------------------|----------------|---------------|------------------|------------------|---------|
| APPORTIONMENT OF PATIENT SERVICE COS | TS | | Provider C | CN: 15-0001 | Peri od: | Worksheet H-3 | |
| | | | | | From 01/01/2016 | | |
| | | | HHA CCN: | 15-7510 | To 12/31/2016 | | |
| | | | | | | 1/16/2018 3:0 | I pm |
| | | | litle | e XVIII | Home Health | PPS | |
| | | | | | Agency I | | |
| Cost Center Description | From Wkst. C, | Cost to Charge | Total HHA | HHA Shared | Transfer to | | |
| | Part I, col. | Ratio | Charge (from | Ancillary | Part I as | | |
| | 9, line | | provi der | Costs (col. | 1 Indicated | | |
| | | | records) | x col. 2) | | | |
| | 0 | 1.00 | 2.00 | 3.00 | 4.00 | | |
| PART II - APPORTIONMENT OF COS | T OF HHA SERVIC | CES FURNI SHED B | Y SHARED HOSPI | TAL DEPARTMEN | NTS | | |
| 1.00 Physical Therapy | 66.00 | 0. 457113 | C |) | 0 col. 2, line 2 | . 00 | 1.00 |
| 2.00 Occupational Therapy | 67.00 | 0. 207719 | C | | Ocol. 2, line 3 | . 00 | 2.00 |
| 3.00 Speech Pathology | 68.00 | 0. 334916 | C | | 0 col. 2, line 4 | . 00 | 3.00 |
| 4.00 Cost of Medical Supplies | 71.00 | 0. 404994 | C | | 0 col. 2, line 1 | 5.00 | 4.00 |
| 5.00 Cost of Drugs | 73.00 | 0. 382108 | C | | 0 col. 2, line 1 | 6. 00 | 5.00 |

| | Financial Systems JOHNSON MEMORIAL I ATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CC | N: 15-0001 | Peri od: | u of Form CMS-2 Worksheet H-4 | |
|--------------|---|--------------|------------|----------------------------------|----------------------------------|----------|
| 2002 | | HHA CCN: | 15-7510 | From 01/01/2016 To 12/31/2016 | Part I-II Date/Time Pre | pare |
| | | Title | XVIII | Home Health | 1/16/2018 3:0 PPS | прш |
| | | | | Agency I Par | t B | |
| | | | Part A | Not Subject to Deductibles & | Subject to | |
| | | | | Coi nsurance | Coi nsurance | |
| | | t t | 1.00 | 2.00 | 3.00 | |
| | PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM Reasonable Cost of Part A & Part B Services | IARY CHARGES | 5 | | | |
| 00 | Reasonable cost of services (see instructions) | | | 0 0 | 0 | 1 1 |
| 00 | Total charges | | | 0 0 | 0 | 2 |
| | Customary Charges | | | | | ł., |
| 00 | Amount actually collected from patients liable for payment for | servi ces | | 0 0 | 0 | 3 |
| 00 | on a charge basis (from your records) Amount that would have been realized from patients liable for p | avment | | 0 0 | 0 | 4 |
| 50 | for services on a charge basis had such payment been made in ac with 42 CFR §413.13(b) | | | 0 | 0 | |
| 00 | Ratio of line 3 to line 4 (not to exceed 1.000000) | | 0.0000 | 0. 000000 | 0.000000 | 5 |
| 00 | Total customary charges (see instructions) | | | 0 0 | 0 | 6 |
| 0 | Excess of total customary charges over total reasonable cost (confly if line 6 exceeds line 1) | complete | | 0 0 | 0 | 7 |
| 00 | Excess of reasonable cost over customary charges (complete only 1 exceeds line 6) | /ifline | | 0 0 | 0 | 8 |
| 0 | Primary payer amounts | | | 0 5, 467 | 0 | 9 |
| | | I | | Part A | Part B | <u> </u> |
| | | | | Servi ces 1. 00 | Servi ces 2.00 | |
| | PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT | | | | | |
| 00 | Total reasonable cost (see instructions) | | | 0 | -5, 467 | |
| 00 00 | Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers | | | 0 | 763, 058 11, 318 | |
| 00 | Total PPS Reimbursement - LUPA Episodes | | | 0 | 5, 195 | |
| 00 | Total PPS Reimbursement - PEP Episodes | | | 0 | 6,069 | |
| 00 | Total PPS Outlier Reimbursement - Full Episodes with Outliers | | | 0 | 937 | |
| 00 | Total PPS Outlier Reimbursement - PEP Episodes | | | 0 | 0 | |
| 00 | Total Other Payments | | | 0 | 9 | |
| 00 | DME Payments | | | 0 | 0 | 18 |
| 00 | Oxygen Payments | | | 0 | 0 | 19 |
| 00 | Prosthetic and Orthotic Payments | | | 0 | 0 | |
| 00 | Part B deductibles billed to Medicare patients (exclude coinsur | rance) | | | 0 | |
| 00 | Subtotal (sum of lines 10 thru 20 minus line 21) | | | 0 | 781, 119 | |
| 00 | Excess reasonable cost (from line 8) | | | 0 | 0 | |
| 00 | Subtotal (line 22 minus line 23) | | | 0 | 781, 119 | |
| 00 | Coinsurance billed to program patients (from your records) | | | | 0 701 110 | |
| 00 00 | Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) | | | 0 | 781, 119 | 26 |
| 00 | Reimbursable bad debts for dual eligible beneficiaries (see ins | structions) | | | | 28 |
| 00 | Total costs - current cost reporting period (line 26 plus line | 27) | | 0 | 781, 119 | |
| 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | , | | 0 | 0 | |
| 50 | Pioneer ACO demonstration payment adjustment (see instructions) |) | | 0 | 0 | |
| 00 | Subtotal (see instructions) | | | 0 | 781, 119 | |
| 01 | Sequestration adjustment (see instructions) | | | 0 | 15, 622 | |
| 00 | Interim payments (see instructions) | | | 0 | 765, 478 | |
| | Tentative settlement (for contractor use only) | | | 0 | 0 | 33 |
| . 00 | | | | | | |
| . 00 . 00 | Balance due provider/program (line 31 minus lines 31.01, 32, ar Protested amounts (nonallowable cost report items) in accordance | , | | 0 | 19 | 34 |

| | IS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED | Provider CO | CN: 15-0001 | | eriod: | Worksheet H-5 | |
|----------|---|-------------|-------------|------------|--------------------------------|----------------------------------|---|
| PRO | GRAM BENEFICIARIES | HHA CCN: | 15-7510 | Fr To | rom 01/01/2016 p 12/31/2016 | Date/Time Prep 1/16/2018 3:01 | |
| | | | | | Home Health Agency I | PPS | |
| | | I npati en | t Part A | | | t B | |
| | - | mm/dd/yyyy | Amount | | mm/dd/yyyy | Amount | |
| | Tatal interim normate noid to provide | 1.00 | 2.00 | 0 | 3.00 | 4.00 | 1 |
|)0)0 | 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 | | 765, 478 0 | 2 |
| 0 | 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 2 | | | | 0 0 | | 0 | 3 |
| 3 | | | | 0 | | 0 | 3 |
| 4 | | | | 0 | | 0 | 3 |
| 5 | | | | 0 | | 0 | 3 |
| ~ | Provider to Program | | | 0 | | 0 | |
| 0 1 | | | | 0 0 | | 0 | |
| 2 | | | | 0 | | o | 3 |
| 3 | | | | 0 | | 0 | З |
| 4 | | | | 0 | | 0 | 3 |
| 9 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | | 0 | | 0 | З |
| 0 | 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 | | 765, 478 | 4 |
| | TO BE COMPLETED BY CONTRACTOR | | | | | | |
| 0 | 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)2 | | | | 0 0 | | 0 | 5 |
| 12 13 | | | | 0 | | 0 | 5 |
| 2 | Provider to Program | | · | 5 | | | |
| 0 | | | | 0 | | 0 | 5 |
| 1 | | | | 0 | | 0 | 5 |
| 2 9 | Subtotal (sum of lines 5.01–5.49 minus sum of lines | | | 0 0 | | 0 | 5 |
| , 0 | 5.50-5.98) Determined net settlement amount (balance due) based on | | | U | | 0 | 6 |
| | the cost report. (1) | | | | | | |
| 1 | SETTLEMENT TO PROVIDER | | | 0 | | 19 | 6 |
|)2 | SETTLEMENT TO PROGRAM | | | 0 | | 0 765, 497 | 6 |
| 00 | Total Medicare program liability (see instructions) | | | 0 | Contractor | NPR Date | 7 |
| | | | | | Number | (Mo/Day/Yr) | |
| | | (|) | | 1.00 | 2.00 | |

| | Financial Systems JOHNSON MEMOR ATION OF CAPITAL PAYMENT | RIAL HOSPITAL Provider CCN: 15-0001 | Peri od: | u of Form CMS-2 Worksheet L | 2002 |
|------------------------------|---|---|----------------------------------|------------------------------------|------------|
| | | | From 01/01/2016 To 12/31/2016 | Date/Time Pre | |
| | | Title XVIII | Hospi tal | 1/16/2018 3: 0 ² PPS | 1 pm |
| | | | nospitai | FFJ | |
| | | | | 1.00 | |
| | PART I - FULLY PROSPECTIVE METHOD | | | | |
| | CAPITAL FEDERAL AMOUNT | | | | |
| | Capital DRG other than outlier | | | 456, 408 | |
| | Model 4 BPCI Capital DRG other than outlier | | | 0 | |
| | Capital DRG outlier payments | | | 4, 307 | |
| | Model 4 BPCI Capital DRG outlier payments | | | 0 | |
| | Total inpatient days divided by number of days in the cost | t reporting period (see inst | ructions) | 18.12 | |
| | Number of interns & residents (see instructions) | | | 0.00 | |
| | Indirect medical education percentage (see instructions) | the sum of lines 1 and 1 01 | | 0.00 | |
| | Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions) | | | 0 | |
| | Percentage of SSI recipient patient days to Medicare Part 30) (see instructions) | | , part A line | 0.00 | |
| | Percentage of Medicaid patient days to total days (see ins | structions) | | 0.00 | |
| | Sum of lines 7 and 8 | | | 0.00 | |
| | Allowable disproportionate share percentage (see instructi | ons) | | 0.00 | |
| | Disproportionate share adjustment (see instructions) | | | 0 | |
| . 00 | Total prospective capital payments (see instructions) | | | 460, 715 | 12. |
| | | | | 1.00 | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | 1100 | |
| 00 | Program inpatient routine capital cost (see instructions) | | | 0 | 1 1. |
| 00 | Program inpatient ancillary capital cost (see instructions | 5) | | 0 | 2. |
| 00 | Total inpatient program capital cost (line 1 plus line 2) | | | 0 | 3. |
| 00 | Capital cost payment factor (see instructions) | | | 0 | 4. |
| | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 5. |
| | | | | 1.00 | |
| | PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | | |
| | Program inpatient capital costs (see instructions) | | | 0 | 1 |
| 00 | Program inpatient capital costs for extraordinary circumst | tances (see instructions) | | 0 | 2. |
| | Net program inpatient capital costs (line 1 minus line 2) | | | 0 | - |
| | Applicable exception percentage (see instructions) | | | 0.00 | |
| | Capital cost for comparison to payments (line 3 x line 4) | | | 0 | |
| | Percentage adjustment for extraordinary circumstances (see | | | 0.00 | |
| | Adjustment to capital minimum payment level for extraordir | nary circumstances (line 2 x | line 6) | 0 | |
| | Capital minimum payment level (line 5 plus line 7) | | | 0 | |
| | Current year capital payments (from Part I, line 12, as ap | | | 0 | |
| . 00 | Current year comparison of capital minimum payment level t | | · · · | 0 | |
| | Carryover of accumulated capital minimum payment level ove Worksheet L, Part III, line 14) | | 5 | 0 | |
| . 00 | | navmonte (line 10 plue lin | e 11) | 0 | |
| . 00 . 00 | Net comparison of capital minimum payment level to capital | | | | |
| . 00 . 00 . 00 | Current year exception payment (if line 12 is positive, er | nter the amount on this line |) | 0 | |
| . 00 . 00 . 00 | Current year exception payment (if line 12 is positive, er Carryover of accumulated capital minimum payment level over | nter the amount on this line |) | | 13. 14. |
| . 00 . 00 . 00 . 00 | Current year exception payment (if line 12 is positive, er Carryover of accumulated capital minimum payment level ove (if line 12 is negative, enter the amount on this line) | nter the amount on this line er capital payment for the f |) | 0 | 14. |
| . 00 . 00 . 00 . 00 | Current year exception payment (if line 12 is positive, er Carryover of accumulated capital minimum payment level over | nter the amount on this line er capital payment for the f instructions) |) | | 14 15 |