Heal th Financi	al Systems	JOHNSON MEMORIAL	HOSPI TAI	Inlie	u of Form CMS-2552-10
This report is	s required by law (42 USC 1395g; 42 since the beginning of the cost re	2 CFR 413.20(b)). Fai	lure to report can resu	It in all interim	
HOSPITAL AND I AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COST R T SUMMARY	REPORT CERTIFICATION	Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 9:15 am
PART I - COST	REPORT STATUS				
Provi der use only	1. [X] Electronically filed cost 2. [] Manually submitted cost re 3. [0] If this is an amended repo	eport	of times the provider r	Date: 5/29/20	
	4. [F] Medicare Utilization. Ente	er "F" for full or "L	_" for low.		
Contractor use only	(1) As Submitted 7. Co (2) Settled without Audit 8. [nte Received: ntractor No. N]Initial Report fo N]Final Report for	11. pr this Provider CCN 12.		pr Code: 4 Dumn 1 is 4: Enter Des reopened = 0-9.
PART II - CER	TI FI CATI ON		· · · · · · · · · · · · · · · · · · ·		
ADMI NI STRATI VI PROVI DED OR PI ADMI NI STRATI VI CERTI I HER el ect Expen and e compl excep heal t	TION OR FALSIFICATION OF ANY INFORM E ACTION, FINE AND/OR IMPRISONMENT ROCURED THROUGH THE PAYMENT DIRECTL E ACTION, FINES AND/OR IMPRISONMENT FICATION BY CHIEF FINANCIAL OFFICEF EBY CERTIFY that I have read the ab ronically filed or manually submitt ses prepared by JOHNSON MEMORIAL HC nding 12/31/2017 and to the best of ete and prepared from the books and t as noted. I further certify that h care services, and that the servi and regulations.	UNDER FEDERAL LAW. Y OR INDIRECTLY OF A MAY RESULT. R OR ADMINISTRATOR OF bove certification st ted cost report and t DSPITAL (15-0001) f my knowledge and be d records of the prov t I am familiar with	FURTHERMORE, IF SERVICES KICKBACK OR WERE OTHER PROVIDER(S) catement and that I have the Balance Sheet and St for the cost reporting p elief, this report and s ider in accordance with the laws and regulation	S IDENTIFIED IN TH WISE ILLEGAL, CRIM e examined the acco atement of Revenue veriod beginning O' statement are true, applicable instru- s regarding the pu	IIS REPORT WERE IINAL, CIVIL AND pompanying e and 1/01/2017 correct, uctions, rovision of
	I have read and agree with the above signature on this certification sta				

(Si gned)

Officer or Administrator of Provider(s)

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-27, 909	19, 343	0	-141, 010	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-12, 159	0		-40, 605	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-40, 068	19, 343	0	-181, 615	200.00

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

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I		MEMORIA TA		AL der CCN	N: 15-	0001	I Period: From 01/01 To 12/31	/2017	Worksh Part I Date/T	r <u>m CMS-</u> eet S-2 ime Pre 018 3:4	pared:
	1.00		00		3.00				4.00			
1.00	Hospital and Hospital Health Care Co Street: 1125 WEST JEFFERSON STREET	PO Box:										1.00
2.00	City: FRANKLIN	State: I		Zip Coc				ty: JOHNSON				2.00
		Component Na	ame	CCN Number	CBS/ Numb		rovi der Type	r Date Certified		ent Syst , 0, or		
				Number	Numb		туре	Certified	V			-
		1.00		2.00	3.0	0	4.00	5.00	6.00	7.00	8.00	
3.00	Hospital and Hospital-Based Componen Hospital	t Identification: JOHNSON MEMORIAL		150001	2690	0	1	07/01/1966	5 N	Р	0	3.00
3.00		HOSPI TAL		150001	2090		1	0770171986				3.00
4.00	Subprovider - IPF						_			_		4.00
5.00	Subprovider - IRF	TODD AIKENS REHAE	3	15T001	2690	00	5	01/01/2005	5 N	P	0	5.00
6.00 7.00	Subprovider - (Other) Swing Beds - SNF	GENTER										6.00 7.00
8.00 9.00	Swing Beds - NF Hospital-Based SNF											8.00 9.00
10.00	Hospi tal -Based NF											10.00
11.00	Hospital-Based OLTC			457540				07 (04 (400				11.00
12.00	Hospital-Based HHA	JOHNSON MEMORIAL	HOME	157510	2690	00		07/01/1997	7 N	P	N	12.00
13.00	Separately Certified ASC											13.00
	Hospital-Based Hospice											14.00
15.00 16.00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC											15.00 16.00
17.00	Hospital -Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other							From	.	To	<u> </u>	19.00
								1.00			00	
20. 00 21. 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions) Inpatient PPS Information							01/01/2	2017	12/31	/2017	20.00 21.00
22.00	Does this facility qualify and is it share hospital adjustment, in accord									1	N	22.00
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en	ter "Y" for yes o	or "N" fo	or no.								
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to	es or "N" for no October 1. Enter	for the in colum	portion n 2, "Y	of the ' for y	e cos [.] yes oi	t ~ "N"	Y		١	(22.01
22 02	for no for the portion of the cost r (see instructions) Is this a newly merged hospital that			·				N			N	22.02
22.02	determined at cost report settlement or "N" for no, for the portion of th	? (see instructio	ons) Ente	er in co	umn 1,	"Y"	for ye			I	v	22.02
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on of th	ne cost	reporti	ng pe	eriod c					
22. 03	Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for	statistical area	is adopte	ed by CM	S in F\	Y2015′	? Enter			1	N	22.03
	prior to October 1. Enter in column	2, "Y" for yes or	"N" for	no for	the po	ortio	n of th	ne				
	cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,	t more than 499 b	eds (as	counted				h				
23.00	Which method is used to determine Me	dicaid days on li	nes 24 a	nd/or 2				1	3	١	N	23.00
	1, enter 1 if date of admission, 2 i method of identifying the days in th	is cost reporting	period	di ffere	nt from	n the	method					
	used in the prior cost reporting per	<u>iod? in column 2</u>	<u>enter</u> In-Stat		yes or tate	<u>~ "N"</u> Out			Medi ca	id ()ther	
			Medi cai pai d day	d Medi ys elig unp	cai d i bl e ai d	Sta Medi pai d	ate caid	State Medi cai d el i gi bl e	HMO da	ys Me	di cai d days	
		-	1 00		ys	2	00	unpai d	E 00		6 00	-
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum	n 1, in-state	<u>1.00</u> 1	20	00 914	3.	0	4.00	5.00	307	<u>6.00</u> C	24.00
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai	olumn 3,										
	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	t unpaid days in column 6.										
25.00	If this provider is an IRF, enter th Medicaid paid days in column 1, the			0	102		0	0		46		25.00
	Medicaid eligible unpaid days in col out-of-state Medicaid days in column											
	Medicaid eligible unpaid days in col	umn 4, Medicaid										
	HMO paid and eligible but unpaid day	s in column 5.										

SPI I	Financial Systems JOHNSON AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AL HOSPITAL Provider CO	CN: 15-0001	Period: From 01/01/20 To 12/31/20	017 017	<u>of For</u> Workshe Part I Date/Ti	et S-2 me Pre	parec
					Urban/Rura		<u>5/25/20</u> Date of		
					1.00		2.0		
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			ginning of th	e	1			26.
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ige) st "2" f	atus at the end or rural. If a			1			27.
. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.
					Begi nni ng 1. 00	:	Endi 1 2. 0		-
00	Enter applicable beginning and ending dates of SCH st	atus.	Subscript line	36 for numbe			2.0		36.
00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	ds MDH status		0			37.
01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.
00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
	enter subsequent dates.				Y/N		Y/I		
00	Does this facility qualify for the inpatient hospital	navme	nt adjustment	for low volum	1.00 e Y		2.0 N		39.
00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (i eage r	i)? Enter in co equirements in	olumn 1 "Y" accordance			N		
00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1.	Enter "Y" for y				N		40.
	ine meetamin z, for disenarges on or after october i.	(300				V 1. 00	XVIII 2.00	XI X 3. 00	
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for	di enconorti ona:	to charo in a	scordanco	N	N	N	45.
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption	for extraordina	ary circumsta	nces	N	N	N	46.
00 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment					N N	N	N N	47.
00	Teaching Hospitals Is this a hospital involved in training residents in					N			56.
00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes o h of t (", com	r "N" for no in his cost repor plete Workshee	n column 1. I ting period?	f column 1 Enter "Y"				57.
00	If line 56 is yes, did this facility elect cost reimb	urseme	nt for physicia	ans' services	as	Ν			58.
00	defined in CMS Pub. 15–1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	•		Pt. I.		Ν			59.
		<u> </u>		NAHE 413.85 Y/N	Worksheet Line #	(Pass-Th Qualific criterio	cation	
0.5		())		1.00	2.00		3.0	00	1
00	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (N Direct GME	IME	_	Di rect	GMF	60.
00	Did your hospital receive FTE slots under ACA	1.00	2.00	3.00	4.00	0. 00	5.0	0. 00	61
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care								61
		1	1	1					
01	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)								
01	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								61

HOODETAL AND HOODETAL HEALTH CARE CONDUCY LOCATION DA		AL HOSPITAL	01 45 0004		u of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provider C		Period: From 01/01/2017 To 12/31/2017		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's 						61. 04 61. 05
primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 51.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
care or general surgery. (see first detroits)	Pro	ogram Name	Program Code	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 10
51.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
52.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		I IN THIS COST	reporting pe	riod for which	0.00	62.00
62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc Teaching Hospitals that Claim Residents in Nonprovide	gram. (s	see instructio		o your hospital	0.00	62.01
53.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.00
		S of through	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	2.00	2.00	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi c	der Settinas	1.00 This base yea	2.00 ris your cost r	3.00 Teporting	
period that begins on or after July 1, 2009 and befor	re June	30, 2010.				44.00
54.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	i-primar all non מור non-pr מו column	ry care provider imary care 3 the ratio	0.0	00 0.00	0. 000000	64.00
Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEsin	Ratio (col. 3/ (col. 3 + col. 4))	

HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA	TA Provider C		eriod: -om 01/01/2017		
			То	b 12/31/2017	Date/Time Pre 5/25/2018 3:4	pared:
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovider Site	Hospi tal	4))	
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)						
			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	2.00	3.00	-
Section 5504 of the ACA Current Y	ear FTE Residents ir	n Nonprovider Setting			3.00 ng periods	
beginning on or after July 1, 201 56.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	nweighted non-primar curring in all nonpr nweighted non-primar I. Enter in column 3	rovider settings. Ty care resident 3 the ratio of	0.00 Unweighted	0.00 Unweighted	0.000000 Ratio (col. 3/	
_	Ĵ		FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4))	_
7.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
				1.0	0 2.00 3.00	-
Inpatient Psychiatric Facility PF 70.00 Is this facility an Inpatient Psy		PE) or does it cont	tain an IPE subn			70.00
Enter "Y" for yes or "N" for no. 1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	the facility have ar fore November 15, 2C umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	n approved GME teachi 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y	, ng program in t yes or "N" for n s in a new teach yes or "N" for n	he most N o. (see ing o.	0	71.00
5.00 Is this facility an Inpatient Reh	abilitation Facility	(IRF), or does it o	contain an IRF	Y		75.00
subprovider? Enter "Y" for yes a 1f line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility t CFR 412.424 (d)(1)(iii)(D)? Enter indicate which program year began	the facility have ar ng on or before Nove rain residents in a "Y" for yes or "N"	ember 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes or n in accordance f column 2 is Y,	"N" for	0	76.00

Heal th	Financial Systems JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPI TA	F	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/25/2018 3:4	pared:
			1.00	
80. 00 81. 00	<u>ong Term Care Hospital PPS</u> s this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. s this a LTCH co-located within another hospital for part or all of the cost reporting 'Y" for yes and "N" for no.	period? Enter	N N	80. 00 81. 00
85. 00 86. 00	IEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section S412.40(f)(1)(i)2. Enter "Y" for yes end "N" for an		N	85. 00 86. 00
87.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		Ν	87.00
		V 1.00	XI X 2.00	-
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90.00
	yes or "N" for no in the applicable column. 's this hospital reimbursed for title V and/or XIX through the cost report either in	N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column.	IN IN		
	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see nstructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y" for yes or "N" for no in the applicable column.	N	N	93.00
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	Ν	94.00
96.00	f line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95.00 96.00
97.00 98.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 Y	0. 00 Y	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 2, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	Y	Y	98.01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ded costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	Y	98. 02
98.03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1	Ν	Ν	98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of putpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	Ν	N	98. 04
98.05	n column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y	Y	98. 05
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers Does this hospital qualify as a CAH?	N		105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost	N		107.00
108.00	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Ν		108. 00
	Physical Occupational 1.00 2.00	Speech 3.00	Respi ratory 4.00	-
	f this hospital qualifies as a CAH or a cost provider, are N N therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	109.00
			1.00	
	Did this hospital participate in the Rural Community Hospital Demonstration project (§4 Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. I complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 throug applicable.	f yes,	Ν	110.00

lealth Financial Systems JOHNSON MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	N: 15-0001		riod: om 01/01/	2017	u of For Workshe Part I Date/Ti 5/25/20	eet S-2 me Pre	2 epared:
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	t reporting p umn 1 is Y, e icipating in	eriod? Enter enter the column 2.		1.00 N		2. (00	111.0
Niccol Longous Cost Deporting Information					1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 s 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; Pub. 15-1, chapter 22, §2208.1.	lf column 2 i for long ter	s "E", ente m care (inc	r ir Iude	column s	N		0	115. 0
16.00 Is this facility classified as a referral center? Enter "Y" for 17.00 Is this facility legally-required to carry malpractice insuran no.			r "N	" for	N Y			116. 0 117. 0
18.00 Is the malpractice insurance a claims-made or occurrence policiclaim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 i	f the polic	yis		2			118.0
		Premi ums		Losses	5	Insur	ance	
10 01 list execute of melopractice premiums and poid lesses.		1.00	402	2.00	0	3. () 0118.0
18.01 List amounts of malpractice premiums and paid losses:		742, 4	403	1.00	0	2. (-
 18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedul and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in of "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 	le listing co Harmless prov column 1, "Y" lifies for th	nst centers Mision in ACA for yes or Ne Outpatien		N		N		118. (119. (120. (
21.00Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices	charged to		Y				121. (
2.00 Does the cost report contain healthcare related taxes as defined to Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.	ned in §1903(is "Y", enter	w)(3) of the in column	e 2	N				122. (
 Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 	er the certif	ication dat		N				125. 0 126. 0 127. 0
28.00 f this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 29.00 f this is a Medicare certified lung transplant center, enter								128. C
column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, en	nter the cert							130. 0
date in column 1 and termination date, if applicable, in colum 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum	enter the ce	erti fi cati on						131. (
2.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certifi							132. (
 3.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. 4.00 If this is an organ procurement organization (0P0), enter the 								133. (
and termination date, if applicable, in column 2. All Providers 40.00 Are there any related organization or home office costs as der chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye	fined in CMS	Pub. 15-1,	s	N				140. 0

	X IDENTIFICATION DATA	RIAL HOSPITAL Provider CC	N: 15-0001		iod: m 01/01/2017 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/25/2018 3:4	epared:
		. 00			3.00	-6	
If this facility is part of a cha home office and enter the home of				e name	and address	or the	
41. 00 Name:	Contractor's Name:			actor's	Number:		141.00
42.00 Street:	PO Box:						142.00
43.00 Ci ty:	State:		Zip Co	ode:			143.00
						1.00	-
44.00 Are provider based physicians' cos	sts included in Worksheet	t A?				Y	144.00
					1.00	2.00	1.15.00
45.00 If costs for renal services are cl inpatient services only? Enter "Y"	aimed on Wkst. A, line /	4, are the costs	s tor solump 1 i	-			145.00
no, does the dialysis facility in							
period? Enter "Y" for yes or "N"							
46.00 Has the cost allocation methodolog					Ν		146. 00
Enter "Y" for yes or "N" for no in		15-2, chapter 4	10, §4020)	lf			
yes, enter the approval date (mm/o	dd/yyyy) in column 2.						
						1.00	1
47.00 Was there a change in the statist						N	147.00
48.00Was there a change in the order of				_		N	148.00
49.00Was there a change to the simplifi	ed cost finding method?	-				N Title XIX	149.0
		Part A 1.00	Part 2.00		<u>Title V</u> 3.00	4,00	-
Does this facility contain a prov	der that qualifies for a						
or charges? Enter "Y" for yes or							
55.00Hospi tal	•	N	N		N	N	155. 0
56.00 Subprovider - IPF		N	N		N	N	156.0
57.00 Subprovider - IRF		N	N		Ν	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		Ν	N	158. 0 159. 0
60.00HOME HEALTH AGENCY		N	N		N	N	160. 0
61.00 CMHC			N		Ν	N	161.00
						1.00	
Multicampus 65.00 s this hospital part of a Multica	amous bospital that has o	ne or more campi	ises in di	fferent	CBSAs2	N	165.00
Enter "Y" for yes or "N" for no.				riciciit	0000031	in the	100.00
· · ·	Name	County	State	Zip Co	ode CBSA	FTE/Campus	
	0	1.00	2.00	3.00	0 4.00	5.00	
66.00 If line 165 is yes, for each							0166.00
						0.00	100.00
campus enter the name in column						0.00	
						0.00	
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						0.00	
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,						0.00	
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							_
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)	T) incentive in the Ameri	can Recovery and	d Rei nvest	ment Ad	ct	1.00	_
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					ct		-
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) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10	under §1886(n)? Enter D5 is "Y") and is a meani	"Y" for yes or " ngful user (line	'N" for no			1.00 Y	167. 0
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) Health Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l	r under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi	"Y" for yes or " ngful user (line ons)	'N" for no e 167 is "'	Y"), en	nter the	1.00 Y	167. 0 0168. 0
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) Health Information Technology (HI 67.00 Is this provider a meaningful usee 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l 68.01 If this provider is a CAH and is n	r under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi not a meaningful user, do	"Y" for yes or " ngful user (line ons) pes this provider	N" for no e 167 is " qualify	Y"), er for a h	nter the	1.00 Y	167. 0 0168. 0
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) Heal th Information Technology (HI 67.00 Is this provider a meaningful used off this provider is a CAH (line 10 reasonable cost incurred for the I f this provider is a CAH and is n exception under §413.70(a)(6)(ii) ⁷	r under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi not a meaningful user, do P Enter "Y" for yes or "N	"Y" for yes or " ngful user (line ons) bes this provider N" for no. (see i	N" for no 2 167 is " qualify nstructio	Y"), en for a h ns)	nter the nardship	1.00 Y	167. 00 0168. 00 168. 0
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) Health Information Technology (HI 67.00 Is this provider a meaningful usee 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l 68.01 If this provider is a CAH and is n	under §1886(n)? Enter 5 is "Y") and is a meani HT assets (see instructi not a meaningful user, dc 2 Enter "Y" for yes or "N user (line 167 is "Y") ar	"Y" for yes or " ngful user (line ons) bes this provider N" for no. (see i	N" for no 2 167 is " qualify nstructio	Y"), en for a h ns)	nter the nardship	1.00 Y	167. 00 0168. 00 168. 0
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) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful use	under §1886(n)? Enter 5 is "Y") and is a meani HT assets (see instructi not a meaningful user, dc 2 Enter "Y" for yes or "N user (line 167 is "Y") ar	"Y" for yes or " ngful user (line ons) bes this provider N" for no. (see i	N" for no 2 167 is " qualify nstructio	Y"), en for a h ns)	nter the nardship , enter the Beginning	1.00 Y 9.9 Endi ng	167. 00 0168. 00 168. 0
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) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii) 01 If this provider is a meaningful of transition factor. (see instruction	under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi not a meaningful user, do P Enter "Y" for yes or "N user (line 167 is "Y") ar ons)	"Y" for yes or " ngful user (line ons) pes this provider N" for no. (see i nd is not a CAH (N" for no e 167 is " qualify nstructio (line 105	Y"), en for a h ns)	nter the nardship , enter the Beginning 1.00	1.00 Y 9.9 Endi ng 2.00	167.00 168.00 168.0 9169.00
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) Health Information Technology (HI 67.00 Is this provider a meaningful usee 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi not a meaningful user, do P Enter "Y" for yes or "N user (line 167 is "Y") ar ons)	"Y" for yes or " ngful user (line ons) pes this provider N" for no. (see i nd is not a CAH (N" for no e 167 is " qualify nstructio (line 105	Y"), en for a h ns)	nter the nardship , enter the Beginning	1.00 Y 9.9 Endi ng	- 167.00 0168.00 168.0 ⁻ 9169.00
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) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is n exception under §413.70(a) (6) (ii) 01 If this provider is a meaningful of transition factor. (see instruction	under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi not a meaningful user, do P Enter "Y" for yes or "N user (line 167 is "Y") ar ons)	"Y" for yes or " ngful user (line ons) pes this provider N" for no. (see i nd is not a CAH (N" for no e 167 is " qualify nstructio (line 105	Y"), en for a h ns)	nter the nardship , enter the Beginning 1.00	1.00 Y 9.9 Endi ng 2.00	167.00 168.00 168.0 9169.00
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) Health Information Technology (HI 67.00 Is this provider a meaningful usee 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi not a meaningful user, do P Enter "Y" for yes or "N user (line 167 is "Y") ar ons)	"Y" for yes or " ngful user (line ons) pes this provider N" for no. (see i nd is not a CAH (N" for no e 167 is " qualify nstructio (line 105	Y"), en for a h ns)	nter the nardship , enter the Beginning 1.00	1.00 Y 9.9 Endi ng 2.00	167. 00 168. 01 9169. 00 170. 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) Heal th Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is in exception under §413.70(a) (6) (ii) 7 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this provider	under §1886(n)? Enter 5 is "Y") and is a meani 11 assets (see instructi not a meaningful user, do 2 Enter "Y" for yes or "N user (line 167 is "Y") ar pons) peginning date and ending vider have any days for i	"Y" for yes or " ngful user (line ons) bes this provider U" for no. (see i nd is not a CAH (g date for the re ndividuals enrol	N" for no e 167 is " nstructio line 105 eporting led in	Y"), er for a h ns) i s "N")	nter the nardship n, enter the Beginning 1.00 01/01/2017	1.00 Y 9.9 Endi ng 2.00 12/31/2017 2.00	- 167.00 0168.00 168.0 ⁻ 9169.00
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) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is in exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful user transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	- under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instructi not a meaningful user, do 2 Enter "Y" for yes or "N user (line 167 is "Y") ar poginning date and ending vider have any days for i reported on Wkst. S-3, Pt	"Y" for yes or " ngful user (line ons) bes this provider " for no. (see i nd is not a CAH (g date for the re ndividuals enrol t. I, line 2, col	N" for no e 167 is " nstructio (line 105 eporting led in . 6? Ente	Y"), er for a h ns) i s "N")	nter the nardship n, enter the Beginning 1.00 01/01/2017 1.00	1.00 Y 9.9 Endi ng 2.00 12/31/2017 2.00	- 167. 0 0168. 0 168. 0 9169. 0 - 170. 0

iospi t	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet S-: Part II Date/Time Pro 5/25/2018 3:4	epared:
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses. Ente			-
	mm/dd/yyyy format.					_
	COMPLETED BY ALL HOSPITALS					_
. 00	Provider Organization and Operation 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 c	column 2. (see	instructions)			
			Y/N	Date	V/I	
2.00	Has the provider terminated participation in the Medicare F	program2 lf	1.00 N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members or of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Dan-st-		1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.00
5.00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.00
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities					
5.00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s N		6.00
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	structions		Ν		7.00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	Ū.	Ν		8. 00
9.00	Are costs claimed for Interns and Residents in an approved		cal education	Ν		9.00
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c		he current	N		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	
	Bad Debts				1.00	-
2.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 00 13. 00
4.00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	⁻yes, see in:	structions.	N	14.0
5.00	Did total beds available change from the prior cost reporti		yes, see ins t A	tructions. Par	N t B	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	04/10/2018	Y	04/10/2018	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	N		Ν		19. 0

Health Financial Systems JOHNSON MEMOR	REAL HOSPETAL		In Lie	eu of Form CMS	8-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet S- Part II	-2 repared:
		i pti on	Y/N	Y/N	
	-	2	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:		1	N	N	20.00
	Y/N	Date	Y/N	Date	
21.00 Wee the east report prepared only using the provider's	1.00 N	2.00	3.00	4.00	21.00
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)			
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, se		alo mada duni	ing the east		22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	ars made duri	ing the cost		23.00
24.00 Were new leases and/or amendments to existing leases enter	ed into during	this cost rep	porting period?		24.00
25.00 Have there been new capitalized leases entered into during	the cost repor	ting period?	lf yes, see		25.00
instructions. 26.00 Were assets subject to Sec.2314 of DEFRA acquired during t	he cost reporti	ng period? It	f yes, see		26.00
instructions. 27.00 Has the provider's capitalization policy changed during th		0.1	5		27.00
copy. Interest Expense			yes, subili t		
28.00 Were new Loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost	reporting		28.00
29.00 period? If yes, see instructions.29.00 Did the provider have a funded depreciation account and/or	bond funds (De	bt Service Re	eserve Fund)		29.00
30.00 treated as a funded depreciation account? If yes, see inst table to the sexisting debt been replaced prior to its scheduled mat		debt? If ves.	see		30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without i	5	5			31.00
instructions. Purchased Services					
32.00 Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		d through cor	ntractual		32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		g to competit	tive bidding? If		33.00
Provi der-Based Physi ci ans				1	
34.00 Are services furnished at the provider facility under an a	rrangement with	provi der-bas	sed physi ci ans?		34.00
35.00 If line 34 is yes, were there new agreements or amended ex	isting agreemen	uts with the r	provi der-based		35.00
physicians during the cost reporting period? If yes, see i					
			Y/N	Date	
Home Office Costs			1.00	2.00	-
Home Office Costs					26 00
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 p	repared by the	home office?			36.00 37.00
1f yes, see instructions.38.001f line 36 is yes , was the fiscal year end of the home of					38.00
the provider? If yes, enter in column 2 the fiscal year en 39.00 If line 36 is yes, did the provider render services to oth					39.00
40.00 If line 36 is yes, did the provider render services to the	home office?	lfves see			40.00
instructions.					10.00
	1.	00	2.	00	_
Cost Report Preparer Contact Information	1				
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	AUSTIN		FI SHER		41.00
respectively.42.00 Enter the employer/company name of the cost report	BLUE & CO				42.00
43.00 Enter the telephone number and email address of the cost	3172757438		AFI SHER@BLUEAN	DCO COM	43.00
report preparer in columns 1 and 2, respectively.				200.000	13.00

Heal th I	Financial Systems JOH	HNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPI TA	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIO	ONNAI RE	Provider (Period:	Worksheet S-2	
					From 01/01/2017 To 12/31/2017		pared: <u>3 pm</u>
			3	. 00			
C	Cost Report Preparer Contact Information						
41.00 I	Enter the first name, last name and the title/po	osition S	ENI OR ACCOUN	TANT			41.00
1	held by the cost report preparer in columns 1, 2	2, and 3,					
1	respectively.						
42.00 I	Enter the employer/company name of the cost repo	ort					42.00
I	preparer.						
43.00	Enter the telephone number and email address of	the cost					43.00
	report preparer in columns 1 and 2, respectively	/.					

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JOHNSON MEMORIA	Provider CC	N. 15_0001	Peri od:	u of Form CMS-2 Worksheet S-3	
NU3P1 1	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N. 13-0001	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	pared:
						5/25/2018 3:4 /P Days / 0/P	3 pm
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number	0.00	Avai I abl e	4.00	F 00	
1.00	Userital Adults & Dada (aslumas E. (. 7 and	1.00	2.00	3.00	4.00	5.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	//	28, 10	0.00	0	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 I PF 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		77	28, 10	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	6	2, 19	90 0.00	0	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)	43.00				0	12.00
13.00 14.00	NURSERY	43.00	83	30, 29	95 0.00	0	13.00 14.00
14.00	Total (see instructions) CAH visits		03	30, 21	<i>y</i> 5 0.00	0	14.00
16.00	SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF	41.00	11	4, 0	15	0	17.00
18.00	SUBPROVIDER			., 0		, i i i i i i i i i i i i i i i i i i i	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)		94				27.00
28.00	Observation Bed Days					0	28.00
29.00 30.00	Ambulance Trips						29.00 30.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)		0		0		31.00
32.00	Total ancillary labor & delivery room		0				32.00
52.01	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33.01

10SPI 1	_Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	AL DATA	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/25/2018 3:4	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, 366	27	5, 52	8		1.00
2.00	HMO and other (see instructions)	686	1, 221				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	0	148				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 366	27		8		7.00
3. 00	INTENSIVE CARE UNIT	455	0	72	9		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		55	67	1		13.00
14.00	Total (see instructions)	2, 821	82			510. 58	
15.00	CAH visits	2, 021	0		0	010.00	15.00
16.00	SUBPROVIDER - IPF	, in the second s	0				16.00
17.00	SUBPROVI DER – I RF	553	0	1, 37	8 0.00	8.58	
18.00	SUBPROVI DER	555	0	1, 57	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2, 611	76	4, 93	1 0.00	8, 61	
23.00	AMBULATORY SURGICAL CENTER (D. P.)	2,011	70	4, 73	0.00	0.01	22.00
24.00	HOSPICE						23.00
24.10		0	0		0		24.00
25.00	HOSPICE (non-distinct part) CMHC - CMHC	0	0		0		24.10
26.00							26.00
	RURAL HEALTH CLINIC	0	0		0 00	0.00	
26.25	FEDERALLY QUALIFIED HEALTH CENTER	U	0		0 0.00		•
27.00	Total (sum of lines 14-26)		0		0.00	527.77	
28.00	Observation Bed Days		0	88	0		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	Labor & delivery days (see instructions)	0	38				32.00
32.01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33 01	LTCH site neutral days and discharges	0					33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Prep 5/25/2018 3:43	
		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) HMO and other (see instructions)		0		50 27 59 857	1, 992	1.00
3.00 4.00 5.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0		3.00 4.00 5.00
6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						6.00 7.00 8.00
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. 00 10. 00
11.00 12.00 13.00	SURGI CAL INTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						11.00 12.00 13.00
14.00 15.00 16.00	Total (see instructions) CAH visits SUBPROVIDER - IPF	0.00	0	75	50 27	1, 992	14.00 15.00 16.00
17.00 18.00 19.00 20.00 21.00	SUBPROVIDER - IRF SUBPROVIDER - IRF SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0		40 0	93	10.00 17.00 18.00 19.00 20.00 21.00
21.00 22.00 23.00 24.00 24.10 25.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0.00					21.00 22.00 23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0. 00 0. 00					26.00 26.25 27.00 28.00 29.00
30. 00 31. 00 32. 00 32. 01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room						30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		33. 00 33. 01

PI T <i>i</i>	AL WAGE INDEX INFORMATION			Provider CO	1	Period: From 01/01/2017 To 12/31/2017		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200.00	39, 617, 520	-134, 711	39, 482, 80	9 1, 224, 990. 00	32. 23	1.
0	instructions) Non-physician anesthetist Part		C	0		0.00	0.00	2.
0	A Non-physician anesthetist Part		C	0		0.00	0.00	3.
0	B Physician-Part A -		110, 004	0	110, 004	4 1, 575. 00	69.84	4.
1	Administrative						0.00	4.
1 0	Physicians - Part A - Teaching Physician and Non		1, 163, 318	0		0.00 B 12,267.00		
0	Physician-Part B Non-physician-Part B for		C	0		0.00	0.00	6.
-	hospital-based RHC and FQHC services							
0	Interns & residents (in an approved program)	21.00	C	0	(0.00	0.00	7.
1	Contracted interns and		C	0	(0.00	0.00	7.
	residents (in an approved programs)							
0	Home office and/or related organization personnel		674, 425	0	674, 42	5 24, 366.00	27.68	8
0	SNF	44.00	C	0		0.00		
00	Excluded area salaries (see instructions)		13, 238, 842	-155, 288	13, 083, 554	4 263, 095. 00	49. 73	10
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		47, 763	0	47, 76	3 1, 987. 00	24.04	1 11
	Care		47,703		,			
00	Contract Labor: Top Level management and other management and administrative		C	0		0.00	0.00	12
00	services Contract Labor: Physician-Part		1, 378, 916	0	1, 378, 910	6 13, 388. 00	103.00	13
00	A - Administrative Home office and/or related		C	0		0.00	0.00	11
00	orgainzation salaries and		C			0.00	0.00	
01	wage-related costs Home office salaries		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	0.00	15
	Home office and Contract Physicians Part A - Teaching		C	0	(0.00	0.00	16
	WAGE-RELATED COSTS Wage-related costs (core) (see		6, 488, 739	0	6, 488, 739	9		17
	instructions) Wage-related costs (other)		C			o		18
	(see instructions)					-		
00 00	Excluded areas Non-physician anesthetist Part		2, 316, 276 C	0 0	2, 316, 276	6 D		19 20
00	A Non-physician anesthetist Part		C	0		0		21
00	B Physician Part A -		16, 924	0	16, 924	4		22
	Admi ni strati ve		,					
	Physician Part A - Teaching Physician Part B		141, 238	0	141, 238	B		22
	Wage-related costs (RHC/FQHC)		C	0	(D		24
	Interns & residents (in an approved program)		C	0		5		25
	Home office wage-related (core)		C	0				25
51	Related organization wage-related (core)		C	0	(C		25
52	Home office: Physician Part A - Administrative -		C	0	(C		25
53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		C	0		D		25
	wage-related (core)							
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	<u>4.00</u>	3, 288, 673	120, 461	3, 409, 134	4 157, 526. 00	21.64	26
	Administrative & General	5.00	1, 469, 800					

Heal th	Financial Systems		JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION		Provi der CCN: 15-0001			Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part II Date/Time Pre 5/25/2018 3:4	pared:
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		285, 736	0	285, 73	6 2, 800. 00	102.05	28.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	629, 953	0	629, 95	3 28, 824. 00	21.86	30.00
31.00	Laundry & Linen Service	8.00	99, 953	0	99, 95	3 7, 120. 00	14.04	31.00
32.00	Housekeepi ng	9.00	711, 551	0	711, 55	1 52, 827. 00	13. 47	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	818, 552	-488, 289	330, 26	3 23, 323. 00	14. 16	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	0	488, 289	488, 28	9 26, 516. 00	18. 41	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 558, 085	-3, 461	1, 554, 62	4 27, 101. 00	57.36	38.00
39.00	Central Services and Supply	14.00	79, 668	0	79,66	8 4, 123. 00	19. 32	39.00
40.00	Pharmacy	15.00	475, 658	0	475, 65			40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	621, 668		621, 66			
42.00	Soci al Servi ce	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00		43.00

Heal th	Financial Systems		JOHNSON MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part III Date/Time Prep 5/25/2018 3:4	pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		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, 065, 513	-134, 711	37, 930, 80	2 1, 191, 157. 00	31.84	1.00
	instructions)							
2.00	Excluded area salaries (see		13, 238, 842	-155, 288	13, 083, 55	4 263, 095. 00	49. 73	2.00
0.00	instructions)		04 004 474	00 577	04 047 04		0/ 77	
3.00	Subtotal salaries (line 1 minus line 2)		24, 826, 671	20, 577	24, 847, 24	8 928, 062. 00	26. 77	3.00
4.00	Subtotal other wages & related		1, 426, 679	0	1, 426, 67	9 15, 375. 00	92. 79	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		6, 505, 663	0	6, 505, 66	3 0.00	26. 18	5.00
	(see inst.)		~~ ~~ ~ ~ ~ ~ ~ ~ ~					
6.00	Total (sum of lines 3 thru 5)		32, 759, 013					
7.00	Total overhead cost (see		10, 039, 297	44, 632	10, 083, 92	9 436, 459. 00	23. 10	7.00
	instructions)							

HOSPITAL WAGE RELATED COSTS Provider CCN: 15-0001 Period: From 01/01/2017 To 12/31/2017 Part IV Amoun Report PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST	ne Prep 18 3:43 It ed	
PART IV - WAGE RELATED COSTS Part A - Core List	ed	
PART IV - WAGE RELATED COSTS Part A - Core List		
PART IV - WAGE RELATED COSTS Part A - Core List		
Part A - Core List	9 809	
	0 800	
RETIREMENT COST	0 800	
		1 00
		1.00
2.00 Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 4.00 Qualified Defined Benefit Plan Cost (see instructions) 	0	3.00 4.00
4.00 Qualified Defined Benefit Plan Cost (see instructions) PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	0	4.00
5.00 401K/TSA PI an Administration fees	0	5.00
6.00 Legal /Accounting/Management Fees-Pensi on Pl an	0	6,00
7.00 Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST		7.00
	7, 584	8.00
8.01 Health Insurance (Self Funded without a Third Party Administrator)	0	8.00
8.02 Health Insurance (Self Funded without a Third Party Administrator)	0	8.02
8.03 Health Insurance (Purchased)	0	8.03
9.00 Prescription Drug Plan	0	9.00
10.00 Dental, Hearing and Vision Plan	-	10.00
	6, 663	
12.00 Accident Insurance (If employee is owner or beneficiary)		12.00
		13.00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary)		14.00
	7,973	
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.		16.00
Non cumulative portion)	-	
TAXES		
17.00 FICA-Employers Portion Only 2,60	0, 123	17.00
18.00 Medicare Taxes - Employers Portion Only	0	18.00
19.00 Unemployment Insurance	1, 035	19.00
20.00 State or Federal Unemployment Taxes	0	20.00
OTHER		
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))	0	21.00
	0, 313	22.00
	3, 460	
24.00 Total Wage Related cost (Sum of Lines 1 -23) 8,90	3, 177	24.00
Part B - Other than Core Related Cost		
25.00 OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT	COST	Provider CCN: 15-0001	Peri od:	Worksheet S-3	
			From 01/01/2017		
			To 12/31/2017	Date/Time Pre 5/25/2018 3:43	
Cost Center Description			Contract Labor		
			1.00	2.00	
PART V - Contract Labor and B	enefit Cost				
Hospital and Hospital-Based C	omponent Identification:				
1.00 Total facility's contract lab	or and benefit cost		47, 763	8, 963, 177	1.00
2.00 Hospital			47, 763	8, 963, 177	2.00
3.00 Subprovider - IPF					3.00
4.00 Subprovider - IRF			0	0	4.00
5.00 Subprovider - (Other)			0	0	5.00
6.00 Swing Beds - SNF			0	0	6.00
7.00 Swing Beds - NF			0	0	7.00
8.00 Hospital-Based SNF					8.00
9.00 Hospital-Based NF					9.00
10.00 Hospital-Based OLTC					10.00
11.00 Hospital-Based HHA			0	0	11.00
12.00 Separately Certified ASC					12.00
13.00 Hospital-Based Hospice					13.00
14.00 Hospital-Based Health Clinic	RHC				14.00
15.00 Hospital-Based Health Clinic	FQHC				15.00
16.00 Hospital-Based-CMHC					16.00
17.00 Renal Dialysis					17.00
18.00 Other			0	0	18.00

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
HOME I	IEALTH AGENCY STATI STI CAL DATA		Provider C	CN: 15-0001	Period: From 01/01/2017	Worksheet S-4	
			Component	CCN: 15-7510	To 12/31/2017	5/25/2018 3:4	
					Home Health Agency I	PPS	
			1		· · · ·	00	-
0.00	County						0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1 00	HOME HEALTH AGENCY STATISTICAL DATA						1 00
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0 0.00	0 118. 00		0 0 00 0.00		
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numbe	er of hours in	Staff	Contract	Total	
		your normal	work week				
		0		1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	1.	93 0.00	1.93	3.00
4.00	Director(s) and Assistant Director(s)		40.00	0.	0.00	0.00	4.00
5.00 6.00	Other Administrative Personnel Direct Nursing Service			1.			
7.00	Nursing Supervisor			0.	0. 00	0.00	7.00
8.00 9.00	Physical Therapy Service Physical Therapy Supervisor			2. 0.			
10.00	Occupational Therapy Service			1.			
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0. 0.			•
13.00 14.00	Speech Pathology Supervisor Medical Social Service			0. 0.			
15.00	Medical Social Service Supervisor			0.	0.00	0.00	15.00
16.00 17.00	Home Health Aide Home Health Aide Supervisor			0. 0.			
18.00	Other (specify)			0.			
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost						
20.00	reporting period. List those CBSA code(s) in column 1 serviced			18020			20.00
	during this cost reporting period (line 20 contains the first code).						
20. 01				26900			20. 01
		Full Ep Without	isodes With Outliers	LUPA Epi sode	es PEP Only	Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5.00	
	PPS ACTIVITY DATA			1		1	
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	1, 034 248, 160	59 14, 160	1	8 3 20 720	1, 104 264, 960	
23.00	Physical Therapy Visits	849	41		3 6	899	23.00
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	220, 740 517	10, 660 39	1	80 1, 560 1 2	233, 740 559	•
26.00	Occupational Therapy Visit Charges	134, 420	10, 140	1	60 520	145, 340	26.00
27.00 28.00	Speech Pathol ogy Visits Speech Pathol ogy Visit Charges	19 4, 940	28 7, 280	1		47 12, 220	
29.00	Medical Social Service Visits Medical Social Service Visit Charges	2	0		0 0	2	
30. 00 31. 00	Home Health Aide Visits	560 0	0		0 0	560 0	
32.00 33.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	0 2, 421	0 167		0 0 12 11	0 2, 611	
	29, and 31)		107				
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 608, 820	0 42, 240	2, 9	0 0 60 2,800	0 656, 820	
	30, 32, and 34)		12, 240	2, 7			
36.00	Total Number of Episodes (standard/non outlier)	125			4 2	131	36.00
37.00 38.00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	457	4 C		0 0	4 457	37.00 38.00
50.00	The set wat he weared supply that ges	457	0	1			1 33.00

Heal th	Ith Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of F								
		Provider CCN:		Period:	Worksheet S-1	0			
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 3:4				
					1.00				
	Uncompensated and indigent care cost computation				1.00				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by line	202 column	8)	0. 268860	1.00			
	Medicaid (see instructions for each line)			-)					
2.00	Net revenue from Medicaid				2, 748, 461	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		from Medica	i d?		4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid			0	5.00			
6.00	Medicaid charges				19, 801, 846	6.00			
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (line 7 minue	cum of lin	oc 2 and E. if	5, 323, 924 2, 575, 463	7.00 8.00			
0.00	<pre>cero then enter zero)</pre>		Sull OF TH	es z anu s, m	2, 575, 405	0.00			
	Children's Health Insurance Program (CHIP) (see instructions fo								
9.00									
	Stand-alone CHIP charges				0				
11.00					0	11.00			
12.00	Difference between net revenue and costs for stand-alone CHIP ((line 11 minu:	sline 9; i	f < zero then	0	12.00			
	enter zero) Other state or local government indigent care program (see inst	rustions for	angle Line)						
13.00	Net revenue from state or local indigent care program (Net incl)	0	13.00			
14.00	Charges for patients covered under state or local indigent care				0	14.00			
	10)	p: -9: (
15.00	State or local indigent care program cost (line 1 times line 14				0	15.00			
16.00	Difference between net revenue and costs for state or local ind	ligent care p	rogram (lin	e 15 minus line	0	16.00			
	13; if < zero then enter zero)	D and at the /							
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/	rocar rndrg	ent care program	ns (see				
17.00	Private grants, donations, or endowment income restricted to fu	unding charit	v care		0	17.00			
	Government grants, appropriations or transfers for support of h				0	18.00			
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent ca	re programs	(sum of lines	2, 575, 463	19.00			
			Uni nsured	Insured	Total (col. 1				
			patients	patients	+ col . 2)				
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00				
20.00	Charity care charges and uninsured discounts for the entire fac	sility	3, 834, 94	9 0	3, 834, 949	20.00			
20.00	(see instructions)	, in the second s	3,034,74		3,034,747	20.00			
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	1, 031, 06	4 0	1, 031, 064	21.00			
	instructions)								
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00			
23.00	charity care Cost of charity care (line 21 minus line 22)		1, 031, 06	4 0	1, 031, 064	23.00			
23.00			1, 031, 00	<u> </u>	1,031,004	23.00			
					1.00				
24.00	Does the amount on line 20 column 2, include charges for patien		d a length	of stay limit		24.00			
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		are program	's length of	0	25.00			
	stay limit								
	Total bad debt expense for the entire hospital complex (see ins				10, 373, 460				
27.00					138, 015				
	Medicare allowable bad debts for the entire hospital complex (s	see instructi	ons)		212, 331				
28.00		onco (coo !-			10, 161, 129				
29.00 30.00		sense (see in	structions)		2, 806, 237 3, 837, 301				
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			6, 412, 764				
51.00	Total an embersed and ancompensated care cost (The 17 plus II	10 00)			1 0, 412, 704	01.00			

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JOHNSON MEMORIA F EXPENSES	Provider CO	CN: 15-0001 F	Period:	u of Form CMS-2 Worksheet A	2552-10
				F	rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/25/2018 3:4	
	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, 947, 418	1, 947, 418	3 0	1, 947, 418	1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - TOWER		0	C		0	1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP		3, 189, 152	3, 189, 152		3, 189, 152	2.00
4.00 4.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS	330, 534 131, 632	7, 767, 074 249, 211	8, 097, 608 380, 843		8, 310, 848 380, 843	4.00 4.01
4.01 4.02	00402 DATA PROCESSING	711, 477	759, 463	1, 470, 940		1, 470, 940	4.01
4.03	00403 MATERIALS MANAGEMENT	306, 775	51, 224	357, 999		357, 999	4.03
4.04	00404 ADMI TTI NG	710, 659	14, 466	725, 125		725, 125	4.04
4.05 5.00	00405 PATLENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL	1,097,596	663, 420	1, 761, 016		1, 761, 016	4.05 5.00
5.00 7.00	00700 OPERATION OF PLANT	1, 469, 800 629, 953	5, 049, 541 1, 960, 128	6, 519, 341 2, 590, 081		6, 459, 311 2, 590, 081	5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	99, 953	77, 830	177, 783		177, 783	1
9.00	00900 HOUSEKEEPI NG	711, 551	109, 348	820, 899	0	820, 899	9.00
10.00	01000 DI ETARY	818, 552	350, 144	1, 168, 696		471, 536	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 1, 558, 085	0 190, 556	C 1, 748, 641		697, 160 1, 748, 641	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	79, 668	136, 999	216, 667		216, 667	14.00
15.00	01500 PHARMACY	475, 658	4, 014, 097	4, 489, 755		4, 489, 755	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	621, 668	213, 930	835, 598	3 0	835, 598	16.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	4 202 420	750 (44	F 050 072	175 (00)	4 07/ 470	20.00
30.00 31.00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	4, 293, 429 1, 193, 087	758, 644 73, 624	5, 052, 073 1, 266, 711		4, 876, 470 1, 266, 711	30.00 31.00
41.00	04100 SUBPROVI DER – I RF	734, 263	138, 897	873, 160		765, 030	41.00
43.00	04300 NURSERY	0	0	C		175, 603	43.00
	ANCI LLARY SERVI CE COST CENTERS				-1		
50.00 53.00	05000 OPERATING ROOM 05300 ANESTHESIOLOGY	1, 782, 710 0	345, 198 26, 046	2, 127, 908 26, 046		2, 127, 908 26, 046	50.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2,068,458	733, 393	2, 801, 851		2, 801, 851	54.00
60.00	06000 LABORATORY	1, 630, 801	2, 123, 548	3, 754, 349		3, 754, 349	
65.00	06500 RESPI RATORY THERAPY	939, 606	153, 455	1, 093, 061		1, 093, 061	
66.00	06600 PHYSI CAL THERAPY	794, 578	73, 662	868, 240		976, 370	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	249, 623 140, 072	2 24, 418	249, 625 164, 490		249, 625 164, 490	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	479, 947	1, 352, 607	1, 832, 554		1, 832, 554	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	49, 165	7, 243	56, 408		56, 408	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	3, 517, 772	3, 517, 772		2, 645, 141	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0	C	872, 631 0 0	872, 631 0	72.00
76.00	03020 ONCOLOGY	240, 419	148, 781	389, 200		389, 200	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	123, 432	81, 011	204, 443		204, 443	76.97
	OUTPATIENT SERVICE COST CENTERS				_		
	09000 CLINIC 09100 EMERGENCY	749, 603 1, 890, 187	1, 957, 922 212, 252			2, 707, 525 2, 102, 439	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,090,107	212, 232	2, 102, 439	0	2, 102, 439	91.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	674, 425	166, 993	841, 418	3 0	841, 418	101.00
112 00	SPECIAL PURPOSE COST CENTERS		10,000	10.002		10,002	112 00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	27, 787, 366	10, 002 38, 649, 471	10, 002 66, 436, 837			113.00
110.00	NONREI MBURSABLE COST CENTERS	27,707,300	30, 047, 471	00, 430, 037	100, 210	00, 370, 047	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	90, 132	30, 791	120, 923	3 0	120, 923	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	11, 147, 632	3, 861, 878	15, 009, 510		15, 009, 510	
	19201 SOUTH CLINIC	0	0	C			192.01
	19202 WEST CLINIC 19203 DIABETES CENTER	84, 824	13, 027	97, 851			192.02 192.03
	19300 NONPALD WORKERS	01,021	0,027	,,, co (0		193.00
	19301 ADULT/CHI LD CARE	450, 019	122, 342	572, 361	-153, 210	419, 151	
	19302 PHYSICIAN OFFICE BUILDING	0	0	C	0 0		193. 02
	19303 OPTI FAST/FOUNDATI ON	0 452	1, 046, 990	1, 046, 990		1, 046, 990	
	07950 PARTNERSHI P HFC 07951 TRAFALGAR CLI NI C	9, 452	11, 911 0	21, 363 C			194.00 194.01
	07952 EDI NBURGH	o	0	C	0		194.01
		48, 095	0	48, 095	0		194.03
194.03	07953 JAI L	40, 093	0	40,070			
194.03	07954 ATHLETI C TRAI NERS	48, 093 0 39, 617, 520	0 0 43, 736, 410	C	0 0	0	194.04

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	JOHNSON MEMORIA	AL HOSPITAL Provider CCN: 1	15-0001	In Lieu Period:	u of Form CMS Worksheet A	5-2552-10
NECLAS	STITESTION AND ADJUSTMENTS OF IRTAL DALANCE U	LAFLINJEJ		10-0001	From 01/01/2017 To 12/31/2017	Date/Time Pr 5/25/2018 3:	repared: 43 pm
	Cost Center Description		Net Expenses or Allocation 7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	83, 386	2, 030, 804				1.00
. 01	00101 CAP REL COSTS-BLDG & FIXT - TOWER	0	0				1.01
. 00	00200 CAP REL COSTS-MVBLE EQUIP	145 744	3, 189, 152				2.00
. 00 . 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS	-145, 746 -22, 032	8, 165, 102 358, 811				4.00
. 01	00402 DATA PROCESSING	-22,032	1, 470, 940				4.01
. 03	00403 MATERIALS MANAGEMENT	Ő	357, 999				4.03
. 04	00404 ADMI TTI NG	0	725, 125				4.04
. 05	00405 PATIENT ACCOUNTING	-8, 224	1, 752, 792				4.05
. 00	00500 ADMI NI STRATI VE & GENERAL	-3, 517, 374	2, 941, 937				5.00
. 00	00700 OPERATION OF PLANT	-40, 836	2, 549, 245				7.00
. 00	00800 LAUNDRY & LINEN SERVICE	0	177, 783				8.00
. 00 0. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	820, 899 471, 536				9.00
	01100 CAFETERI A	-294, 703	402, 457				11.00
	01300 NURSI NG ADMI NI STRATI ON	234	1, 748, 875				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	216, 667				14.00
	01500 PHARMACY	-860	4, 488, 895				15.00
6.00	01600 MEDICAL RECORDS & LIBRARY	-24, 451	811, 147				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	-1, 567, 082	3, 309, 388				30.00
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	0	1, 266, 711 765, 030				31.00
	04300 NURSERY	o	175, 603				41.00
5.00	ANCI LLARY SERVI CE COST CENTERS		173,003				- 45.00
0. 00	05000 OPERATI NG ROOM	0	2, 127, 908				50.00
3.00	05300 ANESTHESI OLOGY	0	26, 046				53.00
	05400 RADI OLOGY-DI AGNOSTI C	-4, 900	2, 796, 951				54.00
	06000 LABORATORY	-70	3, 754, 279				60.00
	06500 RESPIRATORY THERAPY	0	1, 093, 061				65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	976, 370 249, 625				66.00 67.00
	06800 SPEECH PATHOLOGY	0	164, 490				68.00
	06900 ELECTROCARDI OLOGY	-398	1, 832, 156				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	56, 408				70.00
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 645, 141				71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	872, 631				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
	03020 ONCOLOGY	-125, 500	263, 700				76.00
6.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	-32,000	172, 443				76.97
0 00	09000 CLINIC	-950, 263	1, 757, 262				90.00
	09100 EMERGENCY	-43, 495	2, 058, 944				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
01.00	10100 HOME HEALTH AGENCY	0	841, 418				101.00
10.00	SPECIAL PURPOSE COST CENTERS	10,000	0				112 00
13.00	11300 INTEREST EXPENSE	-10,002	0 E0 995 721				113.00
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-6, 704, 316	59, 885, 731				118.00
90 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	120, 923				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	15,009,510				192.00
92.01	19201 SOUTH CLINIC	0	0				192.01
	19202 WEST CLINIC	0	0				192.02
	19203 DI ABETES CENTER	0	97, 851				192.03
	19300 NONPAID WORKERS	0	0				193.00
	19301 ADULT/CHI LD CARE	0	419, 151				193.01
	19302 PHYSI CLAN OFFICE BUILDING	0	1 044 000				193.02
	19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI P HFC	0	1, 046, 990 21, 363				193.03 194.00
	07950 PARTNERSHIP HPC 07951 TRAFALGAR CLINIC		21, 303				194.00
	07951 TRAFALGAR CELINIC 07952 EDI NBURGH	0	0				194.01
94.03	07953 JAI L	o	48, 095				194.02
	07954 ATHLETIC TRAINERS	0	0				194.04
200.00		-6, 704, 316	76, 649, 614				200.00

	od: Worksheet A-6 01/01/2017 12/31/2017 Date/Time Prepared: 5/25/2018 3:43 pm
	372372010 3.43 pm
Increases	
Cost Center Line # Salary Other	
A - NURSERY RECLASS	
1.00 NURSERY 43.00 149,719 25,884	1.00
TOTALS 149, 71925, 884	
B - IMPLANTABLE RECLASS	
1.00 IMPL. DEV. CHARGED TO 72.00 872,631	1.00
PATI ENT	
TOTALS 0 872, 631	
C - CAFETERIA RECLASS	
1. 00 CAFETERIA 11. 00488, 289208, 871	1.00
TOTALS 488, 289 208, 871	
D - DAY CARE RECLASS	
1.00 <u>EMPLOYEE BENEFITS DEPARTMENT</u> 4.00120,46132,749	1.00
TOTALS 120, 461 32, 749	
G - STD RECLASS	
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 12, 338	1.00
2. 00 NURSI NG ADMI NI STRATI ON 13. 00 3, 461	2.00
3.00 SUBPROVIDER - IRF 41.00 6,365	3.00
4. 00 RADI OLOGY-DI AGNOSTI C 54. 00 14, 405	4.00
5.00 RESPIRATORY THERAPY 65.00 9,650	5.00
6.00 PHYSICIANS' PRIVATE OFFICES 192.00 28,462	6.00
TOTALS 0 74, 681	
H - EMPLOYEE WELLNESS RECLASS	
1. 00 <u>EMPLOYEE BENEFITS DEPARTMENT</u> 4. 00 60, 030	1.00
TOTALS 0 60, 030	
J - PART A RECLASS	
1.00 PHYSICAL THERAPY 66.00 0108,130	1.00
TOTALS 0 108, 130	
500.00 Grand Total: Increases 758, 469 1, 382, 976	500.00

ealth Financial Systems RECLASSIFICATIONS		JOHNSON MEMORIA		CCN: 15-0001	Period:	u of Form CMS-2552 Worksheet A-6
RECLASSIFICATIONS			Provider (LCN: 15-0001	From 01/01/2017	WORKSneet A-6
					To 12/31/2017	Date/Time Prepare 5/25/2018 3:43 pm
	Decreases					
Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref		
6.00	7.00	8.00	9.00	10.00		
A - NURSERY RECLASS						
. 00 ADULTS & PEDIATRICS	30.00	149, 719	25, 884		0	1.
TOTALS		149, 719	25, 884			
B - IMPLANTABLE RECLASS						
. 00 MEDI CAL SUPPLI ES CHARGED TO	71.00		872, 631		0	1.
PATI ENTS						
TOTALS		0	872, 631			
C - CAFETERIA RECLASS				1		
. 00 <u>DI ETARY</u>		488, 289	208, 871		0	1.
TOTALS		488, 289	208, 871			
D – DAY CARE RECLASS				1		
. 00 ADULT/CHI LD_CARE	<u> </u>	<u>120, 4</u> 61	3 <u>2, 7</u> 49		Ō	1.
TOTALS		120, 461	32, 749			
G - STD RECLASS	· · · · · ·			i	-	
. OO ADMI NI STRATI VE & GENERAL	5.00	12, 338	0		0	1.
. OO NURSING ADMINISTRATION	13.00	3, 461	0		0	2.
. 00 SUBPROVI DER – I RF	41.00	6, 365	0		0	3.
. 00 RADI OLOGY-DI AGNOSTI C	54.00	14, 405	0		0	4.
. 00 RESPI RATORY THERAPY	65.00	9, 650	0		0	5.
. 00 PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	2 <u>8, 4</u> 62	0		0	6.
TOTALS		74, 681	0			
H - EMPLOYEE WELLNESS RECLAS		I		1	1	
. 00 ADMI NI STRATI VE & GENERAL	5.00	6 <u>0, 0</u> 30	0		0	1.
TOTALS		60, 030	0			
J - PART A RECLASS				1		
. 00 <u>SUBPROVI DER - I RF</u>	41.00	0	10 <u>8, 1</u> 30		Q	1.
TOTALS		0	108, 130			
00.00 Grand Total: Decreases		893, 180	1, 248, 265			500.

	Financial Systems	JOHNSON MEMORI			-		u of Form CMS-2	
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0001		-iod: om 01/01/2017	Worksheet A-7 Part I	
					To	12/31/2017		nared
					10	12/01/2017	5/25/2018 3:4	
				Acqui si ti on	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							
1.00	Land	4, 743, 329	97		0	97	0	
2.00	Land Improvements	2, 746, 206	60, 860		0	60, 860	0	2.00
3.00	Buildings and Fixtures	0	0		0	0	0	3.00
4.00	Building Improvements	68, 972, 645	3, 492, 113		0	3, 492, 113	0	4.00
5.00	Fixed Equipment	12, 930, 439	77, 166		0	77, 166	0	5.00
6.00	Movable Equipment	50, 480, 013	11, 071, 990		0	11, 071, 990	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	139, 872, 632	14, 702, 226		0	14, 702, 226	0	8.00
9.00	Reconciling Items	0	0		0	0	0	
10.00	Total (line 8 minus line 9)	139, 872, 632	14, 702, 226		0	14, 702, 226	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, 426	0					1.00
2.00	Land Improvements	2, 807, 066	0					2.00
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	72, 464, 758	0					4.00
5.00	Fixed Equipment	13, 007, 605	0					5.00
6.00	Movable Equipment	61, 552, 003	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	154, 574, 858	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	154, 574, 858	0					10.00

Heal th	Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0001	Period: From 01/01/2017 To 12/31/2017		pared:
			S	UMMARY OF CAP	I TAL	072072010 0. 1	
	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		12, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 947, 418	C	D	0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	C	2	0 0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	3, 189, 152	C	2	0 0	0	2.00
3.00	Total (sum of lines 1-2)	5, 136, 570		2	0 0	0	3.00
		SUMMARY OF	CAPI TAL				
	Cost Center Description	Other 1	Fotal (1) (sum	n			
		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, COLUMN	12, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 947, 418	3			1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	C)			1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	3, 189, 152	2			2.00
3.00	Total (sum of lines 1-2)	0	5, 136, 570	0			3.00

Heal th	n Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/25/2018 3:43	
		COMI	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	80, 015, 250		80, 015, 25			1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	13, 007, 605		13, 007, 60			1.01
2.00	CAP REL COSTS-MVBLE EQUIP	61, 552, 003		61, 552, 00			2.00
3.00	Total (sum of lines 1-2)	154, 574, 858		154, 574, 85			3.00
			TION OF OTHER (-		OF CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	C) (2, 030, 804	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	0		0 0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		3, 189, 152	0	2.00
3.00	Total (sum of lines 1-2)	0	0) (5, 219, 956	0	3.00
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	•				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	2, 030, 804	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	c c) (0 0		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	l o		0 0	3, 189, 152	2.00
3.00	Total (sum of lines 1-2)	0	c c		0 0	5, 219, 956	3.00
			•				

	Financial Systems MENTS TO EXPENSES		JOHNSON MEMOR	Provider CCN: 15-0001	In Lie Period:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Prep 5/25/2018 3:43	
				Expense Classification c To/From Which the Amount i			
	Cost Conton Deceription	Dagi o (Cada (2))	Amount	Cost Contor	Line #	What A 7 Def	
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		(NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.0
. 01	2) Investment income - CAP REL COSTS-BLDG & FIXT - TOWER		C	CAP REL COSTS-BLDG & FIXT TOWER	- 1.01	0	1.0
. 00	(chapter 2) Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		(0.00	0	3. 0
ł. 00	(chapter 2) Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4.0
5. 00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.0
. 00	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6.0
. 00	Tel ephone services (pay stations excluded) (chapter 21)		C		0.00	0	7.0
8. 00	Television and radio service (chapter 21)		C		0.00	0	8. 0
0. 00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	(-2, 432, 229		0.00	0	
1. 00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11. (
2. 00	(chapter 23) Related organization	A-8-1	(0	12. (
	transactions (chapter 10) Laundry and linen service		(0.00		
	Cafeteria-employees and guests Rental of quarters to employee and others		(0.00 0.00		
6. 00	Sale of medical and surgical supplies to other than		C		0.00	0	16. 0
7.00	patients Sale of drugs to other than		C		0.00	0	17. (
8. 00	patients Sale of medical records and		C	þ	0.00	0	18. (
9. 00	abstracts Nursing and allied health education (tuition, fees,		C	D	0.00	0	19. (
	books, etc.) Vending machines		(0.00		
1. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		C)	0.00	0	21. (
2. 00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22. (
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23. (
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24. (
5. 00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted **	* 114.00		25. (
6. 00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26. (
6. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		C	FIXT CAP REL COSTS-BLDG & FIXT	- 1.01	0	26. 0
7.00	COSTS-BLDG & FIXT - TOWER Depreciation - CAP REL		C	TOWER CAP REL COSTS-MVBLE EQUIP	2.00	0	27.0
8.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		(*** Cost Center Deleted ***			28.0
9.00 0.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	(D DOCCUPATI ONAL THERAPY	0.00 67.00		29. 0 30. 0
0. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		C	ADULTS & PEDIATRICS	30.00		30. 9

	Financial Systems		JOHNSON MEMORIA			u of Form CMS-	
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2017	Worksheet A-8	
					To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
	·			Expense Classification or			
			T	o/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0 SI	PEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
	Depreciation and Interest		1 40 7 40 0		00.00		0.0.00
33.00	JMH PAIN CARE CENTER REVENUE	В	-142, 740 C	LINIC	90.00	0	33.00
33. 01	CAFETERIA CANTEEN VENDING	В	-290, 203 C	ΔΕΕΤΕΡΙΔ	11.00	0	33.01
55. 01	REVENUE	D	270,2030		11.00	Ĭ	33.01
33. 02	CAFETERIA CANTEEN VENDING	В	-4, 500 C	AFETERI A	11.00	o	33.02
	REVENUE						
33.03	MI SC OTHER REVENUE	В		URSING ADMINISTRATION	13.00		33.03
33.04	MI SC OTHER REVENUE	В		HARMACY	15.00		
33.05	MI SC OTHER REVENUE	В		EDICAL RECORDS & LIBRARY	16.00	0	
33.06	MI SC OTHER REVENUE	В		ATIENT ACCOUNTING	4.05	0	
33.07	MI SC OTHER REVENUE	В		DMINISTRATIVE & GENERAL	5.00		
33.08	MI SC OTHER REVENUE	В		DMINISTRATIVE & GENERAL	5.00		
33.09	MI SC OTHER REVENUE	В		DMINISTRATIVE & GENERAL	5.00		
33.10	MI SC OTHER REVENUE	В		DMINISTRATIVE & GENERAL	5.00	0	
33.11	MI SC OTHER REVENUE	В	- 4 A	DMINISTRATIVE & GENERAL	5.00	0	
33. 12	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 12
33. 13	(3) MI SC OTHER REVENUE	В	_1 138/	DMI NI STRATI VE & GENERAL	5.00	l o	33.13
33.14	MI SC OTHER REVENUE	B		ADI OLOGY-DI AGNOSTI C	54.00		
33.15	MI SC OTHER REVENUE	B	-142, 740C		90.00		
33.17	CABLE SERVICES	Ā		PERATION OF PLANT	7.00		
33. 18	TELEPHONE SERVICES	A		EW CAP REL COSTS-BLDG &	1.00	9	
			F	I XT			
33.19	TELEPHONE SERVICES	A		DMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	COMMUNI CATI ONS	Α		OMMUNI CATI ONS	4.01	0	
33. 21	ADVERTISING EXP - A&G	A		DMINISTRATIVE & GENERAL	5.00	0	
33.23	ADVERTISING EXP - LABORATORY	A		ABORATORY	60.00	0	
33. 24	ADVERTISING EXP - WOUND CARE	A	-1, 029C		90.00	0	
33.25	DAYCARE	В		MPLOYEE BENEFITS DEPARTMEN		0	
33.26	DAYCARE DI SCOUNT	A		MPLOYEE BENEFITS DEPARTMEN		0	
33.27	LOBBYING EXPENSE - AHA	A		DMINISTRATIVE & GENERAL	5.00	0	
33. 28 33. 29	LOBBYING EXPENSE - IHHA PROF - BUILDING	A		DMINISTRATIVE & GENERAL PERATION OF PLANT	5.00		
33.29 33.30	PROF - BUILDING PROF - BUILDING	A A		PERAIION OF PLANI MPLOYEE BENEFITS DEPARTMEN	T 7.00 T 4.00		
33.30 33.31	INTEREST INCOME	B		NTEREST EXPENSE	113.00		•
33.31	1933 AHA LIFE	A		EW CAP REL COSTS-BLDG &	1.00	9	
55. 52				IXT	1.00	2	00.02
33. 33	HAF EXPENSE	А		DMINISTRATIVE & GENERAL	5.00	l o	33.33
33.34	MI SC OTHER REVENUE	В		DMI NI STRATI VE & GENERAL	5.00		•
50.00	TOTAL (sum of lines 1 thru 49)		-6, 704, 316				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

 column 6, line 200.)
 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

 (2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

PROVIDER BASED PINSICI AN ADJUSTNENT ProvI der CR: 15-001 Period : End 2010/12/017 To 212/31/2017 Morksheet A-8-2 (bete/Time) Propared To 212/31/2017 Morksheet A-8-2 (bete/Time) Propared To 0 Morksheet A-8-2 (beter/Time) Propared To 0 Morks	Heal th	Financial Syste	ems	JOHNSON MEMOR	REAL HOSPETAL		In Lie	eu of Form CMS-	2552-10
Image: Next: A Line Cost Center/Physician Total Identifican Total Remuneration Provider Component RCE Amount Physician/Provider Component 1.00 2.00 3.00 4.00 5.00 6.00 Provider Component Provider Compo							Period:	Worksheet A-8	
Wikst: A. Line # Cost Center/Physician Identifier Total Remuneration Professional Component Provider Component REE Amount Mexicial Component REE Amount Hysicial Component Rest Hysicial Component 1.00 30.004ADULTS & PEDIATRICS 1,567,082 1.567,082 0 0 0 10,004 2.00 3.004 4.00 5.00 6.00 7.00 1.557,082 0 0 1.567,082 0 0 1.557,082 0 0 1.575,200 1.567,082 0 0 1.575,200 1.557,200 1.557,200 1.557,200 <									
West: A Line # Cost Center/Physician Identifia Total Remuneration Protessional Component Provider Provider Component RCE Amount Physician/Prov ider Component 1.00 30.00/ADULTS & PEDIATRICS 1,567,082 1,567,082 0 0 0 0.00 2.00 6.00 7.00 0 1.00 2.00 60.00/LEGNRATORY 100.004 0 110.004 211,500 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>10 12/31/201/</td><td></td><td></td></td<>							10 12/31/201/		
Identifier Remuneration Component Component Identifier Identifier 1.00 30.00 4.00 5.00 6.00 7.00 1.00 1.00 30.00 AUDRATORY 110.004 1.567.082 1.00 0.00 1.575 2.00 2.00 60.00 LECTROCARD LOCY 125.500 <		Wkst Aline #	Cost Center/Physician	Total	Professional	Provi der	PCE Amount		s pili
I O 3.0 4.00 5.00 6.00 7.00 1.00 30.00ADULTS & PEDIATRICS 1.567.082 1.567.082 0 0.00 7.00 1.00 3.00 0.00 1.00 3.00 0.00 1.000 2.00 0 0.00 1.557.082 1.00.04 211.500 1.557.20 2.00 0 0.00		WKSU. A LINE #							
1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 30.07010115 & PEDIATRICS 1.567.082 1.567.082 0<			i denti i i ei	Remarier at rom	component	component			
1.00 30.00/ADULTS & PEDIATRICS 1.567.082 0 0 0 1.00 2.00 60.00/LAGRATORY 110.004 0 110.004 211.500 1.557.20 3.00 3.00 69.00/LECTROCARDI OLOGY 398 398 398 0 0 0.01 0.05 0 0.01 0.05 0 0.01 0.05 0 0.01 0.05 0 0.01 0.05 0		1 00	2 00	3 00	4 00	5.00	6.00		
2.00 60.00LABORATORY 110.004 100.004 211.500 1.575 2.00 3.00 69.00ELECTROCANDIOLOGY 398 300 10.00 10.00 <t< td=""><td>1.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1.00</td></t<>	1.00								1.00
3:00 669.00ELECTROCARDIOLOGY 3388 3386 0 0 0 3:00 4:00 76.00[0NCOLOGY 125.500 125.500 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>211.500</td> <td>1.575</td> <td></td>							211.500	1.575	
4.00 76.00 76.00 76.00 76.00 97.00					398				
5.00 91.00 DEMERGENCY 43,495 43,495 32,000 <							ol o	0	
6.00 76.97 (CARDIAC REHABILITATION 32,000 32,000 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>								0	
7.00 90.00 CLINIC 663,754 663,754 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>								0	
8.00 0.00 0.00 0								0	
9.00 0.00 0.00 0				0	0	(0	
200.00 2,542,233 2,432,229 110,004 1,575 200.00 Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit 5 Percent of Unadjusted RCE Limit Cost of Cost of Limit Provider Component Share of col. Provider Of Malpractice Insurance 1.00 2.00 8.00 9.00 12.00 14.00 1.00 2.00 60.00 Laboratory 0 </td <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>ol o</td> <td>0</td> <td></td>				0	0		ol o	0	
200.00 2,542,233 2,42,229 110,004 1,575 200.00 Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit 5 Percent of Unadjusted RCE Limit 5 Percent of Unadjusted RCE Provider Cost of Limit Provider Component Provider Omborships & Component Provider Omborships & Component Provider Islandow Provider Omborships & Component 1.00 14.00 1.00 14.00 0				0	0		ol o	0	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Derivation Description Provider Score Provid				2, 542, 233	2, 432, 229	110,004		1, 575	
Identifier Limit Unadjusted RCE Limit Remberships & Component Education Component Share of col. of Mal practice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 0 2.00 3.00 69.00 LECETROCADI OLOGY 160.150 8.008 0 0 0 0 2.00 5.00 76.00 ONCOLOGY 0 <td< td=""><td></td><td>Wkst. A Line #</td><td>Cost Center/Physician</td><td>Unadi usted RCE</td><td>5 Percent of</td><td></td><td>Provi der</td><td></td><td></td></td<>		Wkst. A Line #	Cost Center/Physician	Unadi usted RCE	5 Percent of		Provi der		
Image: Note of the image in the im									
1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 30.00 ADULTS & PEDIATRI CS 0 <					Limit	Conti nui ng	Share of col.	Insurance	
1.00 30.00/ADULTS & PEDIATRICS 0 0 0 0 0 0 0 0 0 1.00 2.00 60.00 LABORATORY 160,150 8,008 0 0 0 2.00 3.00 4.00 76.00 ONCOLOGY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>Educati on</td> <td></td> <td></td> <td></td>						Educati on			
2.00 60.00 LABORATORY 160,150 8,008 0<		1.00	2.00	8.00	9.00	12.00	13.00	14.00	
3.00 69.00 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 3.00 4.00 76.00 NNCOLOGY 0	1.00				Ŭ			0	
4.00 76.00 ONCOLOGY 0 0 0 0 0 0 0 4.00 5.00 91.00 DEMERGENCY 0	2.00			160, 150	8, 008			0	2.00
5.00 91.00 EMERGENCY 0				0				0	
6.00 76.97 CARDI AC REHABI LI TATI ON 0	4.00			0	0	(0 0	0	4.00
7.00 90.00 CLINIC 0	5.00			0	0	(0 0	0	5.00
8.00 0.00 <th< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td>(</td><td>0 0</td><td>0</td><td></td></th<>				0	0	(0 0	0	
9.00 0.00 0.00 0			CLINIC	0	0	(0 0	0	
10.00 0.00 0 0 0 0 0 0 0 0 10.00 200.00 0				0	0			0	
200.00 160,150 8,008 0 0 0 200.00 Wkst. A Line # Cost Center/Physician Identifier Provider Component Share of col. Adjusted RCE Limit RCE Disal Iowance Adjustment Adjustment Imit Disal Iowance Imit Disal Iowance Imit Imit Disal Iowance Imit Imi				0	0			0	
Wkst. A Li ne # Cost Center/Physici an I denti fi er Provi der Component Share of col. Adj usted RCE Li mi t RCE Di sal I owance Adj ustment 1.00 2.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRI CS 0 0 0 1.567,082 1.00 2.00 60.00 LABORATORY 0 160,150 0 0 2.00 3.00 69.00 ELECTROCARDI OLOGY 0 0 0 125,500 4.00 5.00 91.00 EMERGENCY 0 0 0 0 32,000 66.00 76.07,074 CREHABI LI TATI ON 0 0 0 32,000 66.00 76.07,075 5.00 4.00 7.00 90.00 CLI NI C 0 0 0 0 32,000 6.00 7.00 9.00 0 0 0 0 7.00 9.00 0 0 9.00 9.00 0 9.00 9.00 9.00 0 9.00 10.00		0.00		0	0		° °	0	
Identifier Component Share of col. Limit Disal I owance Image: Component Share of col. Disal I owance Image: Component Share of componentShare of component Share	200.00						,	0	200.00
Image: Constraint of the image: Constraint of th		Wkst. A Line #			5		Adjustment		
Image: Note of the image in the image. Image in the image inthe image in the image in the image in the image in the			I denti fi er		Limit	Di sal I owance			
1.00 2.00 15.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRICS 0 0 0 1,567,082 1.00 2.00 60.00 LABORATORY 0 160,150 0 0 2.00 3.00 69.00 ELECTROCARDI OLOGY 0 0 0 398 3.00 4.00 76.00 ONCOLOGY 0 0 0 125,500 4.00 5.00 91.00 EMERGENCY 0 0 0 322,000 6.00 6.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 32,000 6.00 7.00 90.00 CLI NI C 0 0 0 32,000 6.00 8.00 0.00 0 0 0 0 8.00 9.00 9.00 0.00 0 0 0 9.00 9.00 9.00									
1.00 30.00 ADULTS & PEDIATRICS 0 0 1,567,082 1.00 2.00 60.00 LABORATORY 0 160,150 0 0 2.00 3.00 69.00 ELECTROCARDI OLOGY 0 0 0 3.00 3.00 69.00 ELECTROCARDI OLOGY 0 0 0 3.00 3.00 3.00 4.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00		1.00	2.00		16.00	17.00	10.00		
2.00 60.00 LABORATORY 0 160,150 0 0 2.00 3.00 69.00 ELECTROCARDI OLOGY 0 0 0 398 3.00 4.00 76.00 ONCOLOGY 0 0 0 125,500 4.00 5.00 91.00 EMERGENCY 0 0 0 32,000 6.00 6.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 32,000 6.00 7.00 90.00 CLI NI C 0 0 0 663,754 7.00 8.00 0.00 0 0 0 0 9.00 9.00 10.00 9.00 10.00 0.00 0 0 0 0 9.00 10.00	1 00								1 00
3.00 69.00 ELECTROCARDIOLOGY 0 0 3.00 4.00 76.00 0NCOLOGY 0 0 125,500 4.00 5.00 91.00 EMERGENCY 0 0 0 43,495 5.00 6.00 76.97 CARDIAC REHABILITATION 0 0 0 32,000 6.00 7.00 90.00 CLINIC 0 0 0 63,754 7.00 8.00 0.00 0 0 0 9.00 9.00 9.00 10.00 10.00				-	-				
4.00 76.00 ONCOLOGY 0 0 125,500 4.00 5.00 91.00 EMERGENCY 0 0 0 43,495 5.00 6.00 76.97 CARDI AC REHABILITATION 0 0 0 32,000 6.00 7.00 90.00 CLINIC 0 0 0 663,754 7.00 8.00 0.00 0 0 0 9.00 9.00 10.00 0.00 0 0 0 9.00 10.00				0					
5.00 91.00 EMERGENCY 0 0 43,495 5.00 6.00 76.97 CARDI AC REHABI LI TATI ON 0 0 32,000 6.00 7.00 90.00 CLI NI C 0 0 0 663,754 7.00 8.00 0.00 0 0 0 0 9.00 8.00 9.00 0.00 0 0 0 0 9.00 9.00 10.00 10.00				0					
6.00 76.97 CARDI AC REHABI LI TATI ON 0 0 32,000 6.00 7.00 90.00 CLI NI C 0 0 0 663,754 7.00 8.00 0.00 0 0 0 0 8.00 9.00 9.00 9.00 9.00 10.00 9.00 10.00 9.00 9.00 10.00 </td <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>,</td> <td></td> <td></td>				0	0		,		
7.00 90.00 CLINIC 0 0 663,754 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 0 0 0 9.00 9.00 10.00 0.00 0 0 0 0 10.00				0					
8.00 0.00 0 0 0 8.00 9.00 0.00 0 0 0 9.00 9.00 9.00 9.00 10.00				0					
9.00 0.00 0 0 0 9.00 10.00 0.00 0 0 0 0 10.00				0	-				
10.00 0.00 0 0 0 10.00				0			°		
							-		
					0		-		
	200.00	I	I	1 0	100,100	1	/I Z, 452, 229	1	200.00

Health Financial Systems	JOHNSON MEMORI		ON 15 0001		eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
		CAP	I TAL RELATED	COSTS	5/25/2018 3:4	3 pm
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	BLDG & FIXT TOWER	- MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,030,804	2, 030, 804				1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNI 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 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON	0 3, 189, 152 8, 165, 102 358, 811 1, 470, 940 357, 999 725, 125 1, 752, 792 2, 941, 937 2, 549, 245 177, 783 820, 899 471, 536 402, 457 1, 748, 875	0 21, 907 2, 885 45, 958 28, 089 16, 438 48, 822 69, 936 183, 246 17, 649 13, 707 28, 757 30, 622 72, 440		0 3, 189, 152 0 1, 420 0 0 1, 495, 107 0 7, 083 0 0 12, 502 0 31, 379 0 48, 131 0 5, 300 0 4, 769 0 22, 196 0 0 34, 987 0 25, 002 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 188, 429 27, 615 149, 260 64, 358 149, 088 230, 264 293, 166 132, 157 20, 969 149, 276 69, 286 102, 438 326, 143	$\begin{array}{c} 1. \ 01 \\ 2. \ 00 \\ 4. \ 00 \\ 4. \ 01 \\ 4. \ 02 \\ 4. \ 03 \\ 5. \ 00 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \end{array}$
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	216, 667 4, 488, 895	12, 473 15, 021		0 35, 289 0 5, 965	16, 713 99, 788	
16.00 01600 MEDI CAL RECORDS & LI BRARY	811, 147	28, 478		0 8,618		1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 309, 388 1, 266, 711 765, 030 175, 603	202, 459 57, 896 49, 651 4, 589		0 139, 331 0 38, 066 0 20, 977 0 0	869, 305 250, 297 152, 705 31, 409	31.00 41.00
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 127, 908 26, 046 2, 796, 951 3, 754, 279 1, 093, 061 976, 370 249, 625 164, 490 1, 832, 156 56, 408 2, 645, 141	335, 959 2, 893 121, 371 59, 093 2, 746 46, 531 9, 801 609 7, 929 1, 336 0		0 476, 667 0 15, 178 0 367, 316 0 151, 019 0 16, 558 0 10, 800 0 2, 552 0 400 0 36, 298 0 1, 978 0 15, 004	430, 918 342, 124 195, 095 166, 694 52, 368 29, 386 100, 688	$\begin{array}{c} 53.\ 00\\ 54.\ 00\\ 60.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ \end{array}$
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	872, 631 0	0		0 0	0	
76.00 03020 ONCOLOGY	263, 700	51, 384		0 2, 313		
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	172, 443	18, 435		0 11, 046	25, 895	76.97
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 757, 262 2, 058, 944	84, 546 72, 931		0 17, 664 0 33, 254		
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	841, 418	9, 581		0 69	141, 487	101.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	59, 885, 731	1, 776, 168	3	0 3, 069, 236	5, 737, 853	113. 00 118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	120, 923	9, 522	2	0 4, 772	18, 909	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.01 19201 SOUTH CLI NI C 192.02 19202 WEST CLI NI C	15, 009, 510 0 0	190, 331 0 0		0 114, 563 0 0 0 0	2, 332, 661 0	
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	97, 851 0	2, 951 0		0 581 0 0		192. 03 193. 00
193. 01 19301 ADULT/CHI LD CARE 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	419, 151 0 1, 046, 990 21, 363	35, 475 0 0 16, 357			69, 138 0 0 1, 983	193. 01 193. 02 193. 03 194. 00
194.01 07951 TRAFALGAR CLINIC 194.02 07952 EDINBURGH 194.03 07953 JAIL 194.04 07954 ATHLETIC 200.00 Cross Foot Adjustments Cross	0 0 48, 095 0	0 0 0 0			0 10, 090	194. 01 194. 02 194. 03 194. 04 200. 00
201.00Negative Cost Centers202.00TOTAL (sum Lines 118 through 201)	76, 649, 614	0 2, 030, 804		0 0 0 3, 189, 152		201.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eri od:	Worksheet B	
			T	rom 01/01/2017 5 12/31/2017	Part I Date/Time Pre	
Cost Center Description	COMMUNI CATI ONS	DATA	MATERI ALS	ADMI TTI NG	5/25/2018 3: 4 PATI ENT	3 pm
		PROCESSI NG	MANAGEMENT	7,0,1111110	ACCOUNTING	
GENERAL SERVICE COST CENTERS	4.01	4.02	4.03	4.04	4.05	
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						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS	389, 311					4.00 4.01
4. 02 00402 DATA PROCESSI NG	38, 730	3, 199, 995				4.01
4.03 00403 MATERIALS MANAGEMENT	8, 320	84, 068	549, 917			4.03
4. 04 00404 ADMI TTI NG	9, 754	79, 441	1, 973	981, 819		4.04
4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL	25, 246 22, 091	353, 241 374, 840	4, 054 11, 439	0	2, 426, 921 0	4.05 5.00
7.00 00700 OPERATION OF PLANT	14, 058	27, 766	556	0	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 434	18, 510	2, 428	0	0	8.00
9. 00 00900 HOUSEKEEPI NG	4, 016	0	13, 993	0	0	9.00
10. 00 01000 DI ETARY	7,459	99, 494	37, 979	0	0	
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMINI STRATI ON	0 13, 197	51, 675	0 7, 407	0	0	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0 1/ 0/ 0	8, 571	Ő	0	14.00
15. 00 01500 PHARMACY	6, 598	20, 053	0	0	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10, 615	135, 743	360	0	0	16.00
30. 00 03000 ADULTS & PEDIATRICS	30, 124	230, 609	33, 043	62,067	153, 429	30.00
31. 00 03100 I NTENSI VE CARE UNI T	8, 033	77, 898	9, 618	6, 647	16, 431	31.00
41.00 04100 SUBPROVIDER - IRF	5, 164	14, 654	2, 526	8, 350	20, 642	
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	2, 627	6, 494	43.00
50. 00 05000 OPERATING ROOM	25, 246	313, 906	22, 472	142, 215	351, 556	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	402	19, 627	48, 517	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 918	129, 573	29, 611	178, 945	442, 213	
	19, 509	144, 227	181, 805	136, 351	337,062	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	5, 164 7, 172	107, 206 52, 446	15, 314 3, 044	26, 307 17, 449	65, 031 43, 134	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 721	13, 883	0,011	9, 289	22, 962	67.00
68.00 06800 SPEECH PATHOLOGY	1, 721	13, 112	3	3, 139	7, 760	
69. 00 06900 ELECTROCARDI OLOGY	12, 336	167, 365	9, 888	19, 376	47,897	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	574 0	6, 170 0	183 20, 725	631 48, 565	1, 560 120, 053	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	20, 720	12, 019	29, 710	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	57, 154	141, 285	
76.00 03020 ONCOLOGY	10, 615	40, 877	1,652	3, 612	8, 929	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	1, 147	2, 809	6, 944	76.97
90. 00 09000 CLI NI C	6, 025	36, 250	18, 963	49, 539	122, 461	90.00
91. 00 09100 EMERGENCY	16, 927	130, 344	13, 975	118, 275	292, 376	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	6, 598	60, 159	2, 134	6, 138	15, 173	101.00
SPECIAL PURPOSE COST CENTERS		,		.,		
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	222.245	2 702 510	455 245	021 121	2 201 (10	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	333, 365	2, 783, 510	455, 265	931, 131	2, 301, 619	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 303	37, 792	2, 224	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	47, 053	322, 390	80, 976	50, 309	124, 365	
192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC	0	0	0	0		192.01
192. 02 19202 WEST_CLINIC 192. 03 19203 DI ABETES_CENTER	0 861	0 13, 112	0	379		192. 02 192. 03
193. 00 19300 NONPAI D WORKERS	0	0	0	0		193.00
193. 01 19301 ADULT/CHI LD CARE	1, 434	30, 079	9, 480	0		193. 01
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG	0	0	0	0		193.02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	2, 295	0 13, 112	1, 873 93	0		193. 03 194. 00
194. 01 07951 TRAFALGAR CLINIC	0	0	0	0		194.00
194. 02 07952 EDI NBURGH	0	О	0	О		194. 02
194. 03 07953 JALL	0	0	0	0		194.03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	0	0	0	0	194. 04 200. 00
201.00 Negative Cost Centers	0	О	0	О		201.00
202.00 TOTAL (sum lines 118 through 201)	389, 311	3, 199, 995	549, 917	981, 819	2, 426, 921	202.00

	ncial Systems	JOHNSON MEMORI	AL_HOSPITAL			u of Form CMS-	2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2017	Worksheet B Part I	
				Т	o 12/31/2017	Date/Time Pre 5/25/2018 3:4	
	Cost Center Description	Subtotal /		OPERATION OF	LAUNDRY &	HOUSEKEEPING	
		4A. 05	& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	
GENE	RAL SERVICE COST CENTERS	47.00	3.00	1.00	0.00	7.00	
	O NEW CAP REL COSTS-BLDG & FIXT						1.00
	1 CAP REL COSTS-BLDG & FIXT - TOWER 0 CAP REL COSTS-MVBLE EQUIP						1.01 2.00
	O EMPLOYEE BENEFITS DEPARTMENT						4.00
	1 COMMUNI CATI ONS						4.01
	2 DATA PROCESSI NG						4. 02
	3 MATERIALS MANAGEMENT 4 ADMITTING						4.03
	5 PATIENT ACCOUNTING						4.04 4.05
	O ADMI NI STRATI VE & GENERAL	3, 744, 788	3, 744, 788				5.00
	O OPERATION OF PLANT	2, 955, 159	151, 792				7.00
	O LAUNDRY & LINEN SERVICE	244,073	12, 537			1 120 044	8.00
	O HOUSEKEEPI NG O DI ETARY	1, 006, 660 736, 707	51, 707 37, 841			1, 139, 846 20, 718	•
	0 CAFETERIA	535, 517	27, 507			22, 061	11.00
	NURSING ADMINISTRATION	2, 254, 724	115, 814			52, 188	
	O CENTRAL SERVICES & SUPPLY	289, 713	14, 881			8, 986	•
1	O PHARMACY O MEDI CAL RECORDS & LI BRARY	4, 636, 320 1, 125, 380	238, 145 57, 805			10, 822 20, 517	•
	TI ENT ROUTI NE SERVI CE COST CENTERS	1, 120, 000	37,003	<u> </u>	<u> </u>	20, 317	10.00
30.00 0300	0 ADULTS & PEDI ATRI CS	5, 029, 755	258, 353			145, 859	30.00
		1, 731, 597	88, 943			41, 710	
	0 SUBPROVI DER – I RF 0 NURSERY	1, 039, 699 220, 722	53, 404 11, 337			35, 770 3, 306	
	LLARY SERVICE COST CENTERS	220,722	11, 337	0,000	<u> </u>	5, 500	43.00
50.00 0500	O OPERATING ROOM	4, 169, 922	214, 188			242, 035	
	O ANESTHESI OLOGY	112, 663	5, 787			2, 084	•
	0 RADI OLOGY-DI AGNOSTI C 0 LABORATORY	4, 511, 816 5, 125, 469	231, 749 263, 270			87, 440 42, 572	
	O RESPIRATORY THERAPY	1, 526, 482	78, 408			1, 978	
	O PHYSI CAL THERAPY	1, 323, 640	67, 989			33, 523	•
	O OCCUPATIONAL THERAPY	362, 201	18, 604			7, 061	67.00
	0 SPEECH PATHOLOGY 0 ELECTROCARDI OLOGY	220, 620 2, 233, 933	11, 332 114, 746			439 5, 712	
	0 ELECTROENCEPHALOGRAPHY	2, 233, 433	4, 066			963	•
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 849, 488	146, 364			0	71.00
	O I MPL. DEV. CHARGED TO PATIENT	914, 360	46, 966			0	72.00
	0 DRUGS CHARGED TO PATIENTS 0 ONCOLOGY	198, 439	10, 193			0	73.00
	7 CARDI AC REHABI LI TATI ON	433, 519 238, 719	22, 268 12, 262			37, 019 13, 281	•
	ATIENT SERVICE COST CENTERS		,			,	
	O CLINIC	2, 249, 968	115, 570				90.00
91.00 0910	0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART)	3, 133, 566 0	160, 956	140, 435	43, 180	52, 542	91.00 92.00
	R REIMBURSABLE COST CENTERS	0		1			92.00
101.001010	O HOME HEALTH AGENCY	1, 082, 757	55, 616	18, 448	0	6, 902	101.00
	AL PURPOSE COST CENTERS	[F					110.00
113.001130	O INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	56, 317, 530	2, 700, 400	2, 616, 631	286, 359	956, 398	113.00 118.00
	EI MBURSABLE COST CENTERS	30, 317, 330	2,700,400	2,010,031	200, 337	/30, 370	110.00
190.001900	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	198, 445	10, 193	18, 335			190. 00
	O PHYSI CI ANS' PRI VATE OFFI CES	18, 272, 158	938, 579			137, 121	
	1 SOUTH CLINIC 2 WEST CLINIC	0	0	-	0		192. 01 192. 02
	3 DI ABETES CENTER	134, 473	6, 907	-	Ŭ,		192.02
193.00 1930	O NONPAID WORKERS	0	0	0	0		193.00
	1 ADULT/CHI LD CARE	564, 757	29, 009	68, 309	0		193.01
	2 PHYSICIAN OFFICE BUILDING 3 OPTIFAST/FOUNDATION	0 1, 048, 863	0 53, 875	0	0		193. 02 193. 03
	0 PARTNERSHIP HFC	55, 203	2, 836		0		194.00
	TRAFALGAR CLINIC	00,200	2,000		0		194.01
194. 02 0795		0	0	0	0		194. 02
194.030795		58, 185	2, 989	0	0		194.03
200.00	4 ATHLETIC TRAINERS Cross Foot Adjustments	0	0	, 0	0	0	194. 04 200. 00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	76, 649, 614	3, 744, 788	3, 106, 951	290, 595	1, 139, 846	202.00

Heal th	Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS		Provider C		eriod: ^om 01/01/2017	Worksheet B Part I	
				То	0 12/31/2017	Date/Time Pre 5/25/2018 3:4	
	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	
H	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 4. 04	00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOVEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG 00403 MATERI ALS MANAGEMENT 00404 ADMITTI NG						1.01 2.00 4.00 4.01 4.02 4.03 4.03
5.00 7.00 8.00 9.00 10.00 11.00	00405 PATI ENT ACCOUNTI NG 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	856, 633 0 0	644, 049 19, 890				4.05 5.00 7.00 8.00 9.00 10.00 11.00 13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	3, 124 11, 291		377, 880 0	4, 925, 502	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	25, 244		0	4, 925, 502	
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	585, 482	81, 723	971, 962	0	0	30.00
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	113, 823 157, 328	26, 083 14, 909		0	0	31.00 41.00
	04300 NURSERY	157, 328	3, 331		0	0	
	ANCI LLARY SERVICE COST CENTERS		44 500	E20 214	ol	0	
	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	0	44, 589 C		0	0	50.00 53.00
1	05400 RADI OLOGY-DI AGNOSTI C	0	48, 559		0	0	54.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	53, 962 20, 928		0	0	60.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	19, 567	0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	5, 012 2, 810		0	0	67.00 68.00
	06900 ELECTROCARDI OLOGY	0	10, 429		0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	1, 292		0	0	70.00 71.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		377, 880 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	0 0	0	4, 925, 502	
	03020 ONCOLOGY 07697 CARDIAC REHABILITATION	0	5, 875 3, 012	1	0	0	
	OUTPATIENT SERVICE COST CENTERS	L - L			-1		
	09000 CLINIC 09100 EMERGENCY	0	24, 953 43, 344		0	0	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	43, 344	513, 307	0		92.00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	14, 972	2 0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						112 00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	856, 633	484, 899	2, 582, 104	377, 880	4, 925, 502	113. 00 118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 517	7 0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 SOUTH CLINIC	0	113, 444	t 0	0		192. 00 192. 01
	19201 SOUTH CLINIC 19202 WEST CLINIC	0	0		0		192.01
192.03	19203 DI ABETES CENTER	0	1, 809		0	0	192.03
	19300 NONPALD WORKERS 19301 ADULT/CHILD CARE	0	C 25, 845		0		193. 00 193. 01
	19302 PHYSI CI AN OFFICE BUILDING	0	23, 843		0		193.02
	19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193.03
	07950 PARTNERSHIP HFC 07951 TRAFALGAR CLINIC	0	49 C		0		194. 00 194. 01
194.02	07952 EDI NBURGH	Ő	C	p o	Ö	0	194. 02
	07953 JAI L 07954 ATHLETI C TRAI NERS	0	0 13, 486		0		194. 03 194. 04
200.00	Cross Foot Adjustments		15,400		0		200. 00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0 856, 633	0 644, 049	0 0 2, 582, 104	0 377, 880	0 4, 925, 502	201.00
202.00	TOTAL (Sum TITES TTO THEOUGH 201)	000,000	044, 045	1 2, 302, 104	577,000	+, 720, 00Z	202.00

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B
				From 01/01/2017 To 12/31/2017	Part I Date/Time Prepared:
Cost Center Description	MEDI CAL	Subtotal	Intern &	Total	5/25/2018 3:43 pm
cost center bescription	RECORDS &		Residents Cos		
	LI BRARY		& Post		
			Stepdown Adjustments		
	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS			1		
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 PROCESSING					4.02
4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG					4.03 4.04
4. 05 00405 PATIENT ACCOUNTING					4.05
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 9.00 00900 HOUSEKEEPI NG					8.00 9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY					14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 283, 783				16.00
INPATIENT ROUTINE SERVICE COST CENTERS			1		
30. 00 03000 ADULTS & PEDIATRICS	81, 156	7, 616, 245	1	0 7, 616, 245	30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	8, 691 10, 919	2, 448, 940 1, 597, 466		0 2, 448, 940 0 1, 597, 466	31.00 41.00
43. 00 04300 NURSERY	3, 435	290, 588		0 290, 588	43.00
ANCI LLARY SERVI CE COST CENTERS			1		
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	185, 954	6, 085, 603		0 6, 085, 603 0 151, 767	50.00 53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	25, 663 233, 980	151, 767 5, 371, 046		0 151, 767 0 5, 371, 046	53.00
60. 00 06000 LABORATORY	178, 287	5, 777, 347		0 5, 777, 347	60.00
65. 00 06500 RESPI RATORY THERAPY	34, 398	1, 667, 481		0 1, 667, 481	65.00
66. 00 06600 PHYSI CAL THERAPY	22,815	1, 558, 814	1	0 1, 558, 814	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	12, 146 4, 105	423, 897 240, 479		0 423, 897 0 240, 479	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	25, 335	2, 407, 656		0 2, 407, 656	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	825	88, 873	1	0 88, 873	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	63, 502	3, 437, 234		0 3, 437, 234 0 977, 041	71.00 72.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	15, 715 74, 732	977, 041 5, 208, 866		0 977, 041 0 5, 208, 866	72.00
76.00 03020 ONCOLOGY	4, 723	602, 347		0 602, 347	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 673	306, 444		0 306, 444	76. 97
OUTPATIENT SERVICE COST CENTERS	64, 775	2, 680, 675		0 2, 680, 675	90.00
91. 00 09100 EMERGENCY	154, 651	4, 244, 181		0 4, 244, 181	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REI MBURSABLE COST CENTERS	0.025	1 10/ 700		0 1 104 700	101.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	8, 025	1, 186, 720	1	0 1, 186, 720	101.00
113.00 11300 INTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 217, 505	54, 369, 710		0 54, 369, 710	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	238, 350		0 238, 350	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	65, 782	19, 897, 816		0 19, 897, 816	190.00
192. 01 19201 SOUTH CLINIC	0	0)	0 0	192. 01
192.02 19202 WEST CLINIC	0	0		0 0	192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	496	151, 494		0 151, 494	192. 03 193. 00
193. 01 19300 NONPATD WORKERS 193. 01 19301 ADULT/CHI LD CARE	0	713, 477		0 713, 477	193.00
193. 02 19302 PHYSI CI AN OFFICE BUILDING	0	0		0 0	193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON	0	1, 102, 738		0 1, 102, 738	193.03
194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C	0	101, 369		0 101, 369	194. 00 194. 01
194. 01 07951 TRAFALGAR_CLINIC 194. 02 07952 EDI NBURGH	0	0		0 0	194.01
194. 03 07953 JAI L	0	61, 174		0 61, 174	194. 03
194. 04 07954 ATHLETIC TRAINERS	0	13, 486		0 13, 486	194.04
200.00 Cross Foot Adjustments		0		0 0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 1, 283, 783	0 76, 649, 614		0 0 0 76, 649, 614	201.00 202.00
					1

Health Financial Systems	JOHNSON MEMORI			In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2017	Worksheet B Part II	
	1			To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
		CAP	ITAL RELATED (COSTS		
Cost Center Description	Directly Assigned New Capital	NEW BLDG & FIXT	BLDG & FIXT - TOWER	- MVBLE EQUIP	Subtotal	
	Related Costs	1.00	1.01	2.00	24	
GENERAL SERVICE COST CENTERS	0	1.00	1.01	2.00	2A	
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FLXT - TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.01 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	21, 907		0 1, 420	23, 327	4.00
4. 01 00401 COMMUNI CATI ONS	0	2, 885		0 0	2, 885	1
4. 02 00402 DATA PROCESSI NG 4. 03 00403 MATERI ALS MANAGEMENT	0	45, 958 28, 089		0 1, 495, 107 0 7, 083	1, 541, 065 35, 172	1
4. 04 00404 ADMI TTI NG	0	16, 438	1	0 0	16, 438	1
4. 05 00405 PATI ENT ACCOUNTI NG	0	48, 822		0 12, 502	61, 324	1
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT	0	69, 936 183, 246		0 31, 379 0 48, 131	101, 315 231, 377	1
8.00 00800 LAUNDRY & LINEN SERVICE	0	17, 649		0 48, 131 0 5, 300	231, 377	
9. 00 00900 HOUSEKEEPI NG	0	13, 707		0 4, 769	18, 476	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA	0	28, 757		0 22, 196 0 0	50, 953	1
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	30, 622 72, 440		0 0 0 34,987	30, 622 107, 427	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	12, 473	1	0 35, 289	47, 762	1
15. 00 01500 PHARMACY	0	15, 021	1	0 5, 965	20, 986	1
16.00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	28, 478		0 8, 618	37, 096	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	202, 459	•	0 139, 331	341, 790	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	57, 896		0 38, 066	95, 962	1
41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0	49, 651 4, 589		0 20, 977 0 0	70, 628 4, 589	1
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	4, 309	1	0 0	4, 309	43.00
50. 00 05000 OPERATI NG ROOM	0	335, 959		0 476, 667	812, 626	50.00
53. 00 05300 ANESTHESI OLOGY	0	2, 893		0 15, 178		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	121, 371 59, 093		0 367, 316 0 151, 019	488, 687 210, 112	1
65. 00 06500 RESPI RATORY THERAPY	0	2, 746		0 16, 558	19, 304	1
66. 00 06600 PHYSI CAL THERAPY	0	46, 531		0 10, 800	57, 331	1
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	9, 801 609	1	0 2,552 0 400	12, 353 1, 009	1
69. 00 06900 ELECTROCARDI OLOGY	0	7, 929		0 36, 298	44, 227	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 336		0 1, 978	3, 314	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 15,004	15, 004	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0 0 0	0	
76. 00 03020 ONCOLOGY	0	51, 384		0 2, 313	53, 697	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	18, 435		0 11, 046	29, 481	76.97
OUTPATI ENT SERVICE COST CENTERS 90. 00 009000 CLINIC	0	84, 546		0 17, 664	102, 210	90.00
91. 00 09100 EMERGENCY	0	72, 931		0 33, 254		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0	9, 581		0 69	9,650	101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	7, 301		0 07	7,030	
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	1, 776, 168		0 3, 069, 236	4, 845, 404	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 522		0 4, 772	14, 294	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	190, 331		0 114, 563		1
192. 01 19201 SOUTH CLINIC	0	0		0 0		192.01
192. 02 19202 WEST CLINIC 192. 03 19203 DIABETES CENTER	0	0 2, 951		0 0 0 581		192. 02 192. 03
193. 00 19300 NONPAI D WORKERS	0	2, ,01		0 0		193.00
193. 01 19301 ADULT/CHI LD_CARE	0	35, 475		0 0		193. 01
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0	0		0 0 0 0		193. 02 193. 03
194. 00 07950 PARTNERSHI P HFC	0	16, 357		0 0		193.03
194. 01 07951 TRAFALGAR CLINIC	0	0		0 0	0	194.01
194. 02 07952 EDI NBURGH	0	0	1	0 0		194.02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C_TRAI NERS	0	0		0 0		194. 03 194. 04
200.00 Cross Foot Adjustments		0			0	200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	2, 030, 804	1	0 3, 189, 152	5, 219, 956	J202. 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: 	Worksheet B Part II	
			To		Date/Time Pre 5/25/2018 3:4	
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
1.0100101CAPRELCOSTS-BLDG& FIXT- TOWER2.0000200CAPRELCOSTS-MVBLEEQUIP						1. 01 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS 4. 02 00402 DATA PROCESSI NG	23, 327 79 425	2, 964 295	1, 541, 785			4.00 4.01 4.02
4. 03 00403 MATERIALS MANAGEMENT	183	63	40, 505	75, 923		4.03
4. 04 00404 ADMI TTI NG 4. 05 00405 PATI ENT ACCOUNTI NG	425 656	74 192	38, 275	272	55, 484 0	4.04
5. 00 00500 ADMI NI STRATI VE & GENERAL	836	192	170, 195 180, 601	560 1, 579	0	4.05 5.00
7.00 00700 OPERATION OF PLANT	377	107	13, 378	77	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	60	11	8, 918 0	335	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	426 197	31 57	47, 937	1, 932 5, 244	0	9.00 10.00
11. 00 01100 CAFETERI A	292	0	0	0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	930	100	24, 897	1, 023	0	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	48 284	0 50	0 9, 662	1, 183 0	0	14.00 15.00
16.00 01600 MEDI CAL_RECORDS & LI BRARY	372	81	65, 402	50	0	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.470	000	444 440	4 5 (0	0.504	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	2, 478 713	229 61	111, 110 37, 532	4, 562 1, 328	3, 501 375	30.00 31.00
41. 00 04100 SUBPROVIDER - IRF	435	39	7,060	349	471	41.00
43. 00 04300 NURSERY	90	0	0	0	148	43.00
ANCI LLARY SERVI CE COST CENTERS	1,066	192	151, 243	3, 103	8, 023	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	56	1, 107	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 228	114	62, 429	4, 088	10, 193	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	975 556	149 39	69, 490 51, 653	25, 100	7, 692 1, 484	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	475	55	25, 269	2, 114 420	984	66.00
67.00 06700 OCCUPATI ONAL THERAPY	149	13	6, 689	0	524	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	84 287	13 94	6, 317	0	177	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	287	94	80, 638 2, 973	1, 365 25	1, 093 36	69.00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2, 861	2, 740	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	678	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 ONCOLOGY	144	81	0 19, 695	228	3, 224 204	73.00 76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	74	0	0	158	158	
OUTPATIENT SERVICE COST CENTERS	440	47	17 4/5	2 (10	0 705	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	448 1, 130	46 129	17, 465 62, 801	2, 618 1, 929	2, 795 6, 672	90.00 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	.,		02,001	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0,012	92.00
101.00 10100 HOME HEALTH AGENCY	403	50	28, 985	295	346	101.00
SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	16, 354	2, 537	1, 341, 119	62, 854	52, 625	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	54	33	18, 209	307		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLINIC	6, 636 0	359 0	155, 330 0	11, 180 0		192. 00 192. 01
192. 02 19202 WEST CLINIC	0	0	0	0		192.02
192. 03 19203 DI ABETES CENTER	51	7	6, 317	1		192.03
193. 00 19300 NONPAI D WORKERS 193. 01 19301 ADULT/CHI LD CARE	0 197	0 11	0 14, 493	0 1, 309		193. 00 193. 01
193. 02 19302 PHYSI CI AN OFFICE BUILDING	0	0	14, 493	1, 309		193.02
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0	259	0	193. 03
194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C	6	17	6, 317	13		194. 00 194. 01
194. 02 07952 EDI NBURGH	0	0	0	0		194. 01 194. 02
194. 03 07953 JAI L	29	0	Ö	Ō	0	194. 03
194. 04 07954 ATHLETI C TRAI NERS	0	0	0	0	0	194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0	0	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	23, 327	2, 964	1, 541, 785	75, 923	55, 484	

Health Financial Systems	JOHNSON MEMORI				u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2017	Worksheet B Part II	
					Date/Time Pre 5/25/2018 3:4	pared: 3 pm
Cost Center Description	PATI ENT ACCOUNTI NG	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	4.05	5.00	7.00	8.00	9.00	
1.00 OC100 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 EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNICATIONS						4.00 4.01
4. 02 00402 DATA PROCESSI NG						4. 02
4. 03 00403 MATERIALS MANAGEMENT						4.03
4. 04 00404 ADMITTING 4. 05 00405 PATIENT ACCOUNTING	232, 927					4.04 4.05
5. 00 00500 ADMINI STRATI VE & GENERAL	0	284, 499				5.00
7.00 00700 OPERATION OF PLANT	0	11, 531				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	952 3, 928			33, 806	8.00 9.00
10. 00 01000 DI ETARY	0	2, 875			614	10.00
11. 00 01100 CAFETERIA	0	2, 090			654	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	8, 798 1, 130		0	1, 548 267	13.00 14.00
15. 00 01500 PHARMACY	0			0	321	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	4, 391	4, 533	0	608	16.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 O3000 ADULTS & PEDI ATRI CS	14, 722	19, 626	32, 228	8, 943	4, 326	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 577	6, 757			1, 237	30.00
41. 00 04100 SUBPROVI DER – I RF	1, 981	4, 057	7, 904	1, 551	1, 061	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	623	861	730	0	98	43.00
50. 00 05000 OPERATI NG ROOM	33, 734	16, 271	53, 479	6, 409	7, 180	50.00
53. 00 05300 ANESTHESI OLOGY	4, 655	440	460	0	62	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	42, 483	17,605			2, 593	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	32, 343 6, 240			0	1, 263 59	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 139				994	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 203				209	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	745 4, 596			0 277	13 169	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	150	309			29	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	11, 520			0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	2, 851 13, 557	3, 568 774		0	0	72.00 73.00
76. 00 03020 0NCOLOGY	857	1, 692			1, 098	1
76. 97 07697 CARDI AC REHABI LI TATI ON	666	931	2, 935	0	394	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	11, 751	8, 779	13, 458	211	1, 806	90.00
91.00 09100 EMERGENCY	28, 055					91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	1, 456	4, 225	1, 525	0	205	101.00
SPECIAL PURPOSE COST CENTERS		.,	.,	-1		
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117	220, 904	205 120	214 212	35, 509	20 244	113.00
NONREI MBURSABLE COST CENTERS	220, 904	205, 139	216, 312	35, 509	20, 300	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	774				190. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 01 19201 SOUTH CLINIC	11, 933	71, 322 0				192. 00 192. 01
192. 02 19202 WEST CLINIC	0	0		-		192.01
192. 03 19203 DI ABETES CENTER	90			0	63	192. 03
193. 00 19300 NONPALD WORKERS 193. 01 19301 ADULT/CHI LD CARE	0	0	-	0		193. 00 193. 01
193. 02 19301 ADULT/CHTLD CARE 193. 02 19302 PHYSICIAN OFFICE BUILDING	0	2, 204 0	5, 847	0		193.01
193. 03 19303 OPTI FAST/FOUNDATI ON	0	4, 093		0		193. 03
194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C	0	215		0		194. 00 194. 01
194. 02 07952 EDI NBURGH	0	0		0		194.01
194. 03 07953 JAI L	0	227		0	0	194. 03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	0	0	0	0	194. 04 200. 00
201.00 Negative Cost Centers	0	0	0	О	0	200.00
202.00 TOTAL (sum lines 118 through 201)	232, 927	284, 499	256, 847	36, 034		202.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lieu	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: com 01/01/2017 o 12/31/2017	Worksheet B Part II Date/Time Pre 5/25/2018 3:4	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 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 MATERIALS MANAGEMENT 4.04 00404 ADMI TTI NG 4.05 00405 PATI ENT ACCOUNTI NG 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON	113, 198 0 0	38, 533 1, 190				$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 2. \ 00\\ 4. \ 00\\ 4. \ 01\\ 4. \ 02\\ 4. \ 03\\ 4. \ 04\\ 4. \ 05\\ 5. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ \end{array}$
14.00 01400 CENTRAL SERVICES & SUPPLY	0	187		54, 829		14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	676 1, 510		0	52, 461 0	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	1, 510	, <u> </u>	0	0	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	77, 367	4, 889		0	0	
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	15, 041 20, 790	1, 561 892		0	0	
41.00 04100 SUBPROVIDER - TRF 43.00 04300 NURSERY	20, 790	892 199		0	0	
ANCI LLARY SERVI CE COST CENTERS	<u> </u>		2,110			
50.00 05000 OPERATING ROOM	0	2, 668		0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	2, 905 3, 229		0	0	54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	0	1, 252		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 171		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	300		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	168 624		0	0	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	77		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		54, 829	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	-	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 ONCOLOGY	0	351		0	52, 461 0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	180		0	0	
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	1, 493		0	0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 593	31, 433	0	0	91.00 92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u> </u>			/2.00
101.00 10100 HOME HEALTH AGENCY	0	896	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS			1			112 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	113, 198	29, 011	157, 444	54, 829	52 461	113.00 118.00
NONREI MBURSABLE COST CENTERS	110, 170	27,011	107,111	01,027	02,101	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	270		0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	6, 788	0	0		192.00
192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC	0	0		0		192. 01 192. 02
192. 03 19203 DI ABETES CENTER	0	108	0	0		192.02
193. 00 19300 NONPAI D WORKERS	0	C	0	0		193.00
193. 01 19301 ADULT/CHI LD CARE	0	1, 546	0	0		193.01
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0	0		0		193. 02 193. 03
194. 00 07950 PARTNERSHI P HFC	0	3	0	0		194.00
194. 01 07951 TRAFALGAR CLI NI C	0	C	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	0 807	0	0		194. 03 194. 04
200.00 Cross Foot Adjustments	0	607	0	0	0	200.00
201.00 Negative Cost Centers	0	C	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	113, 198	38, 533	157, 444	54, 829	52, 461	202.00

Cost Center Description MEDICAL RECORDS & LIBRARY Sub 100 00100 NEW CAP REL COSTS-BLDG & FIXT 16.00 24 101 00100 NEW CAP REL COSTS-BLDG & FIXT 101 00101 CAP REL COSTS-BLDG & FIXT 101 101 00101 CAP REL COSTS-BLDG & FIXT 101 00101 CAP REL COSTS-MUBLE EQUIP 4 4.00 00402 DATA PROCESSI NG 4 4 4 00403 MATERIALS MANAGEMENT 4 4.01 00401 COMUNI CATI ONS 4 4 4 00403 MATERIALS MANAGEMENT 4 4.02 00402 PATI ENT ACCOUNTI NG 5 5 0 5 0 5.00 00500 ADMI NI STRATI VE & GENERAL 7 0 6 9 9 9 0 9 9 14 4 <th>Provi der CCN: 15-0001 Peri od: From 01/01/2017 To 12/31/2017 Worksheet B Part II Date/Time Prepared: 5/25/2018 3: 43 pm ubtotal Intern & Resi dents Cost & Post Stepdown Adjustments Total Peri od: Part II Date/Time Prepared: 5/25/2018 3: 43 pm 24.00 25.00 26.00 1.00 1.00 1.01 0 24.00 25.00 26.00 1.00 0 0 2.00 2.00 1.00 0 0 2.00 0 1.00 1.00 0 1.01 0 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 <t< th=""></t<></th>	Provi der CCN: 15-0001 Peri od: From 01/01/2017 To 12/31/2017 Worksheet B Part II Date/Time Prepared: 5/25/2018 3: 43 pm ubtotal Intern & Resi dents Cost & Post Stepdown Adjustments Total Peri od: Part II Date/Time Prepared: 5/25/2018 3: 43 pm 24.00 25.00 26.00 1.00 1.00 1.01 0 24.00 25.00 26.00 1.00 0 0 2.00 2.00 1.00 0 0 2.00 0 1.00 1.00 0 1.01 0 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.01 0 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 <t< th=""></t<>
GENERAL SERVICE COST CENTERS 16.00 24 1.00 00100 NEW CAP REL COSTS-BLOG & FLXT	ubtotal Intern & Residents Cost & Post Stepdown Adjustments Total Intern & Stepdown 24.00 25.00 26.00 1.00 24.00 25.00 26.00 1.00 24.00 25.00 26.00 1.00 24.00 25.00 26.00 1.00 24.00 25.00 26.00 1.00 24.01 25.00 26.00 1.00 24.02 0 692.242 0.00 692.242 0 692.242 30.00 193.080 0 193.080 31.00 128.999 0 128.999 41.00 10.059 0 10.059 43.00
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-BLDG & FIXT 4.01 00401 COMUNICATIONS 4.02 00402 DATA PROCESSI NG 4.03 00404 ADMINICATIONS 4.04 00404 ADMINICATIONS 4.05 00403 PATIENT ACCOUNTING 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 7.00 00700 PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPI NG 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVICES SUPPLY 15.00 01500 PHARMACY 16.00 01400 CENTRAL SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 206 31.00 03100 INTERSI VE CARE UNIT 772	692, 242 0 692, 242 30.00 11.00 1.00 1.00 12.00 4.00 4.01 14.00 4.01 4.02 15.00 7.00 8.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 11.00 1.00 1.00 128, 999 0 1.00 1.00 11.00 1.00 1.00 1.00 11.00 1.00 1.00 1.00
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 EOUI P 4.00 4.01 00401 COMUNI CATI ONS 4.01 4.02 00402 DATA PROCESSI NG 4.02 4.03 00403 MATERI ALS MANAGEMENT 4.04 4.04 00404 DOMIN IN STRATI VE & GENERAL 7.00 7.00 00500 ADMI NI STRATI VE & GENERAL 7.00 7.00 00700 OPERATION OF PLANT 8.00 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 9.00 00900 HOUSEKEEPI NG 10.00 10.00 OLAFETEI A 13.00 01300 13.00 01300 NURSI NG ADMI NI STRATI ON 14.04 1NPATI ENT ROUTINE SERVI CE COST CENTERS 7.206 7.206 30.00 03000 ADULTS & PEDI ATRICS 7.206 31.00 03100 INTERSI VE CARE UNI T 772 11.00 04100 SUBPROVI DER - 1 RF 969 40.00 04000	692, 242 0 692, 242 0 692, 242 30.00 11, 01 2.00 4.00 4.01 4.02 11, 01 2.00 4.03 4.03 4.03 11, 01 2.00 4.03 4.03 4.03 11, 02 0 692, 242 5.00 7.00 11, 00 11.00 11.00 11.00 11.00 128, 999 0 128, 999 41.00 43.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENETIS DEPARTMENT 4.01 00400 EMPLOYEE BENETIS DEPARTMENT 4.02 00400 EMPLOYEE BENETIS DEPARTMENT 4.03 00403 MATERIALS MANAGEMENT 4.04 00404 ADMI TTI NG 5.00 00500 ADMI IN STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01100 CAFETERIA 13.00 01300 NURSI MG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 06100 MDULTS & PEDI ATRI CS 7.206 7.206 31.00 03000 ADULTS & PEDI ATRI CS 7.206 7.206 31.00 03000 ADULTS & PEDI ATRI CS 7.206 7.206 31.00 04100 SUBPROVI DER - I RF 969 43.00 043000 ANURSERY 305 ANCILLARY SERVI CE COST CENTERS 0.00 05400 RADI OLOGY -I AGNOSTI C	692, 242 0 692, 242 0 692, 242 30.00 11, 01 2.00 4.00 4.01 4.02 11, 01 2.00 4.03 4.03 4.03 11, 01 2.00 4.03 4.03 4.03 11, 02 0 692, 242 5.00 7.00 11, 00 11.00 11.00 11.00 11.00 128, 999 0 128, 999 41.00 43.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMUNICATIONS 4.02 00402 DATA PROCESSING 4.03 00403 MATERIALS MANAGEMENT 4.04 00404 ADMITTING 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 00500 ADMINISTRATIVE & GENERAL 7.00 00700 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 011000 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 (MEDI CAL RECORDS & LI BRARY 114,043 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 031000 INTENSI VE CARE UNIT 772 7206 31.00 031000 INTENSI VE CARE UNIT 772 3050 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16.511 1 173.00 05300 ANESTHESI OLOGY 2,279 3,054 60.00 066000 PERATING ROOM 65.00 </td <td>692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00 10, 059 0 10, 059 43. 00</td>	692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00 10, 059 0 10, 059 43. 00
4. 01 00401 COMMUNI CATIONS 4. 02 00402 DATA PROCESSI NG 4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG 5. 00 005000 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HUUSEKEEPI NG 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 OH400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600, MEDI CAL RECORDS & LI BRARY 114, 043 INPATI ENT ROUTI NE SERVI CE COST CENTERS 7, 206 31. 00 03100 I NTENSI VE CARE UNI T 772 41. 00 04100 SUBPROVI DER - I RF 969 93. 00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS 305 ANCI LLARY SERVI CE COST CENTERS 305 50. 00 05000 OPERATI NG ROOM 16, 511 1 53. 00 05300 ANESTHESI OLOG	692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 128, 999 0 128, 999 41.00 10, 059 0 10, 059 43.00
4.02 00402 DATA PROCESSING 4.03 00403 MATERIALS MANAGEMENT 4.04 00404 ADMITTING 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 O11000 CAFETERIA 3.00 03000 AUNRSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 114,043 INPATIENT ROUTINE SERVICE COST CENTERS 7,206 30.00 03000 AUNESEY 305 ANCILLARY SERVICE COST CENTERS 305 60.00 <td>692, 242 0 692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 31.00 128, 999 0 128, 999 41.00 43.00</td>	692, 242 0 692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 31.00 128, 999 0 128, 999 41.00 43.00
4.03 00403 MATERIALS MANAGEMENT 4.04 00404 ADMITTING 4.05 00405 PATIENT ACCOUNTING 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 114,043 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 0.00 03000 ADULTS & PEDIATRICS 7,206 31.00 03100 INTENSIVE CARE UNIT 772 41.00 O4100 SUBPROVIDER - IRF 969 43.00 04300 NRSERY 305 ANCILLARY SERVICE COST CENTERS 305 ANCILLARY SERVICE COST CENTERS 30.00 0.5000 OPERATING ROOM 16,511 153.00 0	692, 242 0 692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 31.00 128, 999 0 128, 999 41.00 43.00
4. 04 00404 ADMI TTI NG 4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HUSEKEEPI 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 PHAMMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 114. 043 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 030001 ADUI TS & PEDI ATRI CS 31. 00 03100 I INTENSI VE CARE UNI T 772 41. 00 O4100 SUBPROVI DER - I RF 969 43. 00 04300 NURSERY 305 ADUI LLARY SERVI CE COST CENTERS 005300 ANESTHESI OLOGY 2,279 54. 00 05400 RADI OLOGY -DI AGNOSTI C 20,834 65. 00 05500 RESPI RATORY THERAPY	692, 242 0 692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00
5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LINEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 O1100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 O1400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 114,043 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 7,206 31.00 03100 INTENSI VE CARE UNI T 772 41.00 04100 SUBPROVI DER - I RF 969 43.00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS 305 ANCI LLARY SERVI CE COST CENTERS 50.00 05300 ANESTHESI 0LOGY 2,279 54.00 05400 RADI 0LOGY-DI AGNOSTI C 20,834 60.00 06600 PHYSI CAL THERAPY 1,078 68.00 06500 RESPI RATORY THERAPY 1,078 68.00	692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 128, 999 0 128, 999 41.00 10, 059 0 10, 059 43.00
7.00 00700 0PERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 11.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 O1400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 114,043 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03100 INTENSI VE CARE UNI T 772 41.00 04100 SUBPROVI DER - I RF 969 43.00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS 305 ANCI LLARY SERVI CE COST CENTERS 305 ANCI LLARY SERVI CE COST CENTERS 305 40.00 05400 RADI OLOGY - DI AGNOSTI C 20, 834 60.00 06000 LABORATORY 15, 830 65.00 06500 RESPI RATORY THERAPY 3, 054 66.00 06600 PHYSI CAL THERAPY 1, 078 68.00 <t< td=""><td>692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00</td></t<>	692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00
8.00 00800 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 003000 ADULTS & PEDI ATRI CS 7.206 31.00 03100 31.00 03100 INTENSI VE CARE UNI T 772 71.00 04100 41.00 SUBPROVI DER - 1 RF 969 43.00 04300 NURSERY 30.00 05000 OPERATI NG ROOM 16, 511 73.00 05000 OPERATI NG ROOM 16, 511 74.00 05400 RADI OLOGY -DI AGNOSTI C 20, 834 60.00 06000 LABORATORY 15, 830 65.00 06500 RESPI RATORY THERAPY 2, 026 67.00 06700 OCUPATI ONAL THERAPY 2, 026 67.00 06700 OCUPATI ONAL THERAPY 2, 249 71.0	692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 128, 999 0 128, 999 41.00 0 0.059 0 10.059
9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 114,043 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDI ATRICS 7,206 31.00 03100 INTENSI VE CARE UNI T 772 41.00 04100 SUBPROVI DER - I RF 969 43.00 04300 NURSERY 305 ANCILLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 16,511 1 53.00 05300 ANESTHESI OLOGY 2,279 54.00 06400 PHATORY 2,279 54.00 06500 RADI OLOGY-DI AGNOSTI C 20,834 0.00 0.00 06000 LIBRATORY 15,830 65.00 06500 RESPI RATORY 15,830 054 06400 06600 PHATORY	692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 128, 999 0 128, 999 41.00 10, 059 0 10, 059 41.00
10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 114,043 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 7,206 31.00 03100 INTENSI VE CARE UNI T 772 41.00 O4100 SUBPROVI DER - I RF 969 43.00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 16,511 1 53.00 05000 OPERATI NG ROOM 16,511 1 54.00 05400 RADI OLOGY -DI AGNOSTI C 20,834 60.00 66.00 06500 RESPI RATORY THERAPY 3,054 66.00 6600 65.00 06500 RESPI RATORY THERAPY 2,026 67.00 67.00 66700 0CUPATI ONAL THERAPY 3,054 66	692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00 10, 059 0 10, 059 43. 00
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 114,043 16.00 MEDI CAL RECORDS & LI BRARY 114,043 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 7,206 31.00 03100 INTENSI VE CARE UNI T 772 41.00 04100 SUBPROVI DER - 1 RF 969 43.00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 16, 511 1 53.00 05300 ANESTHESI OLOGY 2, 279 305 440.00 04000 RADI OLOGY-DI AGNOSTI C 20, 834 6 60.00 06600 RABORATORY 15, 830 65.00 06500 RESPI RATORY THERAPY 2, 026 67.00 06700 CCUPATI ONAL THERAPY 2, 026 73 64 69.00 06600 PHYSI CAL THERAPY 3, 054 66.00 06600 SPEECH PATHOLOGY 364 64	692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00 10, 059 0 10, 059 43. 00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 114,043 16.00 01600 MEDICAL RECORDS & LIBRARY 114,043 INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7,206 31.00 03100 INTENSIVE CARE UNIT 772 41.00 04100 SUBPROVIDER - IRF 969 43.00 04300 NURSERY 305 ANCILLARY SERVICE COST CENTERS 305 ANCILLARY SERVICE COST CENTERS 50.00 05000 05300 ANESTHESI OLOGY 2,279 54.00 05400 RADI OLOGY-DI AGNOSTIC 20,834 60.00 064000 RADI OLOGY-DI AGNOSTIC 20,834 65.00 06500 RESPI RATORY THERAPY 3,054 66.00 06600 PHYSICAL THERAPY 2,026 67.00 06700 OCCUPATI ONAL THERAPY 1,078 68.00 06800 SPEECH PATHOLOGY 364 69.00 04800 SPEECH PATHOLOGY 364 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI E	692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00 10, 059 0 10, 059 43. 00
15.00 01500 PHARMACY 16.00 01600 MEDI CAL_RECORDS & LI BRARY 114,043 INPATI ENT ROUTI NE SERVI CE COST CENTERS 7,206 31.00 03000 ADULTS & PEDI ATRI CS 7,206 31.00 03100 INTENSI VE CARE UNI T 772 41.00 04100 SUBPROVI DER - I RF 969 43.00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS 305 400 50.00 05300 OPERATI NG ROOM 16,511 1 53.00 05300 ANESTHESI OLOGY 2,279 54.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 20,834 60.00 0 06500 RESPI RATORY 15,830 65.00 06600 PHYSI CAL THERAPY 2,026 67.00 06700 OCUPATI ONAL THERAPY 1,078 68.40 66.00 06600 PHYSI CAL THERAPY 2,249 70.00 7000 ELECTROCARDI OLOGY 2,249 71.00 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5,	692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00 0 0, 059 0 10, 059 43. 00
16.00 01600 MEDI CAL RECORDS & LI BRARY 114,043 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 7,206 31.00 03100 INTENSI VE CARE UNI T 772 41.00 SUBPROVI DER - I RF 969 43.00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS 300 4000 50.00 05000 OPERATI NG ROOM 16,511 1 53.00 05300 ANESTHESI OLOGY 2,279 2,279 54.00 05400 RADI OLOGY-DI AGNOSTI C 20,834 6 0 06500 RESPI RATORY 15,830 65 0 06500 RESPI RATORY THERAPY 3,054 66 0 06600 PHYSI CAL THERAPY 1,078 68 0 06600 SPEECH PATHOLOGY 3,64 69 00 6600 6600 9000 ELECTROCARDI OLOGY 2,249 73 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS <td< td=""><td>692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 128, 999 0 128, 999 41.00 10, 059 0 10, 059 43.00</td></td<>	692, 242 0 692, 242 30.00 193, 080 0 193, 080 31.00 128, 999 0 128, 999 41.00 10, 059 0 10, 059 43.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 7, 206 31. 00 03100 I NTENSI VE CARE UNI T 772 41. 00 04100 SUBPROVI DER - I RF 969 43. 00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS 305 ANCI LLARY SERVI CE COST CENTERS 05300 ANESTHESI OLOGY 2, 279 54. 00 05400 RADI OLOGY-DI AGNOSTI C 20, 834 60. 00 06000 LABORATORY 15, 830 65. 00 065000 RESPI RATORY THERAPY 3, 054 66. 00 06600 PHYSI CAL THERAPY 3, 054 67. 00 06700 OCCUPATI ONAL THERAPY 1, 078 68. 00 06600 SPEECH PATHOLOGY 364 69. 00 06900 ELECTROCARDI OLOGY 2, 249 70. 00 07000 ELECTROEPHALOGRAPHY 73 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5, 638 72. 00 072001 IMPL. DEV. CHARGED TO PATI ENT 1, 395 73. 00 073000 DRUGS CHARGED TO PATI ENTS 6, 635 76. 00 03020 ONCOLOGY 419 </td <td>692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00 10, 059 0 10, 059 43. 00</td>	692, 242 0 692, 242 30. 00 193, 080 0 193, 080 31. 00 128, 999 0 128, 999 41. 00 10, 059 0 10, 059 43. 00
31.00 03100 INTENSIVE CARE UNIT 772 41.00 04100 SUBPROVI DER - IRF 969 43.00 04300 NURSERY 305 ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16, 511 1 53.00 05400 RADI OLOGY 2, 279 2 54.00 05400 RADI OLOGY 20, 834 4 60.00 06000 LABORATORY 15, 830 6 65.00 06500 RESPI RATORY THERAPY 2, 026 3, 054 66.00 06600 PHYSI CAL THERAPY 2, 026 364 67.00 06700 OCCUPATI ONAL THERAPY 1, 078 68.00 06800 SPEECH PATHOLOGY 364 69.00 069000 ELECTROCARDI OLOGY 2, 249 70.00 07000 ELECTROCARDI OLOGY 2, 249 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5, 638 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1, 395 73.00 07300 DRUGS CHARGED TO PATI ENTS	193,080 0 193,080 31.00 128,999 0 128,999 41.00 10,059 0 10,059 43.00
41.00 04100 SUBPROVI DER - I RF 969 43.00 04300 NURSERY 305 ANCI LLARY SERVI CE COST CENTERS	128, 999 0 128, 999 41. 00 10, 059 0 10, 059 43. 00
43.00 04300 NURSERY 305 ANCI LLARY SERVICE COST CENTERS	10, 059 0 10, 059 43. 00
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 16, 511 1 53.00 05300 ANESTHESI OLOGY 2, 279 54.00 05400 RADI OLOGY-DI AGNOSTI C 20, 834 60.00 06500 LABORATORY 15, 830 65.00 06500 RESPI RATORY THERAPY 3, 054 66.00 06600 PHYSI CAL THERAPY 2, 026 67.00 06700 OCCUPATI ONAL THERAPY 2, 249 68.00 068000 SPEECH PATHOLOGY 364 69.00 06900 ELECTROCARDI OLOGY 2, 249 70.00 07000 ELECTROCARDI OLOGY 2, 249 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5, 638 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 5, 638 73.00 07300 DRUGS CHARGED TO PATI ENTS 6, 635 76.00 03020 ONCOLOGY 419 76.97 CARDI AC REHABI LI TATI ON 326 OUTPATI ENT SERVI CE COST CENTERS 0000	
50.00 05000 OPERATING ROOM 16, 511 1 53.00 05300 ANESTHESI OLOGY 2, 279 54.00 05400 RADI OLOGY-DI AGNOSTI C 20, 834 60.00 06000 LABORATORY 15, 830 65.00 06500 RESPI RATORY THERAPY 3, 054 66.00 06600 PHYSI CAL THERAPY 2, 026 67.00 06700 OCCUPATI ONAL THERAPY 364 69.00 06800 SPEECH PATHOLOGY 364 69.00 06900 ELECTROCARDI OLOGY 2, 249 70.00 07000 ELECTROENCEPHALOGRAPHY 73 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5, 638 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 1, 395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6, 635 76.00 03020 ONCOLOGY 419 76.97 CARDI AC REHABI LI TATI ON 326 OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLI NI C 5, 751	1 144 941 0 1 144 941 50 00
54.00 05400 RADI OLOGY-DI AGNOSTI C 20, 834 60.00 06000 LABORATORY 15, 830 65.00 06500 RESPI RATORY THERAPY 3, 054 66.00 06600 PHYSI CAL THERAPY 2, 026 67.00 06700 OCCUPATI ONAL THERAPY 2, 026 67.00 06700 OCCUPATI ONAL THERAPY 3, 054 68.00 06800 SPEECH PATHOLOGY 364 69.00 06900 ELECTROCARDI OLOGY 2, 249 70.00 07000 ELECTROENCEPHALOGRAPHY 73 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5, 638 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 1, 395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6, 635 76.00 03020 ONCOLOGY 419 76.97 CARDI AC REHABI LI TATI ON 326 OUTPATI ENT SERVICE COST CENTERS 00000 5, 751	
60.00 06000 LABORATORY 15,830 65.00 06500 RESPI RATORY THERAPY 3,054 66.00 06600 PHYSI CAL THERAPY 2,026 67.00 06700 OCCUPATI ONAL THERAPY 2,026 68.00 06600 SPEECH PATHOLOGY 364 69.00 06900 ELECTROCARDI OLOGY 2,249 70.00 07000 ELECTROCARDI OLOGY 2,249 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5,638 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6,635 6,635 76.00 03020 ONCOLOGY 419 76.97 76.97 CARDI AC REHABI LI TATI ON 326 0 0UTPATI ENT SERVICE COST CENTERS 5,751 5	27, 130 0 27, 130 53. 00
65.00 06500 RESPI RATORY THERAPY 3,054 66.00 06600 PHYSI CAL THERAPY 2,026 67.00 06700 OCCUPATI ONAL THERAPY 1,078 68.00 06800 SPEECH PATHOLOGY 364 69.00 06900 ELECTROCARDI OLOGY 2,249 70.00 07000 ELECTROENCEPHALOGRAPHY 73 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5,638 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6,635 76.00 03020 ONCOLOGY 419 76.97 CARDI AC REHABI LI TATI ON 326 OUTPATI ENT SERVI CE COST CENTERS 5,751	675, 429 0 675, 429 54. 00
66.00 06600 PHYSI CAL THERAPY 2,026 67.00 06700 OCCUPATI ONAL THERAPY 1,078 68.00 06800 SPEECH PATHOLOGY 364 69.00 06900 ELECTROCARDI OLOGY 2,249 70.00 07000 ELECTROENCEPHALOGRAPHY 73 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5,638 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6,635 76.00 03020 ONCOLOGY 419 76.97 CARDI AC REHABI LI TATI ON 326 OUTPATI ENT SERVI CE COST CENTERS 5,751	395, 590 0 395, 590 60. 00 92, 148 0 92, 148 65. 00
67.00 06700 OCCUPATI ONAL THERAPY 1,078 68.00 06800 SPEECH PATHOLOGY 364 69.00 06900 ELECTROCARDI OLOGY 2,249 70.00 07000 ELECTROENCEPHALOGRAPHY 73 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5,638 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6,635 76.00 03020 ONCOLOGY 419 76.97 CARDI AC REHABI LI TATI ON 326 OUTPATI ENT SERVI CE COST CENTERS 5,751	105, 644 0 105, 644 66. 00
69.00 06900 ELECTROCARDI OLOGY 2,249 70.00 07000 ELECTROENCEPHALOGRAPHY 73 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5,638 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 1,395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6,635 76.00 03020 ONCOLOGY 419 76.97 CARDI AC REHABI LI TATI ON 326 OUTPATI ENT SERVICE COST CENTERS 5,751	26, 491 0 26, 491 67. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 73 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5, 638 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 1, 395 73.00 07300 DRUGS CHARGED TO PATIENT 6, 635 76.00 03020 ONCOLOGY 419 76.97 CARDIAC REHABILITATION 326 OUTPATIENT SERVICE COST CENTERS 5, 751	9, 848 0 9, 848 68. 00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5,638 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 1,395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6,635 76.00 03020 ONCOLOGY 419 76.97 CARDI AC REHABI LI TATI ON 326 0UTPATI ENT SERVICE COST CENTERS 90.00 09000	145, 598 0 145, 598 69. 00 7, 232 0 7, 232 70. 00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 1,395 73.00 07300 DRUGS CHARGED TO PATI ENTS 6,635 76.00 03020 ONCOLOGY 419 76.97 O7697 CARDI AC REHABI LI TATI ON 326 90.00 09000 CLI NI C 5,751	7, 232 0 7, 232 70. 00 103, 711 0 103, 711 71. 00
73.00 07300 DRUGS CHARGED TO PATI ENTS 6,635 76.00 03020 ONCOLOGY 419 76.97 07697 CARDI AC REHABI LI TATI ON 326 0UTPATI ENT SERVICE COST CENTERS 5,751	8, 492 0 8, 492 72. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON 326 OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLI NI C 5, 751	76, 651 0 76, 651 73. 00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 5,751	86, 645 0 86, 645 76. 00
90. 00 09000 CLINIC 5, 751	35, 303 0 35, 303 76. 97
	168, 831 0 168, 831 90. 00
91. 00 09100 EMERGENCY 13, 731	285, 407 0 285, 407 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 92.00
OTHER REIMBURSABLE COST CENTERS	
101. 00 10100 HOME HEALTH AGENCY 713 SPECI AL PURPOSE COST CENTERS	<u>48, 749</u> 0 <u>48, 749</u> 101. 00
113. 00 11300 I NTEREST EXPENSE	113. 00
	4, 468, 120 0 4, 468, 120 118. 00
NONREI MBURSABLE COST CENTERS	
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 5, 841	35, 660 0 35, 660 190. 00 612, 011 0 612, 011 102, 00
192.00 PHYSI CLANS' PRI VATE OFFICES 5, 841 192.01 SOUTH CLINIC 0	612, 011 0 612, 011 192. 00 0 0 0 192. 01
192. 02 19202 WEST CLINIC 0	0 0 0 192.02
192. 03 19203 DI ABETES CENTER 44	11, 229 0 11, 229 192. 03
193. 00 19300 NONPALD WORKERS 0	0 0 193.00
193. 01 19301 ADULT/CHI LD CARE 0 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 0	61, 640 0 61, 640 193. 01 0 0 0 193. 02
193. 02 19302 PHYSICIAN OFFICE BUILDING 0	
194. 00 07950 PARTNERSHIP HFC 0	
194. 01 07951 TRAFALGAR CLINIC 0	
194. 02 07952 EDI NBURGH 0	4, 352 0 4, 352 193. 03
194. 03 07953 JAIL 0	4, 352 0 4, 352 193.03 25, 881 0 25, 881 194.00 0 0 0 194.01 0 0 0 194.02 0 0 0 194.02
194.04 07954 ATHLETIC TRAINERS 0 200.00 Cross Foot Adjustments 0	4, 352 0 4, 352 193.03 25, 881 0 25, 881 194.00 0 0 0 194.01 0 0 0 194.02 256 0 256 194.03
201.00 Negative Cost Centers 0	4, 352 0 4, 352 193.03 25, 881 0 25, 881 194.00 0 0 0 194.01 0 0 0 194.02 256 0 256 194.02 807 0 807 194.03
202.00 TOTAL (sum lines 118 through 201) 114,043 5	4, 352 0 4, 352 193.03 25, 881 0 25, 881 194.00 0 0 0 194.01 0 0 0 194.02 256 0 256 194.03

	Financial Systems LLOCATION - STATISTICAL BASIS	JOHNSON MEMOR			eriod:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/25/2018 3:4	
		CAP	ITAL RELATED CO	OSTS			
	Cost Center Description	NEW BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)		COMMUNI CATI ONS (# NON PT PHONES)	
		1.00	1.01	2.00	4.00	4.01	
1.00 1.01 2.00 4.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	276, 616 0 2, 984	76, 991	2, 575, 452			1.00 1.01 2.00 4.00
4.01 4.02 4.03 4.04 4.05	00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG 00403 MATERI ALS MANAGEMENT 00404 ADMI TTI NG 00405 PATI ENT ACCOUNTI NG	393 6, 260 3, 826 2, 239 6, 650	0 0 0 0 1,639	0 1, 207, 398 5, 720 0	131, 632 711, 477 306, 775 710, 659	1, 357 135 29 34 88	4.03 4.04
5.00 7.00 8.00 9.00 10.00	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	9, 526 24, 960 2, 404 1, 867 3, 917	0 C 0 11, 123 0 C 834	25, 341 38, 869 4, 280 3, 851	1, 397, 432 629, 953 99, 953 711, 551	77 49 5 14 26	5.00 7.00 8.00 9.00
11.00 13.00 14.00 15.00 16.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	4, 171 9, 867 1, 699 2, 046 3, 879		28, 254 28, 498 4, 817	79, 668 475, 658		13.00 14.00
30. 00 31. 00 41. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04300 NURSERY	27, 577 7, 886 6, 763 625	7, 886 6, 763	30, 741 16, 940	1, 193, 087 727, 898	105 28 18 0	31.00 41.00
50.00 53.00 54.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 053001 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 0000 LADORATORY	45, 761 394 16, 532	0 2 10, 735	12, 257 296, 632	0 2, 054, 053	88 0 52	53.00 54.00
60. 00 65. 00 66. 00 67. 00 68. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	8, 049 374 6, 338 1, 335 83	1, 071 0 0	13, 372 8, 722 2, 061	929, 956 794, 578 249, 623	68 18 25 6 6	65.00
69.00 70.00 71.00 72.00 73.00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	1, 080 1, 080 182 0 0 0 6, 999) 88 2 182 0 0 0 0 0 0	29, 313 1, 597 12, 117 0 0	479, 947 49, 165 0 0 0	43 2 0 0 0	69.00 70.00 71.00 72.00 73.00
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	2, 511	<u>с</u>	8, 920	123, 432	0	1
	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 516 9, 934				21 59	90.00 91.00 92.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	1, 305	c	56	674, 425	23	101.00
113. 00 118. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	241, 932	2 75, 292	2, 478, 612	27, 350, 583	1, 162	113. 00 118. 00
192. 00 192. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 SOUTH CLINIC 19202 WEST CLINIC	1, 297 25, 925 0 0		92, 517		164 0	190. 00 192. 00 192. 01 192. 02
192. 03 193. 00 193. 01	19203 DI ABETES CENTER 19300 NONPAI D WORKERS 19301 ADULT/CHI LD CARE	402 0 4, 832	2 402 0 0 2 0		84, 824 0 329, 558	3 0 5	192. 03 193. 00 193. 01
193. 03 194. 00 194. 01	19302 PHYSI CI AN OFFI CE BUILDI NG 19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI P HFC 07951 TRAFALGAR CLI NI C 07952 EDI NRUBCH	0 0 2, 228 0			0 9, 452 0	0 8 0	193. 02 193. 03 194. 00 194. 01 194. 02
194.03	3	0			48, 095 0	0	194. 02 194. 03 194. 04 200. 00 201. 00
201.00		2, 030, 804	C	3, 189, 152	8, 188, 429	389, 311	•

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
	CAP	ITAL RELATED CO	OSTS			
Cost Center Description	NEW BLDG & FLXT	BLDG & FIXT - TOWER	MVBLE EQUIP		COMMUNI CATI ONS	
	(TOTAL FEET)	(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMENT (GROSS	(# NON PT PHONES)	
	1.00	1.01	2.00	SALARIES) 4.00	4. 01	
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 341600					203.00
204.00 Cost to be allocated (per Wkst. B,				23, 327	2, 964	204.00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part II)				0. 000598	2. 184230	205. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial S COST ALLOCATION -		JOHNSON MEMORI	AL HOSPITAL Provider CC	N: 15 0001 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
COST ALLOCATION -	STATISTICAL DASIS		Provider co	F	rom 01/01/2017 o 12/31/2017	Date/Time Pre	pared:
Cost	Center Description	DATA PROCESSI NG (WORK ORDERS)	MATERI ALS MANAGEMENT (SUPPLY USAGE)	ADMI TTI NG (GROSS REVENUE)	PATI ENT ACCOUNTI NG (GROSS REVENUE)	5/25/2018 3:4: Reconciliation	
		4.02	4.03	4.04	4. 05	5A	
	VICE COST CENTERS				1		
1.01 00101 CAP RI 2.00 00200 CAP RI 4.00 00400 EMPLO' 4.01 00401 COMUI 4.02 00402 DATA I 4.03 00403 MATERI 4.04 00404 ADMI T 4.05 00405 PATI EI 5.00 00500 ADMI N 7.00 00700 OPERA' 8.00 00800 LAUNDI 9.00 00900 HOUSEI 10.00 01000 DI ETAI 11.00 01100 CAFETI 13.00 01300 NURSI I 14.00 01400 CENTR/ 15.00 01500 PHARM	PROCESSING I ALS MANAGEMENT TING NT ACCOUNTING I STRATIVE & GENERAL TION OF PLANT RY & LINEN SERVICE KEEPING RY ERIA NG ADMINISTRATION AL SERVICES & SUPPLY ACY	4, 149 109 103 458 486 36 24 0 129 0 67 0 26	3, 600, 300 12, 918 26, 541 74, 892 3, 643 15, 893 91, 615 248, 651 0 48, 492 56, 114 0	213, 844, 005 C C C C C C C C C C C C C C C C C C	213, 844, 005 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-3, 744, 788 0 0 0 0 0 0 0 0 0 0	8.00 9.00 10.00 11.00 13.00 14.00 15.00
	AL RECORDS & LIBRARY	176	2, 356	С	0	0	16.00
30.00 03000 ADULTS 31.00 03100 I NTENS 41.00 04100 SUBPRO 43.00 04300 NURSE		299 101 19 0	216, 329 62, 968 16, 538 0	13, 519, 178 1, 447, 795 1, 818, 844 572, 213	1, 447, 795 1, 818, 844	0 0	31. 00 41. 00
ANCI LLARY S 50. 00 05000 0PERA	ERVICE COST CENTERS	407	147, 127	30, 976, 810	30, 976, 810	0	50.00
60.00 06000 LABOR/ 65.00 06500 RESPI 1 66.00 06600 PHYSI 0 67.00 06700 OCCUP/ 68.00 06800 SPEECI 69.00 06900 ELECTI 70.00 07000 ELECTI	LOGY-DI AGNOSTI C ATORY RATORY THERAPY CAL THERAPY ATI ONAL THERAPY 4 PATHOLOGY ROCARDI OLOGY ROENCEPHALOGRAPHY	0 168 187 139 68 18 17 217 8	2, 634 193, 866 1, 190, 271 100, 258 19, 928 0 18 64, 736 1, 198	4, 275, 008 38, 964, 355 29, 699, 667 5, 730, 152 3, 800, 658 2, 023, 294 683, 762 4, 220, 376 137, 496	38, 964, 355 29, 699, 667 5, 730, 152 3, 800, 658 2, 023, 294 683, 762 4, 220, 376 137, 496	0 0 0 0 0 0 0 0	54.00 60.00 65.00 66.00 67.00 68.00 69.00 70.00
	AL SUPPLIES CHARGED TO PATIENTS DEV. CHARGED TO PATIENT	0	135, 686 0	10, 578, 304 2, 617, 894		0	
	CHARGED TO PATIENTS	0	0	12, 449, 137		0	73.00
76.00 03020 ONCOL		53	10, 815	786, 780		-	76.00
	AC REHABILITATION	0	7, 508	611, 835			76.97
	SERVICE COST CENTERS						
		47 169	124, 153 91, 493	10, 790, 441 25, 762, 302		0	
101.00 10100 HOME H	HEALTH AGENCY	78	13, 972	1, 336, 914	1, 336, 914	0	101.00
	POSE COST CENTERS				1		110 05
	TALS (SUM OF LINES 1 through 117) ABLE COST CENTERS	3, 609	2, 980, 613	202, 803, 215	202, 803, 215		113.00 118.00
192.00 19200 PHYSI (192.01 19201 SOUTH		49 418 0	14, 559 530, 150 0	C 10, 958, 216 C		0	190. 00 192. 00 192. 01
192. 02 19202 WEST (192. 03 19203 DI ABE 193. 00 19300 NONPA	TES CENTER	0 17 0	0 39 0	C 82, 574 C	0 82, 574 0	0	192. 02 192. 03 193. 00
193. 01 19301 ADULT,		39	62, 068	C	0	0	193.01
193. 02 19302 PHYSI (193. 03 19303 OPTI F 194. 00 07950 PARTNI		0 0 17	0 12, 264 607	C C C	0 0 0	0	193. 02 193. 03 194. 00
194.0107951 TRAFAI		0	0	C	0		194.01
194. 02 07952 EDI NBI 194. 03 07953 JAI L 194. 04 07954 ATHLE ⁻ 200. 00 Cross		0 0 0	0 0 0	C C	0 0 0	0	194. 02 194. 03 194. 04 200. 00
201.00 Negati	ve Cost Centers to be allocated (per Wkst. B,	3, 199, 995	549, 917	981, 819	2, 426, 921		201. 00 202. 00
203.00 Unit (cost multiplier (Wkst. B, Part I) to be allocated (per Wkst. B,	771. 268980 1, 541, 785	0. 152742 75, 923	0. 004591 55, 484			203. 00 204. 00

Health Fir	ancial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CC	CN: 15-0001	Period: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/25/2018 3:4	epared: 13 pm
	Cost Center Description	DATA	MATERI ALS	ADMI TTI NG	PATI ENT	Reconciliation	1
		PROCESSI NG	MANAGEMENT	(GROSS	ACCOUNT I NG		
		(WORK	(SUPPLY	REVENUE)	(GROSS		
		ORDERS)	USAGE)		REVENUE)		
		4.02	4.03	4.04	4.05	5A	
205.00	Unit cost multiplier (Wkst. B, Part	371. 604001	0. 021088	0.0002	0. 001089		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

JUSI A	LLOCATION - STATISTICAL BASIS		AL HOSPITAL Provider C		eri od:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre	
	Cost Center Description	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (TOTAL FEET)	5/25/2018 3: 4 DI ETARY (MEALS SERVED)	<u>3 pm</u>
		5.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.0
1. 01 2. 00 4. 01 4. 02 4. 03 4. 03 4. 05 5. 00 7. 00 3. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00	00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATIONS 00402 DATA PROCESSING 00402 DATA PROCESSING 00404 ADMITTING 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 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	72, 904, 826 2, 955, 159 244, 073 1, 006, 660 736, 707 535, 517 2, 254, 724 289, 713 4, 636, 320 1, 125, 380	219, 778 2, 404 1, 867 3, 917 4, 171 9, 867 1, 699 2, 046 3, 879	391, 523 74, 218 8, 074 0 0 0 0 0 0 0	215, 507 3, 917 4, 171 9, 867 1, 699 2, 046	7, 955 0 0 0 0 0	1.0 2.0 4.0 4.0 4.0 4.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0 15.0
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	5, 029, 755	27, 577	97, 150	27, 577	5, 437	30.0
30.00	03100 I NTENSI VE CARE UNI T	1, 731, 597	7, 886			1,057	
41.00	04100 SUBPROVIDER - IRF	1, 039, 699	6, 763			1, 461	41.00
13.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	220, 722	625	0	625	0	43.00
50.00	05000 OPERATI NG ROOM	4, 169, 922	45, 761		45, 761	0	50.0
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	112, 663	394		- · ·	0 0	
54.00 50.00	06000 LABORATORY	4, 511, 816 5, 125, 469	16, 532 8, 049			0	54.0 60.0
55.00	06500 RESPI RATORY THERAPY	1, 526, 482	374		374	0	65.0
56.00 57.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 323, 640 362, 201	6, 338 1, 335			0	66.0 67.0
58.00	06800 SPEECH PATHOLOGY	220, 620	83		83	0	68.0
59.00	06900 ELECTROCARDI OLOGY	2, 233, 933	1, 080			0	69.0
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	79, 154	182 0			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 849, 488 914, 360	0		_	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	198, 439	0	-	-	0	
76.00 76.97	03020 ONCOLOGY 07697 CARDI AC REHABI LI TATI ON	433, 519 238, 719	6, 999 2, 511			0	76.0
0. 77	OUTPATIENT SERVICE COST CENTERS	230,717	2, 511		2, 511	0	1 /0. 7
90.00	09000 CLI NI C	2, 249, 968	11, 516			0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 133, 566	9, 934	58, 177	9, 934	0	91.0 92.0
72.00	OTHER REIMBURSABLE COST CENTERS	II		I	I		72.0
101.00	10100 HOME HEALTH AGENCY	1, 082, 757	1, 305	0	1, 305	0	101. 0
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.0
118.00		52, 572, 742	185, 094	385, 816	180, 823	7, 955	118.0
	NONREIMBURSABLE COST CENTERS		1 007		1 007		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	198, 445 18, 272, 158	1, 297 25, 925		1, 297 25, 925		190. 0 192. 0
	19201 SOUTH CLINIC	0	20, 720	0	0		192.0
	19202 WEST CLINIC	0	0	0	0		192.0
	19203 DI ABETES CENTER 19300 NONPAI D WORKERS	134, 473	402	0	402		192. 0 193. 0
	19301 ADULT/CHI LD CARE	564, 757	4, 832	0	4, 832		193.0
	19302 PHYSICIAN OFFICE BUILDING	0	0	0	0		193. 0
	19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI P HFC	1, 048, 863 55, 203	0 2, 228	0	0 2, 228		193. 0 194. 0
	07950 PARTNERSHIP HPC 07951 TRAFALGAR CLINIC	00,203	2,220	0	2,220		194.0
	07952 EDI NBURGH	0	0	0	0		194. 0
	07953 JAI L 07954 ATHLETI C TRAI NERS	58, 185	0	0	0		194. 0 194. 0
194.04 200.00		0	0		0	0	200. 0
201.00	Negative Cost Centers						201.0
202.00		3, 744, 788	3, 106, 951	290, 595	1, 139, 846	856, 633	202. 0
	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 051365	14. 136770	0. 742217	5. 289137	107.684852	203. 0
203.00							

Health Fin	ancial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
	Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICI	E (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. 003902	1. 168666	0. 09203	5 0. 156867	14. 229793	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems LLOCATION - STATISTICAL BASIS	JOHNSON MEMOR	IAL HOSPITAL Provider CC		eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2017 o 12/31/2017	Date/Time Pre	
	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	5/25/2018 3: 4 MEDI CAL RECORDS & LI BRARY (GROSS REVENUE) 16.00	3 pm
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 01\\ 4.\ 02\\ 4.\ 03\\ 4.\ 04\\ 4.\ 05\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 16.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT 00404 ADMITTING 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 NDATIENT POULTINE EEDWLCE COST CENTEDS	770, 785 23, 804 3, 739 13, 513 30, 212	259, 825 3, 739 0	100 0 0	100	213, 844, 005	1.00 1.01 2.00 4.00 4.01 4.02 4.03 4.04 4.05 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 16.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	97, 804	97, 804	0	0	13, 519, 178	30.00
31.00 41.00 43.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04300 NURSERY	31, 216 17, 843 3, 987	17, 843	0 0 0	0	1, 447, 795 1, 818, 844 572, 213	41.00
	ANCILLARY SERVICE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
50.00 53.00 54.00 60.00 65.00 66.00 67.00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY	53, 363 0 58, 114 64, 581 25, 046 23, 418 5, 998			0 0 0 0 0	30, 976, 810 4, 275, 008 38, 964, 355 29, 699, 667 5, 730, 152 3, 800, 658 2, 023, 294	53.00 54.00 60.00 65.00 66.00
68. 00 69. 00 70. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT	3, 363 12, 481 1, 546 0 0		0 0 0 100 0	0 0 0 0	683, 762 4, 220, 376 137, 496 10, 578, 304 2, 617, 894	68.00 69.00 70.00 71.00
	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY 07697 CARDLAC REHABILITATION	0 7, 031 3, 605		0 0 0		12, 449, 137 786, 780 611, 835	76.00
90.00	OUTPATIENT SERVICE COST CENTERS	29, 863	0	0	0	10, 790, 441	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	51, 873	51, 873	0	0	25, 762, 302	91.00 92.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	17, 918	0	0	0	1, 336, 914	101. 00
113. 00 118. 00	11300 INTEREST EXPENSE	580, 318	259, 825	100	100	202, 803, 215	113. 00 118. 00
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES 19201 SOUTH CLINIC	5, 406 135, 766 0		0 0		10, 958, 216	190. 00 192. 00 192. 01
192. 02 192. 03	19202 WEST CLINIC 19203 DIABETES CENTER	0 2, 165	0	0	0	0 82, 574	192. 02 192. 03
193. 01 193. 02	19300 NONPAI D WORKERS 19301 ADULT/CHI LD CARE 19302 PHYSI CI AN OFFI CE BUI LDI NG 19303 OPTI FAST/FOUNDATI ON	30, 931 0 0		0 0 0 0	0 0 0	0 0	193. 00 193. 01 193. 02 193. 03
194.01 194.02 194.03	07950 PARTNERSHI PHFC 07951 TRAFALGAR CLI NI C 07952 EDI NBURGH 07953 JAI L 07954 ATHLETI CTRAI NERS	59 0 0 0 16, 140	0 0 0	0 0 0 0 0 0	0 0 0 0	0 0 0	194. 00 194. 01 194. 02 194. 03 194. 04
200.00 201.00	Cross Foot Adjustments Negative Cost Centers	644, 049		377, 880	4, 925, 502		200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	044,047	2, 302, 104	377,000	4, 723, 302	1, 283, 783	202.00

Heal th F	nancial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2017	Worksheet B-1	
					To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
	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	
204.00	Cost to be allocated (per Wkst. B,	38, 533	157, 444	54, 82	9 52, 461	114, 043	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 049992	0. 605962	548.29000	524.610000	0.000533	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Health Financia	al Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF	RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	nared
					10 12/31/2017	5/25/2018 3:4	3 pm
			Title	XVIII	Hospi tal	PPS	
					Costs		
Cc	ost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2.00	2.00	4.00	F 00	
	NT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	DULTS & PEDIATRICS	7, 616, 245	I	7, 616, 24	5 0	7, 616, 245	30.00
	ITENSIVE CARE UNIT	2, 448, 940		2, 448, 94		2, 448, 940	
	JBPROVIDER - IRF	1, 597, 466		1, 597, 46		1, 597, 466	•
43.00 04300 NU		290, 588		290, 58		290, 588	
	RY SERVICE COST CENTERS	290, 300		290, 30	0 0	290, 300	43.00
	PERATING ROOM	6, 085, 603		6, 085, 60	3 0	6, 085, 603	50.00
	NESTHESI OLOGY	151, 767		151, 76		151, 767	
	ADI OLOGY-DI AGNOSTI C	5, 371, 046		5, 371, 04		5, 371, 046	
	ABORATORY	5, 777, 347		5, 777, 34		5, 777, 347	
	ESPI RATORY THERAPY	1, 667, 481				1, 667, 481	
	IYSI CAL THERAPY	1, 558, 814		1, 558, 81		1, 558, 814	•
	CCUPATIONAL THERAPY	423, 897		423, 89		423, 897	
	PEECH PATHOLOGY	240, 479		240, 47		240, 479	
	LECTROCARDI OLOGY	2, 407, 656		2, 407, 65		2, 407, 656	
	LECTROENCEPHALOGRAPHY	88, 873		88, 87		88, 873	•
71.00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENTS	3, 437, 234		3, 437, 23	4 0	3, 437, 234	71.00
72.00 07200 IN	NPL. DEV. CHARGED TO PATIENT	977, 041		977, 04	1 0	977, 041	72.00
73.00 07300 DR	RUGS CHARGED TO PATIENTS	5, 208, 866		5, 208, 86	6 0	5, 208, 866	73.00
76.00 03020 ON		602, 347		602, 34	7 0	602, 347	76.00
76. 97 07697 CA	ARDIAC REHABILITATION	306, 444		306, 44	4 0	306, 444	76.97
	ENT SERVICE COST CENTERS						
90.00 09000 CL		2, 680, 675		2, 680, 67	5 0	2, 680, 675	90.00
91.00 09100 EN		4, 244, 181		4, 244, 18		., =,	
	SSERVATION BEDS (NON-DISTINCT PART)	1,045,924		1, 045, 92	4	1, 045, 924	92.00
	EIMBURSABLE COST CENTERS				_		
	DME HEALTH AGENCY	1, 186, 720		1, 186, 72	0	1, 186, 720	101.00
	PURPOSE COST CENTERS		i	1			-
	NTEREST EXPENSE						113.00
	ubtotal (see instructions)	55, 415, 634					
	ess Observation Beds	1,045,924		1, 045, 92		1, 045, 924	
202.00 To	otal (see instructions)	54, 369, 710	0	54, 369, 71	0 0	54, 369, 710	202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
			e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	· · · · ·		1			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 402, 865		11, 402, 86			30.00
31.00 03100 INTENSIVE CARE UNIT	1, 447, 795		1, 447, 79			31.00
41. 00 04100 SUBPROVI DER – I RF	1, 818, 844		1, 818, 84			41.00
43. 00 04300 NURSERY	572, 213		572, 21	3		43.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·					
50.00 05000 OPERATING ROOM	5, 662, 910	25, 313, 901			0. 000000	
53. 00 05300 ANESTHESI OLOGY	743, 728	3, 531, 280			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 470, 080	34, 492, 577	38, 962, 65	0. 137851	0.00000	54.00
60. 00 06000 LABORATORY	5, 958, 454	23, 741, 213			0.00000	
65. 00 06500 RESPI RATORY THERAPY	2, 970, 072	2, 757, 283			0.00000	
66. 00 06600 PHYSI CAL THERAPY	1, 217, 610	2, 583, 048	3, 800, 65		0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	1, 204, 787	818, 507			0.00000	
68.00 06800 SPEECH PATHOLOGY	366, 175	317, 587			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	926, 449	3, 861, 999	4, 788, 44	8 0. 502805	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	46, 076	91, 420	137, 49	6 0. 646368	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 968, 953	7, 609, 352	10, 578, 30	0. 324932	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	840, 657	1, 777, 237	2, 617, 89	4 0. 373216	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 197, 479	8, 251, 358	12, 448, 83	0. 418422	0.00000	73.00
76.00 03020 ONCOLOGY	1, 294	678, 019	679, 31	3 0.886700	0.00000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 458	609, 047	611, 50	0. 501131	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	6, 891	10, 645, 113	10, 652, 00	0. 251659	0. 000000	90.00
91.00 09100 EMERGENCY	3, 346, 576	22, 415, 675	25, 762, 25	0. 164744	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	148, 160	1, 071, 166	1, 219, 32	6 0.857789	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1, 336, 914	1, 336, 91	4		101.00
SPECIAL PURPOSE COST CENTERS	•					
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	50, 320, 526	151, 902, 696	202, 223, 22	2		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	50, 320, 526	151, 902, 696	202, 223, 22	2		202.00
				i I		

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0001 Period: Worksheet C From 01/01/2017 Part I	
To 12/31/2017 Date/Time Prepar 5/25/2018 3:43	red: om
Title XVIII Hospital PPS	
Cost Center Description PPS Inpatient Ratio 11.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
31.00 03100 INTENSIVE CARE UNIT 3 41.00 04100 SUBPROVIDER - IRF 4	0. 00 1. 00 1. 00
	3.00
ANCI LLARY SERVI CE COST CENTERS	
	0.00
	3.00
	4.00
	0.00
	5.00
	6.00
	7.00
	8.00
	9.00
	0.00
	1.00
	2.00
	3.00
	6.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 501131 7	6. 97
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0. 251659 9	0.00
91.00 09100 EMERGENCY 0.164744 9	1.00
	2.00
OTHER REIMBURSABLE COST CENTERS	
	1.00
SPECIAL PURPOSE COST CENTERS	
	3.00
	0.00
	1.00
202.00 Total (see instructions)	2.00

Health Fina	ncial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	N OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	nared
					10 12/01/2017	5/25/2018 3:4	13 pm
		1	Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		<u>26)</u> 1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	0 ADULTS & PEDIATRICS	7, 616, 245		7, 616, 24	5 0	7, 616, 245	30, 00
	O I NTENSI VE CARE UNI T	2, 448, 940		2, 448, 94		2, 448, 940	
	0 SUBPROVI DER – I RF	1, 597, 466		1, 597, 46		1, 597, 466	1
43.00 0430		290, 588		290, 58		290, 588	
	LLARY SERVICE COST CENTERS	270,000	I	270, 30	0 0	270, 300	40.00
	O OPERATING ROOM	6,085,603		6, 085, 60	3 0	6, 085, 603	50.00
	O ANESTHESI OLOGY	151, 767		151, 76		151, 767	
	0 RADI OLOGY-DI AGNOSTI C	5, 371, 046		5, 371, 04		5, 371, 046	
	0 LABORATORY	5, 777, 347		5, 777, 34		5, 777, 347	
	0 RESPI RATORY THERAPY	1, 667, 481				1, 667, 481	
66.00 0660	O PHYSI CAL THERAPY	1, 558, 814		1, 558, 81		1, 558, 814	
67.00 0670	O OCCUPATIONAL THERAPY	423, 897		423, 89		423, 897	
68.00 0680	O SPEECH PATHOLOGY	240, 479		240, 47	9 0	240, 479	68.00
69.00 0690	0 ELECTROCARDI OLOGY	2, 407, 656		2, 407, 65	6 0	2, 407, 656	69.00
70.00 0700	0 ELECTROENCEPHALOGRAPHY	88, 873		88, 87	3 0	88, 873	70.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 437, 234		3, 437, 23	4 0	3, 437, 234	71.00
	OIMPL. DEV. CHARGED TO PATIENT	977, 041		977, 04	1 0	977, 041	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	5, 208, 866		5, 208, 86	6 0	5, 208, 866	
	O ONCOLOGY	602, 347		602, 34	7 0	602, 347	76.00
	7 CARDI AC REHABI LI TATI ON	306, 444		306, 44	4 0	306, 444	76.97
	ATIENT SERVICE COST CENTERS	1					
		2, 680, 675		2, 680, 67		_, ,	
91.00 0910		4, 244, 181		4, 244, 18		., =,	
	O OBSERVATION BEDS (NON-DISTINCT PART)	1,045,924		1, 045, 92	4	1, 045, 924	92.00
	R REIMBURSABLE COST CENTERS				-		
	O HOME HEALTH AGENCY	1, 186, 720		1, 186, 72	0	1, 186, 720	101.00
	I AL PURPOSE COST CENTERS		1	1	-		110.00
	0 INTEREST EXPENSE	EE 41E 404			4	EE 41E 404	113.00
200.00	Subtotal (see instructions) Less Observation Beds	55, 415, 634					
201.00 202.00	Total (see instructions)	1, 045, 924 54, 369, 710		1, 045, 92 54, 369, 71		1, 045, 924 54, 369, 710	
202.00	Total (see instructions)	54, 309, /10	1 (54, 369, 71	0 0	54, 369, 710	1202.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0001	Period: From 01/01/2017	Worksheet C Part I	
				To 12/31/2017	Date/Time Pre	pared:
					5/25/2018 3:4	3 pm
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6,00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	11, 402, 865		11, 402, 8	55		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 447, 795		1, 447, 7			31.00
41. 00 04100 SUBPROVI DER – I RF	1, 818, 844		1, 818, 8			41.00
43. 00 04300 NURSERY	572, 213		572, 2			43.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	5, 662, 910	25, 313, 901	30, 976, 8	0. 196457	0.00000	50.00
53. 00 05300 ANESTHESI OLOGY	743, 728	3, 531, 280		0. 035501	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 470, 080	34, 492, 577	38, 962, 6	0. 137851	0. 000000	54.00
60. 00 06000 LABORATORY	5, 958, 454	23, 741, 213	29, 699, 6	0. 194526	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	2, 970, 072	2, 757, 283	5, 727, 3	55 0. 291143	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 217, 610	2, 583, 048	3, 800, 6	58 0. 410143	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 204, 787	818, 507				
68.00 06800 SPEECH PATHOLOGY	366, 175	317, 587	683, 7			
69. 00 06900 ELECTROCARDI OLOGY	926, 449	3, 861, 999				
70. 00 07000 ELECTROENCEPHALOGRAPHY	46, 076	91, 420				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 968, 953	7, 609, 352			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	840, 657	1, 777, 237			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 197, 479	8, 251, 358				
76.00 03020 ONCOLOGY	1, 294	678, 019				
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 458	609, 047	611, 50	0. 501131	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS	(001	10 (15 110	40.450.0	0.054/50	0.00000	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	6, 891	10, 645, 113				
	3, 346, 576	22, 415, 675				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	148, 160	1, 071, 166	1, 219, 3	0. 857789	0. 000000	92.00
101.00 10100 HOME HEALTH AGENCY	0	1, 336, 914	1, 336, 9	14		101.00
SPECIAL PURPOSE COST CENTERS	0	1, 550, 914	1, 330, 9	14		
113. 00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	50, 320, 526	151, 902, 696	202, 223, 23	22		200.00
201.00 Less Observation Beds	50, 520, 520	131, 702, 070	202, 223, 2.			200.00
202.00 Total (see instructions)	50, 320, 526	151, 902, 696	202, 223, 23	22		201.00
	00, 020, 020	.01, 702, 070	1 202,220,2	1	I	1-02.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	ı of Form CMS-2552	2-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepart 5/25/2018 3:43 p	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				30	0. 00
31. 00 03100 I NTENSI VE CARE UNI T				31	1.00
41. 00 04100 SUBPROVIDER - IRF				41	1.00
43. 00 04300 NURSERY				43	3.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0.000000			50	0. 00
53.00 05300 ANESTHESI OLOGY	0. 000000			53	3.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	4.00
60. 00 06000 LABORATORY	0. 000000			60	0. 00
65. 00 06500 RESPI RATORY THERAPY	0, 000000			65	5.00
66. 00 06600 PHYSI CAL THERAPY	0.000000			66	5.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				7.00
68.00 06800 SPEECH PATHOLOGY	0.000000			68	3. 00
69.00 06900 ELECTROCARDI OLOGY	0. 000000			69	9.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0, 000000			70	0. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73	3.00
76.00 03020 ONCOLOGY	0. 000000			76	5.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76	5. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0.000000			90	0. 00
91.00 09100 EMERGENCY	0. 000000			91	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92	2.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY				101	1.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					3.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)				202	2.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	PLTAL COSTS	Provider C		Period: From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/25/2018 3:4	epared: 3 pm
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	692, 242	C	692, 24	2 6, 408	108.03	30.00
31.00 INTENSIVE CARE UNIT	193, 080		193, 08	729	264.86	31.00
41.00 SUBPROVIDER - IRF	128, 999	C	128, 99	9 1, 378	93.61	41.00
43.00 NURSERY	10, 059		10, 05	9 671	14.99	43.00
200.00 Total (lines 30 through 199)	1, 024, 380		1, 024, 38	9, 186		200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 366	255, 599				30.00
31.00 INTENSIVE CARE UNIT	455	120, 511				31.00
41.00 SUBPROVIDER - IRF	553	51, 766				41.00
43.00 NURSERY	0	C				43.00
200.00 Total (lines 30 through 199)	3, 374	427, 876				200.00

	inancial Systems	JOHNSON MEMOR				u of Form CMS-2	2552-10
APPORTI O	INMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/25/2018 3:4	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,		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	
	VCILLARY SERVICE COST CENTERS						
50.00 05	5000 OPERATI NG ROOM	1, 144, 841	30, 976, 811	0. 03695	8 1, 856, 863	68, 626	50.00
53.00 05	5300 ANESTHESI OLOGY	27, 130	4, 275, 008	0.00634	6 67, 429	428	53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	675, 429	38, 962, 657	0. 01733	5 2, 053, 709	35, 601	54.00
60.00 06	6000 LABORATORY	395, 590	29, 699, 667	0. 01332	0 2, 718, 390	36, 209	60.00
65.00 06	6500 RESPI RATORY THERAPY	92, 148	5, 727, 355	0. 01608	9 1, 228, 913	19, 772	65.00
66.00 06	6600 PHYSI CAL THERAPY	105, 644	3, 800, 658	0. 02779	6 258, 538	7, 186	66.00
67.00 06	6700 OCCUPATI ONAL THERAPY	26, 491	2, 023, 294	0.01309	3 228, 996	2, 998	67.00
68.00 06	6800 SPEECH PATHOLOGY	9, 848	683, 762	0.01440	3 51, 767	746	68.00
69.00 06	6900 ELECTROCARDI OLOGY	145, 598	4, 788, 448	0. 03040	6 668, 575	20, 329	69.00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	7,232	137, 496	0. 05259	8 1, 581	83	70.00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	103, 711	10, 578, 305	0.00980	4 1, 538, 882	15, 087	71.00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENT	8, 492	2, 617, 894	0.00324	4 73, 427	238	72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	76, 651	12, 448, 837	0.00615	7 1, 897, 882	11, 685	73.00
76.00 03	3020 ONCOLOGY	86, 645	679, 313	0. 12754	8 0	0	76.00
76.97 07	7697 CARDI AC REHABI LI TATI ON	35, 303	611, 505	0. 05773	1 0	0	76.97
OL	JTPATIENT SERVICE COST CENTERS						
90.00 09	9000 CLINIC	168, 831	10, 652, 004	0. 01585	0 6, 812	108	90.00
91.00 09	9100 EMERGENCY	285, 407	25, 762, 251	0. 01107	8 1, 488, 474	16, 489	91.00
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	95, 064	1, 219, 326	0. 07796	4 124, 330		
200.00	Total (lines 50 through 199)	3, 490, 055	185, 644, 591		14, 264, 568	245, 278	200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST			Period: From 01/01/2017 To 12/31/2017		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1,00	2A	2,00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	000000000000000000000000000000000000000	000000000000000000000000000000000000000		0 0 0 0 0 0	0 0 0	31.00 41.00
	0	0		0 0	0	
200.00 Total (Lines 30 through 199) Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	0 0 t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200. 00
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 200 04300 NURSERY	0	000000000000000000000000000000000000000	6, 40 72 1, 37 67	9 0.00 8 0.00 1 0.00	455 553 0	31.00 41.00 43.00
200.00 Total (lines 30 through 199) Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		9, 18	.0]	3, 374	200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 INTENSI VE CARE UNI T 41.00 04100 SUBPROVI DER - I RF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)						30. 00 31. 00 41. 00 43. 00 200. 00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2017 To 12/31/2017		parod:
				10 12/31/2017	5/25/2018 3:4	
			XVIII	Hospi tal	PPS	
Cost Center Description				I Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	-					
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	
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	
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	
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 CLINIC	0	C		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/25/2018 3:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1		(from Wkst. C,		
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	(8	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		-	1			
50.00 05000 OPERATING ROOM	0	0		0 30, 976, 811	0. 000000	
53.00 05300 ANESTHESI OLOGY	0	0		0 4, 275, 008		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 38, 962, 657		
60. 00 06000 LABORATORY	0	0		0 29, 699, 667		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 5, 727, 355		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 800, 658		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 023, 294		
68.00 06800 SPEECH PATHOLOGY	0	0		0 683, 762		
69.00 06900 ELECTROCARDI OLOGY	0	0		0 4, 788, 448		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 137, 496		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 10, 578, 305		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 2, 617, 894		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 12, 448, 837		
76.00 03020 ONCOLOGY	0	0		0 679, 313		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 611, 505	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS	-1					
90. 00 09000 CLINIC	0	0		0 10, 652, 004		
91. 00 09100 EMERGENCY	0	0		0 25, 762, 251		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 219, 326		
200.00 Total (lines 50 through 199)	0	0		0 185, 644, 591		200.00

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2017	Worksheet D Part IV	
				To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1	- 1		
50. 00 05000 OPERATI NG ROOM	0. 000000	1, 856, 863		0 5, 115, 389		50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	67, 429		0 698, 723		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 053, 709		0 8, 425, 766		54.00
60. 00 06000 LABORATORY	0. 000000	2, 718, 390		0 2, 199, 803		60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 228, 913		0 655, 968	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	258, 538		0 5, 281	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	228, 996		0 4, 860	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	51, 767		0 931	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	668, 575		0 1, 509, 515	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 581		0 30, 056	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 538, 882		0 1, 127, 168	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	73, 427		0 509, 330	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 897, 882		0 3, 114, 226	0	73.00
76.00 03020 ONCOLOGY	0. 000000	0		0 76, 758	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0 149, 910	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	6, 812		0 2, 696, 609	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 488, 474		0 3, 612, 560	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	124, 330		0 529, 564	0	92.00
200.00 Total (lines 50 through 199)		14, 264, 568		0 30, 462, 417	0	200. 00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/25/2018 3:4	
		Title	XVIII	Hospi tal	PPS	
			Charges	1	Costs	
Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			L			
50. 00 05000 OPERATI NG ROOM	0. 196457			0 0	1, 004, 954	
53. 00 05300 ANESTHESI OLOGY	0. 035501	698, 723		0 0	24, 805	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 137851	8, 425, 766		0 0	1, 161, 500	
60. 00 06000 LABORATORY	0. 194526			0 0	427, 919	•
65. 00 06500 RESPI RATORY THERAPY	0. 291143			0 0	190, 980	
66. 00 06600 PHYSI CAL THERAPY	0. 410143			0 0	2, 166	•
67.00 06700 OCCUPATI ONAL THERAPY	0. 209508			0 0	1, 018	67.00
68.00 06800 SPEECH PATHOLOGY	0. 351700			0 0	327	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 502805	1, 509, 515		0 0	758, 992	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 646368	30, 056		0 0	19, 427	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 324932	1, 127, 168		0 0	366, 253	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 373216	509, 330		0 0	190, 090	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 418422	3, 114, 226	21	9 1, 921	1, 303, 061	73.00
76.00 03020 ONCOLOGY	0. 886700	76, 758		0 0	68, 061	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 501131	149, 910		0 0	75, 125	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 251659	2, 696, 609	1, 45	0 0	678, 626	90.00
91.00 09100 EMERGENCY	0. 164744	3, 612, 560		0 0	595, 148	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 857789	529, 564		0 0	454, 254	92.00
200.00 Subtotal (see instructions)		30, 462, 417	1, 66	9 1, 921	7, 322, 706	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 - line 201)		30, 462, 417	1, 66	9 1, 921	7, 322, 706	202.00

Health Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	JOHNSON MEMOR	AL HOSPITAL	N 15 0001		u of Form CMS-	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	J VACCINE COST	Provi der CC	IN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/25/2018 3:4	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts		· · · · ·		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	0	0				50. C
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
65. 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	92	804				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						
90. 00 09000 CLINIC	365					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)	457	804				200. 0
201.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges						
202.00 Net Charges (line 200 - line 201)	457	804				202.0

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0001	Peri od:	Worksheet D	
		Component	CCN: 15-T001	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narodi
		component	JCN. 13-1001	10 12/31/2017	5/25/2018 3:4	
		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)	0.00	0.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1 144 041	20.07/.011	0.02(0)	E 425	201	50.00
	1, 144, 841					
53. 00 05300 ANESTHESI OLOGY	27, 130				6	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	675, 429					54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	395, 590				1, 919	
66. 00 06600 PHYSI CAL THERAPY	92, 148 105, 644					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	26, 491				3, 729	
68. 00 06800 SPEECH PATHOLOGY	20, 491 9, 848				1, 369	
69. 00 06900 ELECTROCARDI OLOGY	9, 848 145, 598					
70. 00 07000 ELECTROENCEPHALOGRAPHY	7, 232				240	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	103, 711				232	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	8, 492				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	76, 651					
76. 00 03020 ONCOLOGY	86, 645				0	
76. 97 07697 CARDI AC REHABI LI TATI ON	35, 303				0	76.97
OUTPATIENT SERVICE COST CENTERS	00,000	011/000	0100774			
90. 00 09000 CLINIC	168, 831	10, 652, 004	0. 0158	50 0	0	90.00
91.00 09100 EMERGENCY	285, 407				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	1
200.00 Total (lines 50 through 199)	3, 394, 991			1,000,305		200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2017 To 12/31/2017		nared
		oomponent		10 12/01/2011	5/25/2018 3:4	
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description				Allied Health	Allied Health	
	Cost	Post-Stepdown Adjustments		Post-Stepdown Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	28	2.00	JA	3.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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 CLINIC	0	0		0 0	Ű	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50 through 199)		_		0 0	0	92.00 200.00
200.00 TOLAT (TTHES SO LITTOUGH 199)	1 0	0	1	0 0	0	200.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	6 Provider C		Period:	Worksheet D	
THROUGH COSTS		Component (From 01/01/2017 To 12/31/2017		pared [.]
					5/25/2018 3:4	
		Title	XVIII	Subprovider -	PPS	
Cost Costos Description		Tatal Cast	Tatal	I RF		
Cost Center Description	All Other Medical	Total Cost (sum of col 1	Total Outpatient	(from Wkst. C,	Ratio of Cost to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
	Luucation cost	4)	col. 2, 3 and		7)	
		7)	4)		,,,	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS					-	
50.00 05000 OPERATING ROOM	0	0		0 30, 976, 811	0.00000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 4, 275, 008	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 38, 962, 657		54.00
60. 00 06000 LABORATORY	0	0		0 29, 699, 667		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 5, 727, 355		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 800, 658		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 023, 294		
68.00 06800 SPEECH PATHOLOGY	0	0		0 683, 762		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 4, 788, 448		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 137, 496		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 10, 578, 305		
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 2, 617, 894		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 12, 448, 837		
76.00 03020 ONCOLOGY	0	0		0 679, 313		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 611, 505	0.000000	76.97
90. 00 09000 CLINIC	0	0		0 10 (52 004	0,000000	90.00
90. 00 09000 CETNIC 91. 00 09100 EMERGENCY	0	0		0 10, 652, 004		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 25, 762, 251 0 1, 219, 326		
200.00 Total (lines 50 through 199)	0	0		0 185, 644, 591		200.00
	1 0	0	I	0 105, 044, 591	I	200.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO	CN: 15-0001	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-T001	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	narod
		component (JUN. 13-1001	10 12/31/2017	5/25/2018 3:4	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0.00000	5, 435		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	942		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	27, 737		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	144, 054		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	65, 814		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	275, 007		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	284, 811		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	95, 061		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	8, 085		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	23, 679		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	66, 475		0 0	0	73.00
76. 00 03020 ONCOLOGY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0.000000	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	3, 205		0 0	0	92.00
200.00 Total (lines 50 through 199)		1,000,305		0 0	0	200.00

	Financial Systems JOHNSON MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Period: From 01/01/2017	u of Form CMS-2 Worksheet D-1	
			To 12/31/2017	Date/Time Prep 5/25/2018 3:43	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS	a avaluding nowharm)		6, 408	1
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			6, 408	2
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3
0	do not complete this line.	ad dava)		E E20	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	5, 528 0	45
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	- 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	2, 366	9
00	newborn days)	nlu (includine entre t	and day (a)		10
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
00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private m	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		to room days)	0	12
00	through December 31 of the cost reporting period	x only (including privat	te room days)	0	12
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
00	Total nursery days (title V or XIX only)	am (exer daring swring bed	aayoy	0	15
. 00	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 d	of the cost	0.00	17
00	reporting period	an ofter December 21 of	the east	0.00	10
	Medicare rate for swing-bed SNF services applicable to servic 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 reporting period	s after December 31 of 1	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction			7, 616, 245	21
00	Swing-bed cost applicable to SNF type services through Decemb 5 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
. 00	x line 18) 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		0.	0	25
. 00	x line 20)		g period (Trile o	0	23
. 00	Total swing-bed cost (see instructions)	(1) 01 1 11 0()		0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		7, 616, 245	21
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)			0	29
00	Semi-private room charges (excluding swing-bed charges)	· Lipo 28)		0	30
00 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TTHE 28)		0. 000000 0. 00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			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			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	7, 616, 245	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 100 55	
. 00 . 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 188. 55 2, 812, 109	
. 00	Medically necessary private room cost applicable to the Progr			2, 012, 107	40
	Total Program general inpatient routine service cost (line 39	Line (0)		2, 812, 109	1 44

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	JOHNSON MEMORI	Provi der C	CN: 15-0001	Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	
				e XVIII	Hospi tal	5/25/2018 3:4 PPS	13 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	<u>4)</u> 5.00	
12.00	NURSERY (title V & XIX only)	0	2.00				42.0
	Intensive Care Type Inpatient Hospital Units						
3.00	INTENSIVE CARE UNIT	2, 448, 940	729	3, 359. 3	31 455	1, 528, 486	
14.00 15.00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T						44.0
45.00 46.00	SURGICAL INTENSIVE CARE UNIT						45.0
	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description						
8.00	Program inpatient ancillary service cost (Wk	+ D 2 col 2	Line 200)			1.00 3,721,418	10 0
9.00	Total Program inpatient costs (sum of lines			ns)		8, 062, 013	
7.00	PASS THROUGH COST ADJUSTMENTS			///3/		0,002,013	, , , , , , , , , , , , , , , , , , ,
0. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sur	n of Parts I and	376, 110	50.0
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	245, 278	3 51. C
52.00	Total Program excludable cost (sum of lines !	50 and 51)				621, 388	52.0
53.00	Total Program inpatient operating cost exclusion	ding capital re	lated, non-phy	sician anestr	netist, and	7, 440, 625	
	medical education costs (line 49 minus line 1	52)					_
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					C	54.0
5.00	Target amount per discharge					0.00	
6.00	Target amount (line 54 x line 55)					0	
7.00	Difference between adjusted inpatient operat	ng cost and ta	rget amount (I	ine 56 minus	line 53)	C	
8.00	Bonus payment (see instructions)					0	
9.00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996, l	ipdated and co	ompounded by the	0.00	59.0
0. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the m	arket basket		0.00	60. (
51.00	If line 53/54 is less than the lower of line					C	61. (
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	° the target		
52.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				C	62.0
53.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
54.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	C	64.0
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	n period (See	C	65.0
	instructions) (title XVIII only)						
56.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	C	66. 0
(7.00	CAH (see instructions)		December 21	£ +b+			
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 C	or the cost re	eporting period	C	67.C
58.00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	orting period	C	68.0
	(line 13 x line 20)						
59.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					C	69.0
0. 00	Skilled nursing facility/other nursing facil)		70.0
1.00	Adjusted general inpatient routine service co	5		. ,			71.0
2.00	Program routine service cost (line 9 x line						72.0
3.00	Medically necessary private room cost applicate						73.0
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•	,		Part II column		74.0
5.00	26, line 45)	outine service	0313 (110111	ior Rancet D, 1			/ 5. 0
6. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. (
7.00	Program capital-related costs (line 9 x line	,					77.0
B. 00 9. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess	,	rovi der record	(c)			78. 79.
5. 00 D. 00	Total Program routine service costs for compa	· · ·		,	nus line 79)		80.
1.00	Inpatient routine service cost per diem limit				,		81.
2.00	Inpatient routine service cost limitation (I		•				82.
3.00	Reasonable inpatient routine service costs (s)				83.
4.00 5.00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84. 85.
6.00	Total Program inpatient operating costs (sum						86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
37.00	Total observation bed days (see instructions)					880	
38.00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		line 2)			1, 188. 55 1, 045, 924	
0 00							

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
		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	692, 242	7, 616, 245	0. 09089	0 1, 045, 924	95, 064	90.00
91.00 Nursing School cost	0	7, 616, 245	0.00000	0 1, 045, 924	0	91.00
92.00 Allied health cost	0	7, 616, 245	0.00000	0 1, 045, 924	0	92.00
93.00 All other Medical Education	0	7, 616, 245	0.00000	0 1, 045, 924	0	93.00

	Financial Systems JOHNSON MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T001	From 01/01/2017 To 12/31/2017	Date/Time Pre	
		Title XVIII	Subprovider -	5/25/2018 3:4: PPS	<u>3 pm</u>
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS		I	1100	
	I NPATI ENT DAYS				
. 00	Inpatient days (including private room days and swing-bed days			1, 378	1.
00	Inpatient days (including private room days, excluding swing-			1, 378	2.
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od dave)		1, 378	4.
00	Total swing-bed SNF type inpatient days (including private row		r 31 of the cost	1, 370	5.
00	reporting period		i si di the cost	0	J.
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)	- ·			
00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.
	reporting period				
00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (oveluding	swing bod and	553	9
00	newborn days)	o the Frogram (excluding	swillg-bed allu	555	7
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruc		j /	-	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private r	oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, en				
2.00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	e room days)	0	12
	through December 31 of the cost reporting period				10
8.00	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 yo Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	am (exci during swring-bed	uays)	0	15
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17
	reporting period			0.00	10
3. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service:	s through December 31 of	the cost	0.00	19
/. 00	reporting period	s through becchiber st of		0.00	
0. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20
	reporting period				
I. 00	Total general inpatient routine service cost (see instruction			1, 597, 466	21
>	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22
2.00	5 x line 17)				
				_	
	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
3. 00	x line 18)				
3. 00	x line 18) Swing-bed cost applicable to NF type services through December			0 0	
3. 00 4. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost reporti	ng period (line		24
2.00 3.00 4.00 5.00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24
3.00 4.00 5.00 6.00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December 3	r 31 of the cost reporti	ng period (line	0 0 0	24 25 26
3. 00 4. 00 5. 00 5. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	r 31 of the cost reporti 31 of the cost reporting	ng period (line	0	24 25 26
3. 00 4. 00 5. 00 5. 00 7. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26)	ng period (line period (line 8	0 0 1, 597, 466	24 25 26 27
 . 00 	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26)	ng period (line period (line 8	0 0 1, 597, 466 0	24 25 26 27 28
3.00 4.00 5.00 5.00 7.00 8.00 8.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)</pre>	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26)	ng period (line period (line 8	0 0 <u>1, 597, 466</u> 0 0	24 25 26 27 28 29
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)</pre>	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch	ng period (line period (line 8	0 0 1, 597, 466 0 0 0	24 25 26 27 28 29 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December 3 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27)</pre>	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch	ng period (line period (line 8	0 0 1, 597, 466 0 0 0 0 0 0. 000000	24 25 26 27 28 29 30 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)</pre>	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch	ng period (line period (line 8	0 0 1, 597, 466 0 0 0	24 25 26 27 28 29 30 31 32
3. 00 4. 00 5. 00 5. 00 6. 00 7. 00 8. 00 9. 00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)</pre>	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28)	ng period (line period (line 8 arges)	0 0 1, 597, 466 0 0 0 0 0. 000000 0. 00	24 25 26 27 28 29 30 31 32 33
3.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc	ng period (line period (line 8 arges)	0 0 1, 597, 466 0 0 0 0. 000000 0. 000000 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33 34 35
3.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 5.00 6.00 7.00 3.00 5.00 5.00 5.00 5.00 5.00 5.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)</pre>	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc ne 31)	ng period (line period (line 8 arges) tions)	0 0 1, 597, 466 0 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33 34 35 36
3.00 4.00 5.00 5.00 6.00 7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 1.00 2.00 3.00 4.00 5.00 5.00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December 3 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost applied cost applied to the service cost net of swing-bed cost applied to the service cost net</pre>	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc ne 31)	ng period (line period (line 8 arges) tions)	0 0 1, 597, 466 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33 34 35 36
3. 00 4. 00 5. 00 5. 00 7. 00 3. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00	<pre>x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December 3 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 mil Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)</pre>	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc ne 31)	ng period (line period (line 8 arges) tions)	0 0 1, 597, 466 0 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33 34 35 36
3. 00 4. 00 5. 00 5. 00 7. 00 3. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 30 ÷ line 4) Average semi-private room per diem charge differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc ne 31) and private room cost di	ng period (line period (line 8 arges) tions)	0 0 1, 597, 466 0 0 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	24 25 26 27 28 29 30 31 32 33 34 35 36
3. 00 4. 00 5. 00 5. 00 7. 00 7. 00 8. 00 9. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJE	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruc ne 31) and private room cost di	ng period (line period (line 8 arges) tions)	0 0 1, 597, 466 0 0 0. 000000 0. 00 0. 00000000	24 25 26 27 28 29 30 31 32 33 34 35 36 37
3. 00 4. 00 5. 00 5. 00 7. 00 3. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 3. 00 4. 00 5. 00	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch ÷ line 28) nus line 33)(see instruct ne 31) and private room cost di	ng period (line period (line 8 arges) tions)	0 0 1, 597, 466 0 0 0 0. 000000 0. 00 0. 00000000	24 25 26 27 28 29 30 31 32 33 34 35 36 37 38
 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00 	x line 18) Swing-bed cost applicable to NF type services through December 7 x line 19) Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJE	r 31 of the cost reporti 31 of the cost reporting (line 21 minus line 26) d and observation bed ch + line 28) nus line 33)(see instruct ne 31) and private room cost di JSTMENTS instructions) 38)	ng period (line period (line 8 arges) tions)	0 0 1, 597, 466 0 0 0. 000000 0. 00 0. 00000000	34 35 36 37

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST	JOHNSON MEMORIAL	Provider C	CN: 15-0001	Peri od:	eu of Form CMS- Worksheet D-1	
		Component	CCN: 15-T001	From 01/01/2017 To 12/31/2017		
		Title	e XVIII	Subprovider -	5/25/2018 3:4 PPS	43 pm
Cost Center Description	Total	Total	Average Per		Program Cost	
	Inpatient CostIn	3	col . 2)		(col. 3 x col. 4)	
.00 NURSERY (title V & XIX only)	1.00	2.00 C	3.00 0.	4.00	5.00) 42
Intensive Care Type Inpatient Hospital Unit	:S		T		-	
. 00 INTENSIVE CARE UNIT . 00 CORONARY 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
00 Program inputient ancillary convice cost ()	What D 2 col 2	Lino 200)			1.00	10
.00 Program inpatient ancillary service cost (N .00 Total Program inpatient costs (sum of lines			ons)		300, 326 941, 397	
PASS THROUGH COST ADJUSTMENTS .00 Pass through costs applicable to Program in	nationt routing co	rvicos (from		m of Parts L and	51, 766	5 50
III)	ipatrent routine se	IVICES (IIUI	TWRST. D, SU	n of Faits Faitu	51,700	1 50
.00 Pass through costs applicable to Program in and IV)	npatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	17, 295	5 51
.00 Total Program excludable cost (sum of lines					69, 061	
.00 Total Program inpatient operating cost excl medical education costs (line 49 minus line		ted, non-phy	sician anest	netist, and	872, 336	5 53
TARGET AMOUNT AND LIMIT COMPUTATION	<i>L</i>					
.00 Program discharges .00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					0	
 .00 Difference between adjusted inpatient opera .00 Bonus payment (see instructions) 	ating cost and targ	et amount (I	ine 56 minus	line 53)		
.00 Lesser of lines 53/54 or 55 from the cost i	reporting period en	ding 1996, ι	updated and co	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)			Ū		
.00 Relief payment (see instructions) .00 Allowable Inpatient cost plus incentive pay	ment (see instruct	ions)				
PROGRAM INPATIENT ROUTINE SWING BED COST						
.00 Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	osts through Decemb	er 31 of the	e cost report	ng period (See	C	64
.00 Medicare swing-bed SNF inpatient routine co	osts after December	31 of the c	cost reporting	g period (See	C	65
instructions)(title XVIII only) .00 Total Medicare swing-bed SNF inpatient rou:	tine costs (line 64	plus line 6	5)(title XVI	ll onlv). For	l c	66
CAH (see instructions)		•	, .	5.	-	
.00 Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through D	ecember 31 c	of the cost r	eporting period	C	67
.00 Title V or XIX swing-bed NF inpatient routi	ne costs after Dec	ember 31 of	the cost rep	orting period	C	68
(line 13 x line 20) 0.00 <u>Total title V or XIX swing-bed NF inpatien</u>	t routine costs (li	ne 67 + line	e 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHER 0.00 Skilled nursing facility/other nursing faci				<u></u>		1 70
 00 Skilled nursing facility/other nursing faci 00 Adjusted general inpatient routine service 	5)		70
.00 Program routine service cost (line 9 x line	e 71)					72
.00 Medically necessary private room cost appli .00 Total Program general inpatient routine se	υ,					73
.00 Capital-related cost allocated to inpatien	•			Part II, column		75
26, line 45) .00 Per diem capital-related costs (line 75 ÷ l	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 exce		vider record	ls)			78
.00 Total Program routine service costs for cor	• •			nus line 79)		80
.00 Inpatient routine service cost per diem lin	nitation			·		81
.00 Inpatient routine service cost limitation	· · ·					82
 .00 Reasonable inpatient routine service costs .00 Program inpatient ancillary services (see in the service of the	•					83
0.00 Utilization review - physician compensation)				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) (s	see instructions)				0) 89

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
		Component (To 12/31/2017	Date/Time Prep 5/25/2018 3:43	pared: 3 pm
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST			· · · · · · · · · · · · · · · · · · ·		
90.00 Capital-related cost	128, 999	1, 597, 466	0. 08075	2 0	0	90.00
91.00 Nursing School cost	0	1, 597, 466	0.00000	0 0	0	91.00
92.00 Allied health cost	0	1, 597, 466	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 597, 466	0. 00000	0 0	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-00	From 01/01/2017	Worksheet D-1	
			To 12/31/2017	5/25/2018 3:4	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS		<u>\</u>	(100	
00 00	Inpatient days (including private room days and swing Inpatient days (including private room days, excludir	g-bed days, excluding newborn a swing-bed and newborn day) S)	6, 408 6, 408	
00	Private room days (excluding swing-bed and observation			0	
00	do not complete this line.	ruation had dava)		E E 20	
00 00	Semi-private room days (excluding swing-bed and obser Total swing-bed SNF type inpatient days (including pr		ember 31 of the cost	5, 528 0	
	reporting period			-	
00	Total swing-bed SNF type inpatient days (including pr reporting period (if calendar year, enter 0 on this I		ber 31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including pri		mber 31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including pri reporting period (if calendar year, enter 0 on this I		er 31 of the cost	0	8
00	Total inpatient days including private room days appl		ding swing-bed and	27	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title	Will only (including prive	to room dave)	0	10
. 00	through December 31 of the cost reporting period (see		te room days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title		te room days) after	0	11
00	December 31 of the cost reporting period (if calendar Swing-bed NF type inpatient days applicable to titles		ivate room days)	0	12
. 00	through December 31 of the cost reporting period			Ū	'2
. 00	Swing-bed NF type inpatient days applicable to titles			0	13
. 00	after December 31 of the cost reporting period (if ca Medically necessary private room days applicable to t			0	14
	Total nursery days (title V or XIX only)		5 /	671	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			55	16
. 00	Medicare rate for swing-bed SNF services applicable t	to services through December	31 of the cost	0.00	17
~~	reporting period			0.00	
. 00	Medicare rate for swing-bed SNF services applicable t reporting period	to services after December 31	or the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to	o services through December 3	1 of the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to	services after December 31	of the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see ins		norting pariod (line	7, 616, 245	
. 00	Swing-bed cost applicable to SNF type services throug 5 x line 17)	gn becember 31 of the cost re	porting period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after	December 31 of the cost repo	rting period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through	December 31 of the cost rep	orting period (line	0	24
	7 x line 19)			Ū	
. 00	Swing-bed cost applicable to NF type services after E	December 31 of the cost repor	ting period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-b	ed cost (line 21 minus line	26)	7, 616, 245	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding	swing_bed and observation be	d charges)	0	28
	Private room charges (excluding swing-bed charges)	swing bed and observation be	d charges)	0	
	Semi-private room charges (excluding swing-bed charge	-		0	
	General inpatient routine service cost/charge ratio (Average private room per diem charge (line 29 ÷ line			0. 000000 0. 00	
	Average semi-private room per diem charge (line 2) + line			0.00	
. 00	Average per diem private room charge differential (li		tructions)	0.00	
. 00 . 00	Average per diem private room cost differential (line Private room cost differential adjustment (line 3 x l			0.00	35
	General inpatient routine service cost net of swing-b		t differential (line	7, 616, 245	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH	COST ADJUSTMENTS			1
. 00	Adjusted general inpatient routine service cost per d			1, 188. 55	38
	Program general inpatient routine service cost (line		F.)	32, 091	
	Medically necessary private room cost applicable to t	THE PLOTATE LINE 14 Y LINE 3	· • •	0	

UMPUI	TATION OF INPATIENT OPERATING COST		AL HOSPITAL Provider C	CN: 15-0001	Peri od:	eu of Form CMS- Worksheet D-1	
					From 01/01/2017 To 12/31/2017		epare
				~ YI Y		5/25/2018 3:4	43 pm
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Costl		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2)	4.00	4)	
2.00	NURSERY (title V & XIX only)	1.00 290,588	2.00	3.00 433.	4.00 07 55	5.00 23,819	2 42
	Intensive Care Type Inpatient Hospital Units	2,0,000	0,1	1001		20,017	
. 00	I NTENSI VE CARE UNI T	2, 448, 940	729	3, 359.	31 0	C	
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.
. 00							45.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	_
. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1.00	2 48.
. 00	5			ns)		124, 292	
	PASS THROUGH COST ADJUSTMENTS	• · · ·					
. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	C	50.
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillarv	services (fr	om Wkst. D.	sum of Parts II	c c	51.
	and IV)	,					
2.00	Total Program excludable cost (sum of lines		atad see at		hotiot cod	C	
3.00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line 5		ated, non-pny	sician anesti	netist, and	C	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	()					
. 00						C	
. 00 . 00	5 1 5					0.00	
. 00	Difference between adjusted inpatient operat	ng cost and tar	aet amount (I	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	5	J			C	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndi ng 1996, u	pdated and c	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report und	ated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of line					C	
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% o ⁻	f the target		
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)					62.
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decem	ber 31 of the	cost report	ing period (See	C	64.
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportin	g period (See	c c	65.
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVI	ll only). For	C	66.
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost r	eportina period	c c	67.
	(line 12 x line 19)	0					
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost rep	orting period	C	68.
9 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	coutine costs (L	ine 67 + line	68)		c c	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU						
. 00	Skilled nursing facility/other nursing facil	5)		70.
. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71
. 00	Medically necessary private room cost application	,	(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	0	•				74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· · ·		,	nus lino 70)		80
. 00	Inpatient routine service costs for compa		st i i initati Off		nus IIIe /7)		80
. 00	Inpatient routine service cost limitation (I						82
. 00	Reasonable inpatient routine service costs ()				83
. 00	Program inpatient ancillary services (see in:		c)				84
b. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.
50	PART IV - COMPUTATION OF OBSERVATION BED PASS					· · · · · · · · · · · · · · · · · · ·	
7.00	Total observation bed days (see instructions					880	
3.00	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (see	•	iine 2)			1, 188. 55 1, 045, 924	
						., 0, 0, 727	

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
		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	692, 242	7, 616, 245	0. 09089	0 1, 045, 924	95, 064	90.00
91.00 Nursing School cost	0	7, 616, 245	0.00000	0 1, 045, 924	0	91.00
92.00 Allied health cost	0	7, 616, 245	0.00000	0 1, 045, 924	0	92.00
93.00 All other Medical Education	0	7, 616, 245	0. 00000	0 1, 045, 924	0	93.00

Component COI: 15-T001 From Project 2017 To 12/31/2017 Distribution Program APX 1 - ALL PROVIDER COMPORENTS 100 100 100 100 MART 1 - ALL PROVIDER COMPORENTS 100 100 100 100 100 MART 1 - ALL PROVIDER COMPORENTS 100 100 100 100 100 100 100 MART 1 - ALL PROVIDER COMPORENTS 100<		Systems JOHNSON MEMORIAL	Provider CCN: 15-0001	Period:	u of Form CMS-2 Worksheet D-1	
Title XIX Subgroup of er Cost IMP 1.100 1.00 IMPATIENT DAYS 1.00 Impatient days (including private room days, and swing-bed days, excluding newborn) 1.378 Impatient days (including private room days, and swing-bed days, excluding newborn) 1.378 Interview of the system of the sector days (including private room days) through December 31 of the cost 1.378 Interview of the system of the sector days (including private room days) through December 31 of the cost 0 Interview of the system of the sector days (including private room days) through December 31 of the cost 0 Interview of the system of the sector of th	UNFUTATION UF	INFATLINE OFLIGATING COST		From 01/01/2017	Date/Time Prep	par
Cost Center Description 1.00 PMET 1 - ALL PROVIDER COMPONENTS 1.00 INVEXT.EDIT DAYS 1.00 Description Days 1.30 Description Days 1.30 Description Days 1.30 Description Days 1.31 Description Days 1.31 </th <th></th> <th></th> <th>Title XIX</th> <th></th> <th></th> <th>3р</th>			Title XIX			3р
PART I - ALL DROUMDER COMPONENTS INPATE ONS. INPATE ONS. Inpatient days (including private room days, excluding swing-bed and newborn days). 1.378 OT Inpatient days (including private room days, excluding swing-bed and newborn days). 1.378 OS Semi-private room days (coluding swing-bed and observation bed days). 1.378 OS Semi-private room days (coluding swing-bed and observation bed days). 1.378 OS Semi-private room days (coluding swing-bed and observation bed days). 1.378 OT Sami-private room days (coluding swing-bed and observation bed days). 1.378 OT Sami-private room days (coluding swing-bed and observation bed days). 1.378 OT Sami-private room days (coluding private room days). 1.378 OT Sami-private room days (coluding private room days). 1.378 OT Sami-private room days (coluding private room days). 1.378 OT 1.378 1.378 <tr< th=""><th>Cos</th><th>t Center Description</th><th> </th><th></th><th>1.00</th><th></th></tr<>	Cos	t Center Description			1.00	
IMPATTENT DAYS 1.1785 into tays (including private room days, excluding, swing-bed and, newborn) 1.378 0.110000000000000000000000000000000000	PART I -	ALL PROVIDER COMPONENTS			1.00	
00 Inpatient days (including private room days, excluding swing-bed and nextorn days) 1.378 01 Private room days (excluding swing-bed and observation bed days) 1.378 01 Stemi-private room days (accluding swing-bed and observation bed days) 1.378 01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 10 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 10 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 10 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 0 10 Total swing-bed NF type inpatient days applicable to title XVII only (including private room days) 0 10 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) 0 10 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) 0 11 Through December 31 of the cost 0 1 12 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) 0 1 13 Swing-bed SNF type inpatient days applicable to titles V or XX only (including private room day						1
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7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 1, 597, 466 27 minus line 36) 33 PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 34 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 159.26 34 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 44	5 x line 3.00 Swing-be x line 1: 4.00 Swing-be 7 x line 5.00 Swing-be x line 2: 0.00 Total sw 7.00 General 9.00 Private 1.00 Semi-pri 1.00 General 2.00 Average 4.00 Average	17) 17) 17) 17) 17) 17) 17) 17)	31 of the cost reporting r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed cha ÷ line 28) nus line 33)(see instruct	period (line 6 g period (line period (line 8 rges)	0 0 0 0 0 1, 597, 466 0 0 0 0. 000000 0 0. 000000 0. 00 0. 00	22 24 24 26 26 26 26 26 26 30 37 32 32 32 34
27 minus line 36) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,159.26 9.00 Program general inpatient routine service cost (line 9 x line 38) 0 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0	5 x line 3.00 Swing-ber x line 1: 4.00 Swing-ber 7 x line 5.00 Swing-ber x line 2: 5.00 Total sw 7.00 General 9.00 Private 0.00 Semi-pri 1.00 General 2.00 Average 3.00 Average 5.00 Average	17) 17) 17) 17) 17) 17) 17) 17)	31 of the cost reporting r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed cha ÷ line 28) nus line 33)(see instruct	period (line 6 g period (line period (line 8 rges)	0 0 0 0 1, 597, 466 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 22 22 22 22 22 20 30 31 32 32 32 32 32 32 32 32 32 32 32 32 32
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 8.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,159.26 9.00 Program general inpatient routine service cost (line 9 x line 38) 0 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0	5 x line 3.00 Swing-bea x line 1: 4.00 Swing-bea x line 1: 5.00 Swing-bea x line 2: 5.00 Swing-bea x line 2: 5.00 Total sw General 7.00 General PRI VATE F 3.00 General O Private 0.00 Semi - private O Average 3: 3.00 Average 3: 0 Average 3: 4.00 Average 5: 00 Average 5:	17) 17) 17) 17) 17) 17) 17) 17)	31 of the cost reporting r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed cha ÷ line 28) nus line 33)(see instruct ne 31)	period (line 6 g period (line period (line 8 rges)	0 0 0 0 1, 597, 466 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 24 24 24 24 24 24 24 24 24 24 24 24 2
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS8.00Adjusted general inpatient routine service cost per diem (see instructions)1,159.269.00Program general inpatient routine service cost (line 9 x line 38)00.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0	5 x line 3.00 Swing-ber x line 1 4.00 Swing-ber 7 x line 1 5.00 Swing-ber x line 2 5.00 Swing-ber x line 2 5.00 Total sw 7.00 General PRI VATE f 6.00 Private 0.00 Semi-priv 1.00 General 2.00 Average 3.00 Average 5.00 Average 5.00 Average 5.00 Private 7.00 General	17) 17) 17) 17) 17) 17) 17) 17)	31 of the cost reporting r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed cha ÷ line 28) nus line 33)(see instruct ne 31)	period (line 6 g period (line period (line 8 rges)	0 0 0 0 1, 597, 466 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 24 24 24 24 24 24 24 24 24 24 24 24 2
0.00Program general inpatient routine service cost (line 9 x line 38)0300.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040	5 x line 3. 00 Swing-ber x line 1: 4. 00 Swing-ber 7 x line 5. 00 Swing-ber x line 2: 5. 00 Total sw 7. 00 General PRIVATE F 8. 00 General 9. 00 Private 1. 00 General 2. 00 Average 3. 00 Average 3. 00 Average 5. 00	17) 17) 17) 17) 17) 17) 17) 17)	31 of the cost reporting r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed cha ÷ line 28) nus line 33)(see instruct ne 31)	period (line 6 g period (line period (line 8 rges)	0 0 0 0 1, 597, 466 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 24 24 24 24 24 24 24 24 24 24 24 24 2
0 0 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40	5 x line 3. 00 Swing-ber x line 1: 4. 00 Swing-ber 7 x line 5. 00 Swing-ber x line 2: 5. 00 Total sw 7. 00 General PRIVATE F 8. 00 General 9. 00 Private 9. 00 Semi-pri 1. 00 General 2. 00 Average 3. 00	17) 17) 17) 17) 17) 17) 17) 17)	31 of the cost reporting r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed cha ÷ line 28) nus line 33)(see instruct ne 31) and private room cost dif	period (line 6 g period (line period (line 8 rges)	0 0 0 0 1, 597, 466 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 24 24 24 24 24 24 24 24 24 24 24 24 2
5 51 11 5 1	5 x line 3.00 Swing-ber x line 1: 4.00 Swing-ber 7 x line 5.00 Swing-ber x line 2: 5.00 Total sw 7.00 General PRIVATE F 3.00 General 9.00 Private 5.00 Average 5.00 Average	17) d cost applicable to SNF type services after December 3) d cost applicable to NF type services through December 19) d cost applicable to NF type services after December 20) ng-bed cost (see instructions) npatient routine service cost net of swing-bed cost 200M DIFFERENTIAL ADJUSTMENT Inpatient routine service charges (excluding swing-bed coom charges (excluding swing-bed charges) vate room charges (excluding swing-bed charges) vate room charges (excluding swing-bed charges) npatient routine service cost/charge ratio (line 27 - private room per diem charge (line 29 ÷ line 3) semi-private room per diem charge differential (line 32 min per diem private room cost differential (line 34 x line room cost differential adjustment (line 3 x line 35) npatient routine service cost net of swing-bed cost at line 36) HOSPITAL AND SUBPROVIDERS ONLY NPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU general inpatient routine service cost per diem (see	31 of the cost reporting r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed cha ÷ line 28) nus line 33)(see instruct ne 31) and private room cost dif USTMENTS instructions)	period (line 6 g period (line period (line 8 rges)	0 0 0 0 1, 597, 466 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 24 24 26 26 26 30 31 32 34 35 36 37 36 37 37 36 37 37 37 37 37 37 37 37 37 37 37 37 37
	5 x line 3.00 Swing-ber x line 1 4.00 Swing-ber 7 x line 1 5.00 Swing-ber 5.00 Swing-ber 5.00 Total sw 6.00 Total sw 7.00 General 9.00 Private 0.00 Semi-pri 1.00 General 2.00 Average 3.00 Average 5.00 Average 5.00 Average 6.00 Private 7.00 General 2.00 Average 6.00 Private 7.00 General 2.7 minus PART II PROGRAM I PROGRAM I 9.00 Program	17) 17) 17) 17) 17) 17) 17) 17)	31 of the cost reporting r 31 of the cost reportin 31 of the cost reporting (line 21 minus line 26) d and observation bed cha ÷ line 28) nus line 33)(see instruct ne 31) and private room cost dif USTMENTS instructions) 38)	period (line 6 g period (line period (line 8 rges)	0 0 0 0 1, 597, 466 0 0 0, 000000 0, 00 0, 0, 00 0, 00 0,00000000	22 24 24 26 26 26 26 26 26 26 26 26 26 26 26 26

	Financial Systems ATION OF INPATIENT OPERATING COST	JOHNSON MEMORIAL	_ HOSPITAL Provider C	CN: 15-0001	In Lie Period:	u of Form CMS- Worksheet D-1	
				CCN: 15-T001	From 01/01/2017 To 12/31/2017	Date/Time Pre	epared
			Titl	e XIX	Subprovider -	5/25/2018 3:4 Cost	13 pm
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient CostIn	patient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
2 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00) 42.0
2.00	Intensive Care Type Inpatient Hospital Units	0		0.	00 0		7 72.
3.00	INTENSIVE CARE UNIT	0	C	0.	00 00	C	
4.00 5.00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T						44. 45.
6.00	SURGICAL INTENSIVE CARE UNIT						46.
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
0 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Lino 200)			1.00	2 48.
8.00 9.00	Total Program inpatient costs (sum of lines			ons)		24, 262 24, 262	
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine se	rvices (from	n Wkst. D, su	n of Parts I and	C	50.
1.00	Pass through costs applicable to Program inp	ationt ancillary	convicos (fr	om What D	cum of Parts II	c c	51.
	and IV)	5	SCIVICES (T	UNI WKSL. D,	sum of Parts II		
2.00 3.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ted non-nh	veician anest	natist and		
5.00	medical education costs (line 49 minus line		nteu, non-phy				55.
4.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					l c	54.
5.00	Target amount per discharge					0.00	55.
5.00 7.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and targ	et amount (1	ine 56 minus	line 53)		
3.00	Bonus payment (see instructions)	ing cost and targ			True 55)		
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period en	iding 1996, ι	updated and c	ompounded by the	0.00	59.
D. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upda	ted by the m	arket basket		0.00	60.
1.00	If line 53/54 is less than the lower of line	s 55, 59 or 60 en	iter the less	er of 50% of		C	
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% o	f the target		
2.00	Relief payment (see instructions)					c	62.
3. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	ions)			C	63.
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the	e cost report	ng period (See	C	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reportin	g period (See	c c	65.
	instructions)(title XVIII only)						
6. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (Tine 64	pius line a	5)(title XVI	TT ONLY). FOR	C) 66.
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through D	ecember 31 d	of the cost r	eporting period	C	67.
8.00	Title V or XIX swing-bed NF inpatient routine	e costs after Dec	ember 31 of	the cost rep	orting period	C	68.
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	e 68)		C	69.
0 00	PART III - SKILLED NURSING FACILITY, OTHER NU				<u></u>	1	1 70
0.00 1.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	5)		70.
2.00	Program routine service cost (line 9 x line			,			72.
3.00	Medically necessary private room cost applicated	υ.					73.
4.00 5.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•			Part II, column		74.
	26, line 45)			1			
6.00 7.00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.
3. 00	Inpatient routine service cost (line 74 minus	s line 77)					78.
9.00	Aggregate charges to beneficiaries for excess	• •					79.
D. 00 1. 00	Total Program routine service costs for comparing		t limitatior	ı (line 78 mi	nus line 79)		80. 81.
2.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81.
3.00	Reasonable inpatient routine service costs (83.
4.00	Program inpatient ancillary services (see in	structions)					84.
5.00	Utilization review - physician compensation						85.
6.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugh 85)				86.
7.00	Total observation bed days (see instructions					C	87.
	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			0.00	88.
a a -	Observation bed cost (line 87 x line 88) (see						89.

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
		Component (To 12/31/2017	Date/Time Pre 5/25/2018 3:4	pared: 3 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	128, 999	1, 597, 466	0. 08075	2 0	0	90.00
91.00 Nursing School cost	0	1, 597, 466	0.00000	0 0	0	91.00
92.00 Allied health cost	0	1, 597, 466	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 597, 466	0.00000	0 0	0	93.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Li	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0001	Peri od:	Worksheet D-3	
				From 01/01/201		
				To 12/31/201	7 Date/Time Pre 5/25/2018 3:4	
		Title	e XVIII	Hospi tal	PPS	5 piii
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1		1	
30. 00 03000 ADULTS & PEDI ATRI CS				3, 614, 20		30.00
31.00 03100 I NTENSI VE CARE UNI T				595, 60	D	31.00
41. 00 04100 SUBPROVI DER – I RF					p	41.00
43. 00 04300 NURSERY						43.00
ANCI LLARY SERVI CE COST CENTERS					al a <i>t</i> 704	
50. 00 05000 OPERATING ROOM			0. 1964			•
53. 00 05300 ANESTHESI OLOGY			0.0355			•
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 1378			•
60. 00 06000 LABORATORY			0. 1945			•
65. 00 06500 RESPI RATORY THERAPY			0. 2911			
66. 00 06600 PHYSI CAL THERAPY			0. 4101			•
67.00 06700 OCCUPATI ONAL THERAPY			0. 2095			•
68.00 06800 SPEECH PATHOLOGY			0.3517			•
69. 00 06900 ELECTROCARDI OLOGY			0. 5028			•
70.00 07000 ELECTROENCEPHALOGRAPHY			0. 6463			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 3249			•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 3732			•
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 4184			
76.00 03020 ONCOLOGY			0. 8867		0 0	
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 5011	31	0 0	76.97
OUTPATIENT SERVICE COST CENTERS					•	
90. 00 09000 CLI NI C			0. 2516			•
91. 00 09100 EMERGENCY			0. 1647			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0.8577			
200.00 Total (sum of lines 50 through 94 and 96				14, 264, 56		
201.00 Less PBP Clinic Laboratory Services-Prog	ram only charges	(line 61)			C	201.00
202.00 Net charges (line 200 minus line 201)				14, 264, 56	3	202.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITA	_		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de	r CCN: 15-0001		eri od:	Worksheet D-3	
				rom 01/01/2017		
	Compone	nt CCN: 15-T001	To	5 12/31/2017	Date/Time Pre 5/25/2018 3:4	
	Ti	tle XVIII		Subprovider -	PPS	s pili
				IRF	115	
Cost Center Description		Ratio of C	ost	Inpati ent	I npati ent	
		To Charge	s		Program Costs	
				Charges	(col. 1 x col.	
					2)	
		1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				0		30.00
31.00 03100 INTENSIVE CARE UNIT				0		31.00
41.00 04100 SUBPROVI DER – I RF				702, 139		41.00
43. 00 04300 NURSERY						43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM		0. 196		5, 435		
53. 00 05300 ANESTHESI OLOGY		0. 035		942		
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 137		27, 737	3, 824	
60. 00 06000 LABORATORY		0. 194		144, 054		
65. 00 06500 RESPI RATORY THERAPY		0. 291		65, 814		
66. 00 06600 PHYSI CAL THERAPY		0. 410		275, 007		
67.00 06700 OCCUPATI ONAL THERAPY		0. 209		284, 811	59, 670	67.00
68.00 06800 SPEECH PATHOLOGY		0.351		95, 061	33, 433	
69. 00 06900 ELECTROCARDI OLOGY		0. 502		8, 085	4, 065	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.646		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 324		23, 679	7, 694	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.373		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 418		66, 475	27, 815	
76. 00 03020 ONCOLOGY		0.886		0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 501	131	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC		0. 251	659	0	0	90.00
91. 00 09100 EMERGENCY		0. 164		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.857	789	3, 205		92.00
200.00 Total (sum of lines 50 through 94 and				1, 000, 305	300, 326	•
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (line 6	1)		0		201.00
202.00 Net charges (line 200 minus line 201)		I		1, 000, 305		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	e XIX Ratio of Cos	Period: From 01/01/2017 To 12/31/2017 Hospital t Inpatient	Worksheet D-3 Date/Time Pre 5/25/2018 3:4 Cost	pared:
Cost Center Description	Ti tl	Ratio of Cos	To 12/31/2017 Hospi tal	5/25/2018 3:4	
Cost Center Description	Ti tl	Ratio of Cos	Hospi tal	5/25/2018 3:4	
Cost Center Description	Ti tl	Ratio of Cos			
Cost Center Description			t Innationt		
		T 01	i inpatrent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 O3000 ADULTS & PEDI ATRI CS			228, 021		30.00
31.00 03100 I NTENSI VE CARE UNI T			4, 356		31.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0.10/4	-7 117 500	22,102	50.00
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY		0. 1964			
53. 00 [05300] ANESTHESTOLOGY 54. 00 [05400] RADI OLOGY-DI AGNOSTI C		0. 0355 0. 1378			•
60. 00 06000 LABORATORY		0. 1378			60.00
65. 00 06500 RESPIRATORY THERAPY		0. 1945			65.00
66. 00 06600 PHYSI CAL THERAPY		0. 2911			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2095			67.00
68. 00 06800 SPEECH PATHOLOGY		0.3517		72	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.5028		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 6463		45	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3249		4, 693	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 3732		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0, 4184		16, 770	
76.00 03020 ONCOLOGY		0. 8867		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 5011		0	76.97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 2516	59 0	0	90.00
91. 00 09100 EMERGENCY		0. 1647	44 26,005	4, 284	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0.8577		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			312, 209	68, 382	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			312, 209		202.00

Health Financial Systems JOH	INSON MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CO	CN: 15-0001	Peri od:	Worksheet D-3	;
				From 01/01/2017		
		Component (CCN: 15-T001	To 12/31/2017	Date/Time Pre 5/25/2018 3:4	epared:
		Ti †I	e XIX	Subprovider -	Cost	
				IRF		
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			[-		
30. 00 03000 ADULTS & PEDI ATRI CS				C		30.00
31. 00 03100 I NTENSI VE CARE UNI T				0		31.00
41.00 04100 SUBPROVIDER - IRF				78, 512		41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				C		43.00
			0. 1964	7	0	50.00
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY			0. 1964		-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 0355			
60. 00 06000 LABORATORY			0. 1378			
65. 00 06500 RESPIRATORY THERAPY			0. 1945			
66. 00 06600 PHYSI CAL THERAPY			0. 4101			
67. 00 06700 OCCUPATI ONAL THERAPY			0. 2095			
68. 00 06800 SPEECH PATHOLOGY			0. 3517			
69. 00 06900 ELECTROCARDI OLOGY			0. 5028			
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 6463		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 3249		-	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT			0. 3732			
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 4184		0	
76.00 03020 ONCOLOGY			0. 8867		o o	
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 5011		0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC			0. 2516	59 C	0 0	90.00
91.00 09100 EMERGENCY			0. 1647	44 C	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0.8577	39 C	0 0	92.00
200.00 Total (sum of lines 50 through 94 and 96 th	nrough 98)			78, 582	24, 262	200.00
201.00 Less PBP Clinic Laboratory Services-Program	n only charges	(line 61)		C		201.00
202.00 Net charges (line 200 minus line 201)				78, 582	2	202.00

1.00 D 1.01 D 1.02 D 1.03 D 1.03 D 1.04 D 2.00 O 2.01 O 2.02 O 3.00 M 4.00 B 5.00 F 7.01 A 3.01 T 3.01 T 3.02 T 10.00 F 11.00 F	ART A - INPATIENT HOSPITAL SERVICES UNDER IPPS RG Amounts Other than Outlier Payments RG amounts other than outlier payments for discharges occurr nstructions) RG amounts other than outlier payments for discharges occurr nstructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) utlier payments for discharges. (see instructions) utlier reconciliation amount utlier payment for discharges for Model 4 BPCI (see instruct lanaged Care Simulated Payments led days available divided by number of days in the cost repo	ring on or after October For discharges occurring	1 (see prior to October	5/25/2018 3: 4: PPS 1. 00 0 5, 311, 560 0	1.00
1.00 D 1.01 D 1.02 D 1.03 D 1.03 D 1.04 D 2.00 O 2.01 O 2.02 O 3.00 M 4.00 B 5.00 F 7.01 A 3.01 T 3.01 T 3.02 T 10.00 F 11.00 F	RG Amounts Other than Outlier Payments RG amounts other than outlier payments for discharges occurr nstructions) RG amounts other than outlier payments for discharges occurr nstructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) utlier payments for discharges. (see instructions) utlier reconciliation amount utlier payment for discharges for Model 4 BPCI (see instruct lanaged Care Simulated Payments red days available divided by number of days in the cost repo	ring on or after October For discharges occurring	1 (see prior to October	0 0 5, 311, 560 0	1. 01
1.00 D 1.01 D 1.02 D 1.03 D 1.03 D 1.04 D 2.00 O 2.01 O 2.02 O 3.00 M 4.00 B 5.00 F 7.01 A 3.01 T 3.01 T 3.02 T 10.00 F 11.00 F	RG Amounts Other than Outlier Payments RG amounts other than outlier payments for discharges occurr nstructions) RG amounts other than outlier payments for discharges occurr nstructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) utlier payments for discharges. (see instructions) utlier reconciliation amount utlier payment for discharges for Model 4 BPCI (see instruct lanaged Care Simulated Payments red days available divided by number of days in the cost repo	ring on or after October For discharges occurring	1 (see prior to October	0 0 5, 311, 560 0	1. 01
I. 01 DI i. 1. 02 DI i. 1. 03 DI 1. 03 DI 1. 04 DI 0. 02 01 2. 01 00 2. 02 00 3. 00 M 4. 00 Bi 5. 00 F 5. 00 F 7. 00 M 7. 01 A 3. 01 TI 3. 02 TI 13. 01 TI 14. 00 S 15. 00 F 16. 00 F	RG amounts other than outlier payments for discharges occurr nstructions) RG amounts other than outlier payments for discharges occurr nstructions) RG for federal specific operating payment for Model 4 BPCI f (see instructions) RG for federal specific operating payment for Model 4 BPCI f ictober 1 (see instructions) utlier payments for discharges. (see instructions) utlier reconciliation amount utlier payment for discharges for Model 4 BPCI (see instruct lanaged Care Simulated Payments red days available divided by number of days in the cost repo	ring on or after October For discharges occurring	1 (see prior to October	0 5, 311, 560 0	1. 01
1. 02 D 1. 03 D 1. 04 D 2. 00 00 2. 01 0 2. 02 00 3. 00 M 4. 00 B 17 0 5. 00 F 7. 00 M 7. 01 A 3. 01 T 9. 00 S 10. 00 F 11. 00 F	RG amounts other than outlier payments for discharges occurr nstructions) RG for federal specific operating payment for Model 4 BPCl f (see instructions) RG for federal specific operating payment for Model 4 BPCl f (ctober 1 (see instructions) utlier payments for discharges. (see instructions) utlier reconciliation amount utlier payment for discharges for Model 4 BPCl (see instruct lanaged Care Simulated Payments ed days available divided by number of days in the cost repo	for discharges occurring	prior to October	0	1. 02
1.03 DI 1 1 1.04 DI 2.00 00 2.01 00 2.02 00 3.00 M 4.00 Bit 5.00 F 7.00 M 7.01 A 3.00 A 3.01 T 3.02 T 9.00 S 10.00 F	RG for federal specific operating payment for Model 4 BPCl f (see instructions) RG for federal specific operating payment for Model 4 BPCl f (ctober 1 (see instructions) utlier payments for discharges. (see instructions) utlier reconciliation amount utlier payment for discharges for Model 4 BPCl (see instruct lanaged Care Simulated Payments ed days available divided by number of days in the cost repo	for discharges occurring		_	
1. 04 Di 2. 00 0 2. 01 0 2. 02 0 3. 00 M 4. 00 B 5. 00 F 5. 00 F 6. 00 F 7. 00 M 7. 01 A 3. 00 A 3. 00 T 9. 00 S 9. 00 F 10. 00 F 11.00 F	RG for federal specific operating payment for Model 4 BPCl f ictober 1 (see instructions) utlier payments for discharges. (see instructions) utlier reconciliation amount utlier payment for discharges for Model 4 BPCl (see instruct lanaged Care Simulated Payments ed days available divided by number of days in the cost repo	5 5	on or after	۱ ۱	1. 03
2.01 0 2.02 0 3.00 M 4.00 B 5.00 F 5.00 F 5.00 F 7.00 M 7.01 A 11 3.01 T 13.01 T 13.01 T 10.00 F 11.00 F	utlier reconciliation amount utlier payment for discharges for Model 4 BPCI (see instruct lanaged Care Simulated Payments wed days available divided by number of days in the cost repo	i ons)		0	1. 04
3.00 M 4.00 B 5.00 F 5.00 F 7.00 M 7.01 A 3.00 A 3.00 A 3.00 T 1.00 F 11.00 F	lanaged Care Simulated Payments ed days available divided by number of days in the cost repo	ions)		25, 235 0	2. 01
II 5.00 F 0 6 5.00 F 7.00 M 7.01 A 3.00 A 3.00 A 3.01 T 9.02 T 10.00 F 11.00 F	ž į	-		0	3.00
0 5.00 F 7.00 M 7.01 M 7.01 M 10 0 11 0.00 F 11.00 F 0 0 0 0 0 0 0 0 0 0 0 0 0	ndirect Medical Education Adjustment	¥ 1		80. 59	
fi 7. 00 M 7. 01 A 3. 00 A 3. 00 A 11 3. 01 T 13. 01 T 19. 00 S 10. 00 F 11. 00 F	TE count for allopathic and osteopathic programs for the mos r before 12/31/1996. (see instructions)			0.00	
7.01 A 3.00 A 3.01 Ti 3.02 Ti 3.02 Ii 9.00 Si 10.00 F 11.00 F	TE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e) MA Section 422 reduction amount to the IME cap as specified			0. 00 0. 00	
3. 00 A a 1' 3. 01 Ti 3. 02 Ti 9. 00 Si 10. 00 F 11. 00 F	CA § 5503 reduction amount to the IME cap as specified under ost report straddles July 1, 2011 then see instructions.			0.00	
3. 02 7. 00 10. 00 11. 00 7. 0	djustment (increase or decrease) to the FTE count for allopa ffiliated programs in accordance with 42 CFR 413.75(b), 413. 998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
9.00 Si 10.00 F 11.00 F	he amount of increase if the hospital was awarded FTE cap sleeport straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
i 10. 00 F 11. 00 F	he amount of increase if the hospital was awarded FTE cap slinder § 5506 of ACA. (see instructions)		0	0.00	
11.00 F	um of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin nstructions) To such for all and his and actorethic another the such			0.00	
	TE count for allopathic and osteopathic programs in the curr TE count for residents in dental and podiatric programs.	ent year from your reco	ras	0.00	10.00 11.00 12.00
	urrent year allowable FTE (see instructions) otal allowable FTE count for the prior year.				13.00
0	otal allowable FTE count for the penultimate year if that ye therwise enter zero.	ear ended on or after Sep	ptember 30, 1997,	0.00	14.00
	um of lines 12 through 14 divided by 3. djustment for residents in initial years of the program				15.00 16.00
	djustment for residents displaced by program or hospital clo	sure			17.00
	djusted rolling average FTE count				18.00
	urrent year resident to bed ratio (line 18 divided by line 4			0.00000	
	rior year resident to bed ratio (see instructions)			0. 000000 0. 000000	
	nter the lesser of lines 19 or 20 (see instructions) ME payment adjustment (see instructions)			0.000000	
	ME payment adjustment - Managed Care (see instructions)			0	
23.00 N	ndirect Medical Education Adjustment for the Add-on for § 42 lumber of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.00
24. 00 👔	f)(1)(iv)(C). ME FTE Resident Count Over Cap (see instructions)			0.00	
i	f the amount on line 24 is greater than -0-, then enter the nstructions)	lower of line 23 or line	e 24 (see		25.00
27.00 11	esident to bed ratio (divide line 25 by line 4) ME payments adjustment factor. (see instructions)			0. 000000 0. 000000	
	ME add-on adjustment amount (see instructions)			0	
	ME add-on adjustment amount - Managed Care (see instructions	5)		0	
29. 01 <u>T</u>	otal IME payment (sum of lines 22 and 28) otal IME payment – Managed Care (sum of lines 22.01 and 28.0 isproportionate Share Adjustment	01)		0	
	isproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	atient davs (see instru	ctions)	2.57	30.00
	ercentage of Medicaid patient days (see instructions)				31.00
	CICCITENCE OF MEDICALA PALICIL UAVA LACE HISTIUCTIONAL				32.00
33.00 A 34.00 D	um of lines 30 and 31				33.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre	narod
				5/25/2018 3:4	
		Title XVIII	Hospital Prior to 10/1	PPS	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0. 00000000	0.00000000	
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	zero on this line) (see	e 287, 693	605, 548	35.02
35. 03	Pro rata share of the hospital uncompensated care payment amou	nt (see instructions)	215, 179	152, 631	35. 0
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		367, 810		36.0
	Additional payment for high percentage of ESRD beneficiary dis				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding c	lischarges for MS-DRGs	0		40.0
41.00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	3 684 an 685 (see	0		41.0
	instructions)		Ū		
41.01	Total ESRD Medicare covered and paid discharges excluding MS-D	RGs 652, 682, 683, 684	0		41.0
10 00	an 685. (see instructions)		0.00		100
42.00 43.00	Divide line 41 by line 40 (if less than 10%, you do not qualif Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682		0.00		42.0 43.0
43.00	instructions)	., 003, 004 an 003. (See	0		43.0
44.00	Ratio of average length of stay to one week (line 43 divided b	y line 41 divided by 7	0. 000000		44.00
	days)				
45.00 46.00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.		0.00		45.0 46.0
48.00	Subtotal (see instructions)	01)	5, 799, 416		40.0
48.00	Hospital specific payments (to be completed by SCH and MDH, sm	all rural hospitals	0		48.0
	only. (see instructions)	•			
				Amount	
49.00	Total payment for inpatient operating costs (see instructions)			<u>1.00</u> 5,799,416	49.0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			433, 289	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.0
52.00	Direct graduate medical education payment (from Wkst. E-4, lir	e 49 see instructions).		0	52.0
53.00	Nursing and Allied Health Managed Care payment			0	53.0
54.00 54.01	Special add-on payments for new technologies Islet isolation add-on payment			0	54.0 54.0
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	2)		0	55.0
56.00	Cost of physicians' services in a teaching hospital (see intru			0	56.0
57.00	Routine service other pass through costs (from Wkst. D, Pt. II		rough 35).	0	57.0
58.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 11 line 200)		0	58.0
59.00	Total (sum of amounts on lines 49 through 58)			6, 232, 705	
60.00 61.00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	line 60)		3, 862 6, 228, 843	
62.00	Deductibles billed to program beneficiaries	The boy		764, 428	
63.00	Coinsurance billed to program beneficiaries			0	63.0
64.00	Allowable bad debts (see instructions)			73, 229	64.0
65.00	Adjusted reimbursable bad debts (see instructions)			47, 599	
66.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		73, 229	
67.00 68.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for a	upplicable to MS DDCs (so	o instructions)	5, 512, 014 0	67.C
59.00 59.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69.0
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,,	0	70.0
70. 50	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) adjustment (see i	nstructions)	0	70.5
70. 87	Demonstration payment adjustment amount before sequestration			0	70.8
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.8
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	ructions)			70.8
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	
70.91	Bundled Model 1 discount amount (see instructions)			0	70.9
70.93	HVBP payment adjustment amount (see instructions)			24, 774	
70. 94	HRR adjustment amount (see instructions)			0	
0.95	Recovery of accelerated depreciation			0	70.

	ION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0001	Peri od:	Worksheet E	255
				From 01/01/2017	Part A	
				To 12/31/2017	Date/Time Pre 5/25/2018 3:4	
		Title	× XVIII	Hospi tal	PPS	o p
			FFY	′ (yyyy)	Amount	
				0	1.00	
	ow volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70
	ne corresponding federal year for the period prior to 10/1)			-	_	
	ow volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70
	ne corresponding federal year for the period ending on or af	ter 10/1)			0	_,
1	bw Volume Payment-3				0	
	AC adjustment amount (see instructions)	(0 0 70)			0	1
	nount due provider (line 67 minus lines 68 plus/minus lines -	69 & 70)			5, 536, 788	
	equestration adjustment (see instructions)				110, 736	
	emonstration payment adjustment amount after sequestration nterim payments				0 5, 453, 961	
	entative settlement (for contractor use only)				5, 455, 901	73
1	alance due provider/program (line 71 minus lines 71.01, 71.0	2 72 and			-27, 909	
	3)	2, 72, and			-27, 909	1
	rotested amounts (nonallowable cost report items) in accorda	nce with			94, 228	75
	MS Pub. 15-2, chapter 1, §115.2				, 1, 220	
	BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1	I		
	perating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	9
	apital outlier from Wkst. L, Pt. I, line 2	,			0	9
	perating outlier reconciliation adjustment amount (see instr	uctions)			0	9
00 Ca	apital outlier reconciliation adjustment amount (see instruc	tions)			0	9
00 Tł	he rate used to calculate the time value of money (see instr	uctions)			0.00	94
00 Ti	me value of money for operating expenses (see instructions)				0	9
. 00 Ti	me value of money for capital related expenses (see instruc	tions)			0	90
				Prior to 10/1	On/After 10/1	
				1.00	2.00	
LDC.						
	P Bonus Payment Amount					14.04
о. оо <u>н</u> е	SP bonus amount (see instructions)			0	0	10
о. оо не ну	SP bonus amount (see instructions) /BP Adjustment for HSP Bonus Payment					
D. 00 HS HV 1. 00 HV	SP bonus amount (see instructions) /BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions)	c)		0. 000000000	0.000000000	10 ⁻
0.00 HS HV 1.00 H\ 2.00 H\	SP bonus amount (see instructions) /BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction	s)			0.000000000	10 ⁻
0.00 HS HV 1.00 H\ 2.00 H\ HR	SP bonus amount (see instructions) /BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment	s)		0. 0000000000	0.0000000000000000000000000000000000000	10 10
D. 00 HS HV 1. 00 HN 2. 00 HN HR 3. 00 HF	SP bonus amount (see instructions) /BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment RR adjustment factor (see instructions)			0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000	10 10 10
D. 00 HS HV 1. 00 HV 2. 00 HV HR 3. 00 HF 4. 00 HF	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction R Adjustment for HSP Bonus Payment R adjustment factor (see instructions) R adjustment amount for HSP bonus payment (see instructions)	stmant	0. 0000000000	0. 000000000 0 0. 0000	10 10 10
D. 00 HS HV 1. 00 HV 2. 00 HV HR 3. 00 HF 4. 00 HF Ru	SP bonus amount (see instructions) /BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) RR adjustment amount for HSP bonus payment (see instructions) INR adjustment amount for HSP bonus payment (see instructions) INR adjustment yespital Demonstration Project (§410A Demonstration)) ration) Adju		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 10 10 10
D. 00 HS HV 1. 00 HV 2. 00 HV 4. 00 HF 4. 00 HF Ru D. 00 I S	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment RR adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) ral Community Hospital Demonstration Project (§410A Demonstration pe s this the first year of the current 5-year demonstration pe) ration) Adju		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 10 10 10
D. 00 HS HV 1. 00 HV 2. 00 HV 3. 00 HF 4. 00 HF Ru D. 00 I s Ce	SP bonus amount (see instructions) /BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) RR adjustment amount for HSP bonus payment (see instructions) INR adjustment amount for HSP bonus payment (see instructions) INR adjustment yespital Demonstration Project (§410A Demonstration)) ration) Adju		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 ⁻ 10: 10: 104
0. 00 HS HV 1. 00 HV 2. 00 HV 4. 00 HF 4. 00 HF Ru 0. 00 I s Ce Co	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment RR adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) rral Community Hospital Demonstration Project (§410A Demonstr s this the first year of the current 5-year demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 ⁻ 10: 10: 104 200
2. 00 HS HV 2. 00 HN 2. 00 HN 3. 00 HF 4. 00 HF Ru 0. 00 I s Ce Co 1. 00 Me	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction RR Adjustment for HSP Bonus Payment RR adjustment factor (see instructions) RR adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) ral Community Hospital Demonstration Project (§410A Demonstructions) is this the first year of the current 5-year demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no.) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 10 10 10 20
2. 00 HS HV 2. 00 HV 2. 00 HV 4. 00 HF 4. 00 HF 2. 00 Me Co 1. 00 Me 2. 00 Me	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP Adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) real Community Hospital Demonstration Project (§410A Demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. sist Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, Iin) ration) Adju riod under t		0. 000000000000000000000000000000000000	0. 000000000 0 0. 0000 0	10 ⁻ 102 102 200 200
2. 00 HS HV 2. 00 HV 2. 00 HV 4. 00 HF 4. 00 HF 4. 00 HF Co Co 1. 00 Me 2. 00 Me 3. 00 Ca	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP Adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) real Community Hospital Demonstration Project (§410A Demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. sst Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, lin edicare discharges (see instructions)) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 10 10 10 20 20
0. 00 H9 HV 2. 00 HN 2. 00 HN 4. 00 HF 4. 00 HF 4. 00 HF CO CO 1. 00 Me 2. 00 Me 3. 00 C2 CO DO CO	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) real Community Hospital Demonstration Project (§410A Demonstr s this the first year of the current 5-year demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. Ist Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, line edicare discharges (see instructions) ase-mix adjustment factor (see instructions) imputation of Demonstration Target Amount Limitation (N/A in eriod)) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 10 10 10 20 20
0. 00 HS HV 2. 00 HV 2. 00 HV 2. 00 HV 4. 00 HF 4. 00 HF Co Co 1. 00 Me 3. 00 Ca Co PC Co PC Co Co Co Co Co Co Co	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment /BP adjustment factor (see instructions) /BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) st his the first year of the current 5-year demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. Ist Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, Iin edicare discharges (see instructions) ase-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in priod) edicare target amount) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 [°] 102 102 104 200 200 200 200 200
2. 00 HS HV 2. 00 HV 2. 00 HV 4. 00 HF 4. 00 HE 2. 00 ME 2. 00 ME 3. 00 C2 C0 DE 4. 00 ME 5. 00 C2	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP Adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) real Community Hospital Demonstration Project (§410A Demonstration peentury Cures Act? Enter "Y" for yes or "N" for no. so this the first year of the current 5-year demonstration peentury Cures Act? Enter "Y" for yes or "N" for no. so the impatient service costs (from Wkst. D-1, Pt. II, Iin edicare inpatient service costs (from Wkst. D-1, Pt. II, Iin edicare discharges (see instructions) ase-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in eri od) edicare target amount ase-mix adjusted target amount (line 203 times line 204)) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10° 102 102 200 200 200 200 200 200 200 200
0. 00 HS HV . 00 HV . 00 HV . 00 HV HR . 00 HF . 00 HF CO CO . 00 Me . 00 Ca . 00 Me . 00 Ca . 00 Me . 00 Ca . 00 Me	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP Adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) real Community Hospital Demonstration Project (§410A Demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. set Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, lin edicare discharges (see instructions) ase-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in eri od) edicare target amount ase-mix adjusted target amount (line 203 times line 204) edicare inpatient routine cost cap (line 202 times line 205)) ration) Adju riod under t e 49)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 10 10 10 20 20 20 20 20 20 20
0.00 HS 1.00 HV 2.00 HV 2.00 HR 3.00 HF 3.00 HF 4.00 HF 0.00 I s 0.00 I s 0.00 Me 2.00 Me 3.00 Co 4.00 Me 5.00 Ca 6.00 Ca 6.00 Ca 6.00 Ca 6.00 Ca 6.00 Ca	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment factor (see instructions) (R Adjustment for HSP Bonus Payment (see instructions) (R adjustment factor (see instructions) (R adjustment factor (see instructions) (see inpatient service costs (from Wkst. D-1, Pt. II, line (see instructions) (see-mix adjustment factor (see instructions) (see-mix adjustment factor (see instructions) (see-mix adjusted target amount (line 203 times line 204) (sed icare inpatient routine cost cap (line 202 times line 205) (justment to Medicare Part A Inpatient Reimbursement) ration) Adju riod under t e 49) first year	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 ¹ 102 102 200 200 202 203 204 205 204
b. 00 HS HV HV HV HV HV HR HR HR HF HF HV HF HV <td>SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) RR adjustment amount for HSP bonus payment (see instructions) RR adjustment amount for HSP bonus payment (see instructions) RR adjustment factor (see instructions) RR adjustment factor (see instructions) at this the first year of the current 5-year demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. Dest Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, line edicare discharges (see instructions) ase-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) edicare target amount ase-mix adjusted target amount (line 203 times line 204) edicare inpatient routine cost cap (line 202 times line 205) Ij ustment to Medicare Part A Inpatient Reimbursement rogram reimbursement under the §410A Demonstration (see inst</td> <td>) ration) Adju riod under t e 49) first year ructions)</td> <td>he 21st</td> <td>0.0000000000000000000000000000000000000</td> <td>0.000000000 0 0.0000 0</td> <td>102 103 104 200 201 202 203 204 205 206 206 206 206</td>	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment factor (see instructions) RR adjustment amount for HSP bonus payment (see instructions) RR adjustment amount for HSP bonus payment (see instructions) RR adjustment amount for HSP bonus payment (see instructions) RR adjustment factor (see instructions) RR adjustment factor (see instructions) at this the first year of the current 5-year demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. Dest Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, line edicare discharges (see instructions) ase-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in riod) edicare target amount ase-mix adjusted target amount (line 203 times line 204) edicare inpatient routine cost cap (line 202 times line 205) Ij ustment to Medicare Part A Inpatient Reimbursement rogram reimbursement under the §410A Demonstration (see inst) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	102 103 104 200 201 202 203 204 205 206 206 206 206
0. 00 HS HV . 00 HV 2. 00 HV 2. 00 HV B. 00 HF B. 00 HF CC CC CC CC CC CC CC CC CC CC CC CC CC	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction RR Adjustment factor (see instructions) RR adjustment factor (see instructions) St his the first year of the current 5-year demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. Set Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, line edicare discharges (see instructions) ase-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in eriod) edicare target amount ase-mix adjusted target amount (line 203 times line 204) edicare inpatient routine cost cap (line 202 times line 205) justment to Medicare Part A Inpatient Reimbursement rogram reimbursement under the §410A Demonstration (see inst edicare Part A inpatient service costs (from Wkst. E, Pt. A,) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 ¹ 102 102 200 200 203 203 203 204 205 204 205 204 205 204 205 204
2. 00 HS HV 1. 00 HV 2. 00 HV 3. 00 HF 4. 00 HF 4. 00 HF 4. 00 ME 2. 00 ME 5. 00 C2 5. 00 C2 5. 00 ME 5. 00 ME 5. 00 ME 5. 00 ME 5. 00 AC	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP Adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction (R Adjustment factor (see instructions) R adjustment factor (see instructions) R adjustment amount for HSP bonus payment (see instructions) ral Community Hospital Demonstration Project (§410A Demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. sst Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, lin edicare discharges (see instructions) ase-mix adjustment factor (see instructions) edicare target amount ase-mix adjusted target amount (line 203 times line 204) edicare inpatient routine cost cap (line 202 times line 205) ijustment to Medicare Part A Inpatient Reimbursement rogram reimbursement under the §410A Demonstration (see inst edicare Part A inpatient service costs (from Wkst. E, Pt. A, djustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	101 102 103 200 202 203 203 204 205 206 206 206 206 206
D. OO HS 1. OO HV 2. OO HN 2. OO HN 3. OO HR 3. OO HF 4. OO HS CO Ru CO 1. OO ME 2. OO ME 3. OO CO CO ME CO 4. OO ME 5. OO CO 6. OO ME 7. OO AO	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP Adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction R Adjustment factor (see instructions) R adjustment factor (see instructions) R adjustment amount for HSP bonus payment (see instructions) ral Community Hospital Demonstration Project (§410A Demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. sist Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, lin edicare discharges (see instructions) ase-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in eriod) edicare target amount ase-mix adjusted target amount (line 203 times line 204) edicare inpatient routine cost cap (line 202 times line 205) Ij ustment to Medicare Part A Inpatient Reimbursement rogram reimbursement under the §410A Demonstration (see inst edicare Part A inpatient service costs (from Wkst. E, Pt. A, djustment to Medicare IPPS payments (see instructions) eserved for future use) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 ⁻ 10 ⁻ 10 ⁻ 20 ⁻ 2
0.00 HS 1.00 HV 1.00 HV 2.00 HN 2.00 HN 3.00 HF 4.00 HF 0.00 HS 0.00 HS 0.00 HS 0.00 HS 0.00 HS 0.00 ME 2.00 ME 3.00 C2 6.00 C2 5.00 C2 5.00 ME 3.00 ME 3.00 ME 5.00 ME 6.00 ME 7.00 ME 9.00 Ac 0.00 Re 0.00 T 0.00 T	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP Adjustment factor (see instructions) (BP adjustment amount for HSP bonus payment (see instruction R Adjustment factor (see instructions) R adjustment factor (see instructions) R adjustment amount for HSP bonus payment (see instructions) ral Community Hospital Demonstration Project (§410A Demonstration pe entury Cures Act? Enter "Y" for yes or "N" for no. set Reimbursement edicare inpatient service costs (from Wkst. D-1, Pt. II, lin edicare discharges (see instructions) ase-mix adjustment factor (see instructions) mputation of Demonstration Target Amount Limitation (N/A in eri od) edicare target amount ase-mix adjusted target amount (line 203 times line 204) edicare inpatient routine cost cap (line 202 times line 205) Ijustment to Medicare Part A Inpatient Reimbursement "orgam reimbursement under the §410A Demonstration (see inst edicare Part A inpatient service costs (from Wkst. E, Pt. A, djustment to Medicare IPPS payments (see instructions) eserved for future use total adjustment to Medicare IPPS payments (see instructions)) ration) Adju riod under t e 49) first year ructions)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 ⁻ 10 ⁻ 10 ⁻ 20 ⁻ 2
0.00 HS HV 1.00 HV 2.00 HV 2.00 HF 4.00 HF 4.00 HF 4.00 HF 4.00 MF 2.00 MF 2.00 MF 3.00 C2 6.00 MF 5.00 C2 6.00 MF 5.00 C2 6.00 MF 4.00 Pr 8.00 MF 7.00 Pr 8.00 MF 7.00 Pr 8.00 MF 7.00 Pr 8.00 MF	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment factor (see instructions) (R Adjustment for HSP Bonus Payment (R Adjustment factor (see instructions) (R adjustment factor (see instructions) (S adjustment factor (see instructions) (S adjustment factor (see instructions) (S this the first year of the current 5-year demonstration per (set Reimbursement (see inpatient service costs (from Wkst. D-1, Pt. II, Iin (see adjustment factor (see instructions)) (ase-mix adjusted target amount (line 203 times line 204)) (adjustment to Medicare Part A Inpatient Reimbursement (see instructions)) (aser part A inpatient service costs (from Wkst. E, Pt. A, (djustment to Medicare IPPS payments (see instructions)) (seerved for future use (see instructions)) (see instructions)) (seerved for future use (see instructions)) (seerved for future use (seerved for fut) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 ⁻¹ 102 102 200 202 202 203 204 205 206 206 206 206 206 210
0.00 HS HV 1.00 HV 2.00 HV 3.00 HF 4.00 HF 4.00 HF 4.00 HF 4.00 HF 3.00 C2 0.00 Mc 5.00 C2 6.00 Mc 5.00 C2 6.00 Mc 5.00 C2 6.00 Mc 7.00 Pr 8.00 Mc 2.00 Nc 2.00 C2 0.00 C2 0.0	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment factor (see instructions) (BP adjustment factor (see instructions) (BR adjustment to Medicare Part A Inpatient Reimbursment (See instructions) (BR adjustment to Medicare IPPS payments (see instructions) (BR adjustment to Medicare IPPS payments (see instructions) (BR adjustment to Medicare IPPS payments (see instructions) (BR adjustment to Medicare Part A INPATIENT (SEE INSTRUCTIONS) (BR adjustment to Medicare PART A INPATIENT (SEE INSTRUCTIONS) (BR adjustment to Medicare IPPS payments (see instructions) (BR adjustment to Medicare PART A INPATIENT (SEE INSTRUCTIONS) (BR adjustment to Medica) ration) Adju riod under t e 49) first year ructions) line 59)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0	10 ⁻ 102 200 200 200 200 200 200 200 200 200
0.00 HS HV 1.00 HV 2.00 HV 2.00 HV 3.00 HF 4.00 HF 4.00 HF 4.00 HF 2.00 Mc 2.00 Mc 3.00 C2 0 Mc 3.00 C2 0 Mc 3.00 C2 0 Mc 4.00 Mc 5.00 C2 6.00 Mc 7.00 Pr 8.00 Mc 7.00 Pr 8.00 Mc 2.00 Rc 1.00 C2 0.00 Rc 1.00 C2 0.00	SP bonus amount (see instructions) (BP Adjustment for HSP Bonus Payment (BP adjustment factor (see instructions) (BP adjustment factor (see instructions) (R Adjustment for HSP Bonus Payment (R Adjustment factor (see instructions) (R adjustment factor (see instructions) (S adjustment factor (see instructions) (S adjustment factor (see instructions) (S this the first year of the current 5-year demonstration per (set Reimbursement (see inpatient service costs (from Wkst. D-1, Pt. II, Iin (see adjustment factor (see instructions)) (ase-mix adjusted target amount (line 203 times line 204)) (adjustment to Medicare Part A Inpatient Reimbursement (see instructions)) (aser part A inpatient service costs (from Wkst. E, Pt. A, (djustment to Medicare IPPS payments (see instructions)) (seerved for future use (see instructions)) (see instructions)) (seerved for future use (see instructions)) (seerved for future use (seerved for fut) ration) Adju riod under t e 49) first year ructions) line 59) 211)	he 21st	0.0000000000000000000000000000000000000	0.000000000 0 0.0000 0 :rati on	10 ¹ 102 102 200 200 202 203 204 205 204

W VO	LUME CALCULATION EXHIBIT 4			Provider CC		Period: From 01/01/2017	Worksheet E Part A Exhibi	+ -
						To 12/31/2017	Date/Time Pre	par
				Title	XVIII	Hospi tal	5/25/2018 3:4 PPS	3 [
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
0	DRG amounts other than outlier	1.00	0	2.00		4.00		
)1	payments DRG amounts other than outlier	1.01	0	0		0	0	
2	payments for discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	5, 311, 560	0		5, 311, 560	5, 311, 560	
3	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1. 03	O	0		0	0	
4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	
0	Outlier payments for	2.00	25, 235	0		0 25, 235	25, 235	
)1	discharges (see instructions) Outlier payments for	2. 02	0	0		o o	0	
00	discharges for Model 4 BPCI Operating outlier	2. 01	О	0		0 0	0	
00	reconciliation Managed care simulated payments	3.00	0	0		o o	0	
	Indirect Medical Education Adju		0.000000	0.000000	0.00000			
0	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 00000			
0	IME payment adjustment (see instructions)	22.00	0	0		0 0	0	
1	IME payment adjustment for managed care (see instructions)	22.01	0	0		0 0	0	
_	Indirect Medical Education Adju							
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 00000	0 0. 000000		
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0		o o	0	
1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0		0 0	0	
	Disproportionate Share Adjustme							
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0714	0. 0714	0. 071	4 0.0714		1
00	Disproportionate share adjustment (see instructions)	34.00	94, 811	0		0 94, 811	94, 811	1
01	Uncompensated care payments Additional payment for high per	36.00	367,810	0 di scharges	215, 17	9 152, 631	367, 810	1
00	Total ESRD additional payment (see instructions)	46.00	0	0 0		0 0	0	1
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	5, 799, 416 0	0 0	215, 17	9 5, 584, 237 0 0	5, 799, 416 0	
00	small rural hospitals only.) (see instructions) Total payment for inpatient	49.00	5, 799, 416	О	215, 17	9 5, 584, 237	5, 799, 416	1
00	operating costs (see instructions) Payment for inpatient program	50.00	433, 289	0		0 433, 289	433, 289	1
	capital (from Wkst. L, Pt. I, if applicable)							
00	Special add-on payments for new technologies	54.00	0	0		0 0	0	1
01 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	о	0		o o	0	1

	Financial Systems		JOHNSON MEMORI				u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2017 To 12/31/2017	5/25/2018 3:4	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
10 00	SUBTOTAL			0	215, 17	6, 017, 526	6, 232, 705	10 00
19.00	JUDIOTAL	W/S L, line	(Amounts from L)		213, 17	, 0, 017, 320	0, 232, 703	17.00
		0	1.00	2.00	3.00	4,00	5,00	
20.00	Capital DRG other than outlier	1.00	430, 835	0		430, 835	430, 835	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 0 ⁴
21.00	Capital DRG outlier payments	2.00	2, 454	0		2, 454	2, 454	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 0 [.]
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0.0000		22.0
23. 00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25. 0
26. 00	Total prospective capital payments (see instructions)	12.00	433, 289	0		433, 289	433, 289	26. 0
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70.96			0. 09214 19, 82		19, 827	27.0 28.0
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				620, 022	620, 022	29.0
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. 00

1105111	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5	Provider CC		Period: From 01/01/2017	Worksheet E Part A Exhibi	
					To 12/31/2017	Date/Time Prep 5/25/2018 3:43	
				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	0		0	0	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5, 311, 560		5, 311, 560	5, 311, 560	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
2.00	Outlier payments for discharges (see instructions)	2.00	25, 235		0 25, 235	25, 235	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 Indirect Medical Education Adjustment	3.00	0		0 0	0	4.00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0 0. 000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22.00	0		0 0	0	6. 01
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0 0. 000000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0	8.00 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. 0714	0. 071	4 0.0714		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	94, 811		0 94, 811	94, 811	11.00
11.01	Uncompensated care payments	36.00	367, 810	215, 17	9 152, 631	367, 810	11.0
	Additional payment for high percentage of ESR						1
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	5, 799, 416 0		9 5, 584, 237 0 0		13.00 14.00
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	5, 799, 416	215, 17	9 5, 584, 237	5, 799, 416	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	433, 289		0 433, 289	433, 289	16.00
17.00 17.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17.00 17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
	Capital outlier reconciliation adjustment	93.00	0		0 0	0	18.00
18.00	amount (see instructions)	73.00	, i i i i i i i i i i i i i i i i i i i			Ű	

	Financial Systems	JOHNSON MEMOR				In Lie	u of Form CMS-:	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO	CN: 15-0001		od: 01/01/2017 12/31/2017		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	430, 835		0	430, 835	430, 835	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	2, 454		0	2, 454	2,454	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.00	00	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	0.00	00	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	433, 289		0	433, 289	433, 289	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	24, 774		0	24, 774	24, 774	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	0		0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	0	31.01
							(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00		3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0	0	0	02.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N					100. 00

LCUL	Financial Systems JOHNSON MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Peri od:	worksheet E	
			From 01/01/2017 To 12/31/2017	Part B Date/Time Pre	pare
			lloopital	5/25/2018 3:4	3 pr
		Title XVIII	Hospi tal	PPS	
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			1, 261	1 1
00	Medical and other services reimbursed under OPPS (see instruc	tions)		7, 322, 706	
00	OPPS payments			5, 666, 259	3
00	Outlier payment (see instructions)			31, 391	
01	Outlier reconciliation amount (see instructions)			0	
00 00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ctions)		0.000	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0.00	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9
. 00	Organ acqui si ti ons			0	10
. 00	Total cost (sum of lines 1 and 10) (see instructions)			1, 261	11
	COMPUTATION OF LESSER OF COST OR CHARGES				-
. 00	Reasonable charges Ancillary service charges			3, 590	1 12
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
	Total reasonable charges (sum of lines 12 and 13)			3, 590	14
	Customary charges				
. 00	Aggregate amount actually collected from patients liable for				15
. 00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16
. 00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17
	Total customary charges (see instructions)			3, 590	
. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	2, 329	
	instructions)	5			
. 00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20
. 00	instructions) Lesser of cost or charges (see instructions)			1, 261	21
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			5, 697, 650	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Deductibles and coinsurance (for CAH, see instructions)			0	
0.00	Deductibles and Coinsurance relating to amount on line 24 (fo			1, 166, 093	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of fiftes 2.	z and z3] (see	4, 532, 818	21
. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29
	Subtotal (sum of lines 27 through 29)			4, 532, 818	
	Primary payer payments			241	
. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	(ES)		4, 532, 577	32
. 00	Composite rate ESRD (from Wkst. I-5, line 11)	623)		0	33
	Allowable bad debts (see instructions)			139, 102	
. 00	Adjusted reimbursable bad debts (see instructions)			90, 416	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		139, 102	
. 00	Subtotal (see instructions)			4, 622, 993	
	MSP-LCC reconciliation amount from PS&R			0	
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	c)		0	39
. 97	Demonstration payment adjustment amount before sequestration	5)		0	
. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION		-	0	
. 00	Subtotal (see instructions)			4, 622, 993	
. 01	Sequestration adjustment (see instructions)			92, 460	
	Demonstration payment adjustment amount after sequestration			0	
. 00 . 00	Interim payments Tentative settlement (for contractors use only)			4, 511, 190 0	
. 00	Balance due provider/program (see instructions)			19, 343	
. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2.	chapter 1,	0	
-	§115. 2		· · ·		
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90
	Outlier reconciliation adjustment amount (see instructions)			0.00	
00	The rate used to calculate the Time Value of Money				1 72
. 00	Time Value of Money (see instructions)			∩	93

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2017 To 12/31/2017		
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5, 374, 14	6	4, 441, 508	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider	<u> </u>				
3.01	ADJUSTMENTS TO PROVIDER	12/31/2017	79, 81	5 12/31/2017	69, 682	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05	Provider to Program			0	0	3.05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		79, 81	5	69, 682	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 453, 96	1	4, 511, 190	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		-,,			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50 5.51	TENTATIVE TO PROGRAM			0	0	5.50
5.52				0	0	5. 52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER			0	19, 343	6.01
6.02	SETTLEMENT TO PROGRAM		27,90		0	6.02
7.00	Total Medicare program liability (see instructions)		5, 426, 05	2 Contractor	4, 530, 533 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		C)	1.00	2.00	
8.00	Name of Contractor					8.00

ALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0001 CCN: 15-T001	Period: From 01/01/201 To 12/31/201		parec
		Title	XVIII	Subprovider -		0 011
		I npati en	t Part A		nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		860, 3	71 0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.(
02				0	0	
03				0	0	
04				0	0	
05				0	0	3.
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	1 2
50 51	ADJUSTMENTS TO PROGRAM			0	0	
52				0	0	
52 53				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
,,	3. 50-3. 98)			0		
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)		860, 3	71	0	4
	TO BE COMPLETED BY CONTRACTOR					1
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1) Program to Provider					-
)1	TENTATI VE TO PROVIDER			0	0	15
)2				0	0	
)3				0	0	
	Provider to Program					1
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER			0	0	6
)2	SETTLEMENT TO PROVIDER		12, 1	59	0	
)0	Total Medicare program liability (see instructions)		848, 2		0	
-			0.0,2	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der	CCN: 15-0001	Period: From 01/01/2017	Worksheet E-1 Part II	
					To 12/31/2017		
			Ti tl	e XVIII	Hospi tal	PPS	
						1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARE						-
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION						
1.00	Total hospital discharges as defined in AARA			col. 15 line	14		1.00
							2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2						3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 s	sum of lines 1, 8-	12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, co	ol. 8 line 200					5.00
6.00	Total hospital charity care charges from Wks	t. S-10, col. 3 li	ne 20				6.00
7.00	CAH only - The reasonable cost incurred for	the purchase of ce	ertified HI	T technology	Wkst. S-2, Pt. I		7.00
	line 168						
8.00	Calculation of the HIT incentive payment (see	e instructions)					8.00
9.00	Sequestration adjustment amount (see instruct	tions)					9.00
	Calculation of the HIT incentive payment after		see instru	uctions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &			,			1
30.00	Initial/interim HIT payment adjustment (see i	nstructions)					30.00
	Other Adjustment (specify)						31.00
	Balance due provider (line 8 (or line 10) min	nus line 30 and li	ne 31) (se	e instruction	s)		32.00

	Financial Systems JOHNSON MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet E-3	2552
ALCUL	ATTOM OF RELMDORSEMENT SETTLEMENT	Component CCN: 15-T001	From 01/01/2017 To 12/31/2017	Part III Date/Time Pre	pare
		Title XVIII	Subprovider -	5/25/2018 3:4 PPS	3 pm
			I RF		
				1.00	
00	PART III - MEDICARE PART A SERVICES - IRF PPS			7// 0//	1
00	Net Federal PPS Payment (see instructions)			766, 864 0. 0201	1. 2.
00	Medicare SSI ratio (IRF PPS only) (see instructions) Inpatient Rehabilitation LIP Payments (see instructions)			29, 831	3.
00	Outlier Payments			75, 407	4.
00	Unweighted intern and resident FTE count in the most recent c	cost reporting period en	ding on or prior	0.00	5.
00	to November 15, 2004 (see instructions)	bot reporting period en	ang on or prior	0.00	
01	Cap increases for the unweighted intern and resident FTE coun	nt for residents that wer	e displaced by	0.00	5
	program or hospital closure, that would not be counted withou	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
00	teaching program" (see instructions)	+h		0.00	
00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	8
00	teaching program" (see instructions) Intern and resident count for IRF PPS medical education adjus	tmont (coo instructions)		0.00	9
00	Average Daily Census (see instructions)			3. 775342	
. 00	Teaching Adjustment Factor (see instructions)			0.000000	
2.00	Teaching Adjustment (see instructions)			0.000000	12
. 00	Total PPS Payment (see instructions)			872, 102	
. 00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	14
5.00	Organ acquisition (DO NOT USE THIS LINE)			-	15
6. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	16
. 00	Subtotal (see instructions)			872, 102	17
8.00	Primary payer payments			0	18
. 00	Subtotal (line 17 less line 18).			872, 102	19
. 00	Deducti bl es			6, 580	
. 00	Subtotal (line 19 minus line 20)			865, 522	
. 00				0	22
3.00	Subtotal (line 21 minus line 22)			865, 522	
1.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		0	24
5.00 5.00	Adjusted reimbursable bad debts (see instructions)	ructions)		0	25 26
7.00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (sum of lines 23 and 25)	i uctions)		865, 522	27
. 00 3. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		005, 522	28
0.00	Other pass through costs (see instructions)			0	29
. 00	Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	31
. 99	Demonstration payment adjustment amount before sequestration			0	31
2. 00	Total amount payable to the provider (see instructions)			865, 522	32
2. 01	Sequestration adjustment (see instructions)			17, 310	32
. 02	Demonstration payment adjustment amount after sequestration				32
. 00	Interim payments			860, 371	
. 00	Tentative settlement (for contractor use only)			0	34
5.00	Balance due provider/program (line 32 minus lines 32.01, 32.0		-h	-12, 159	
6. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ince with CMS Pub. 15-2,	cnapter 1,	5, 072	36
	TO BE COMPLETED BY CONTRACTOR		1		
0.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			75, 407	
. 00	Outlier reconciliation adjustment amount (see instructions)			0	51
2.00	The rate used to calculate the Time Value of Money			0.00	52

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT P	rovider CCN: 15-0001	Peri od:	Worksheet E-3	2552-10
			From 01/01/2017 To 12/31/2017	Part VII Date/Time Pre 5/25/2018 3:4	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR X	I X SERVICES		-
	COMPUTATION OF NET COST OF COVERED SERVICES		104.000		
1.00	Inpatient hospital/SNF/NF services		124, 292	0	1.00
2.00	Medical and other services		0	0	
3.00 4.00	Organ acquisition (certified transplant centers only) Subtotal (sum of lines 1, 2 and 3)		0 124, 292	0	3.00 4.00
4.00 5.00	Inpatient primary payer payments		124, 272	0	5.00
5.00 5.00	Outpatient primary payer payments		0	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		124, 292	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				1
B. 00	Routine service charges		232, 377		8.00
9.00	Ancillary service charges		312, 209	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		544, 586	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for $\boldsymbol{\mu}$	payment for services o	in O	0	14.00
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
16.00	Total customary charges (see instructions)		544, 586	0	
17.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	420, 294	0	17.00
18.00	line 4) (see instructions)	if line 4 exceeds lin	0	0	18.00
16.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	IT THE 4 exceeds IT	ue u	0	10.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc	rtions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		124, 292	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co			-	
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		124, 292	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		124, 292	0	
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	-	
34.00 35.00	Allowable bad debts (see instructions)		0	0	34.00
35.00 36.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	124, 292	0	35.00 36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	557	124, 292	0	
38.00	Subtotal (line 36 \pm line 37)		124, 292	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		124, 272	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		124, 292	0	
41.00	Interim payments		265, 302	0	
42.00	Balance due provider/program (line 40 minus line 41)		-141, 010	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	0	0	
			9	0	1

CUL		Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Pre	
		•		5/25/2018 3:4	3 r
		Title XIX	Subprovider - IRF	Cost	
			Inpatient	Outpati ent	
				2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	VICES FOR TITLES V OR X	IX SERVICES		
00	Inpatient hospital/SNF/NF services		24, 262		1.
00	Medical and other services		,	0	
00	Organ acquisition (certified transplant centers only)		0		:
00	Subtotal (sum of lines 1, 2 and 3)		24, 262	0	
00	Inpatient primary payer payments		0	_	!
00	Outpatient primary payer payments		24.262	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		24, 262	0	<u> </u>
	Reasonable Charges				1
00	Routi ne servi ce charges		78, 512		1 8
00	Ancillary service charges		78, 582	0	
00	Organ acquisition charges, net of revenue		0		1
00	Incentive from target amount computation		0		1
00	Total reasonable charges (sum of lines 8 through 11)		157, 094	0	1
~ ~	CUSTOMARY CHARGES	· · · · · · · · · · · · · · · · · · ·			4.
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	1
00	basis Amounts that would have been realized from patients liable for	navment for services o	n O	0	1
00	a charge basis had such payment been made in accordance with 42	1 5		0	
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	1
00	Total customary charges (see instructions)		157, 094	0	
00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	132, 832	0	1
	line 4) (see instructions)				
00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds lin	e 0	0	1
00	16) (see instructions) Interns and Residents (see instructions)		0	0	1
00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 10		24, 262	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o				17
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	0	2
00 00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
00	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		24, 262	0	
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		217202		1
00	Excess of reasonable cost (from line 18)		0	0	3
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		24, 262	0	3
	Deducti bl es		0	0	1 -
00	Coinsurance		0	0	
00 00	Allowable bad debts (see instructions) Utilization review		0	0	3
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	24, 262	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	27,202	0	
00	Subtotal (line 36 \pm line 37)		24, 262	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)		24, 262	0	
00	Interim payments		64, 867	0	
00	Balance due provider/program (line 40 minus line 41)		-40, 605	0	
00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43

LANCE S	nancial Systems JOHNSON MEMORI SHEET (If you are nonproprietary and do not maintain	Provider C		Period: From 01/01/2017	u of Form CMS-: Worksheet G	
nd-type Iy)	e accounting records, complete the General Fund column			To 12/31/2017	Date/Time Pre 5/25/2018 3:4	pare 3 pr
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
CU		1.00	2.00	3.00	4.00	
	IRRENT ASSETS ash on hand in banks	40, 559, 390		o lo	0	1 1
	emporary investments	40, 337, 370			0	
	otes recei vabl e			0 0	0	
	ccounts receivable	15, 965, 780		0 0	0	
	ther receivable	C		0 0	0	
IA OC	lowances for uncollectible notes and accounts receivable	C		o o	0	$ \epsilon$
00 Ir	nventory	1, 982, 884		o c	0	
00 Pr	repaid expenses	1, 381, 568		0 0	0	8
	ther current assets	0		0 C	0	
	ue from other funds	C		0 0	0	
	otal current assets (sum of lines 1-10)	59, 889, 622		0 0	0	11
	XED ASSETS	4 742 424	1		0	1 1
	and and improvements	4, 743, 426			0	1
	•	2, 807, 066 -1, 155, 355			0	
	ccumulated depreciation uildings	72, 464, 758			0	
	ccumulated depreciation	-34, 605, 601			0	
	easehold improvements				0	
	ccumulated depreciation				0	
	xed equipment	13,007,605			0	
	ccumul ated depreciation	-10, 766, 528		0 0	0	
	utomobiles and trucks	C		0 0	0	
	ccumulated depreciation	C		o o	0	22
. 00 Ma	ajor movable equipment	61, 552, 003		o c	0	23
00 Ac	ccumulated depreciation	-32, 013, 696		o c	0	24
00 Mi	nor equipment depreciable	C		0 0	0	25
00 Ac	ccumul ated depreciation	0		0 0	0	26
	T designated Assets	0		0 C	0	
	ccumulated depreciation	C		0 0	0	1
	nor equipment-nondepreciable	0		0 0	0	
	otal fixed assets (sum of lines 12-29)	76, 033, 678		0 0	0	30
	HER ASSETS	0		o lo	0	3.
	eposits on Leases				0	
	ue from owners/officers			0 0	0	
	ther assets	2, 797, 202		0 0	0	
	otal other assets (sum of lines 31-34)	2, 797, 202		0 0	0	
	otal assets (sum of lines 11, 30, and 35)	138, 720, 502		0 0	0	
	IRRENT LI ABI LI TI ES	•				
. 00 Ac	ccounts payable	4, 220, 818		0 0	0	37
	alaries, wages, and fees payable	4, 095, 586		0 0	0	38
	ayroll taxes payable	862, 369		o c	0	
	otes and loans payable (short term)	0	' · · · · · · · · · · · · · · · · · · ·	0 0	0	
	eferred income	0		0 0	0	
	ccelerated payments	0				42
	ue to other funds	-38, 188, 500		0 0	0	
	ther current liabilities	17, 509		0 0	0	
	otal current liabilities (sum of lines 37 thru 44) NG TERM LIABILITIES	-28, 992, 218	1	0 0	0	45
	ortgage payable	0		o lo	0	46
	otes payable	265, 571			0	
	nsecured Loans	203, 371			0	
	ther long term liabilities	22, 493			0	
	otal long term liabilities (sum of lines 46 thru 49)	288, 064			0	
	otal liabilities (sum of lines 45 and 50)	-28, 704, 154		0 0	0	
	PITAL ACCOUNTS	, ., .,	•			1
	eneral fund balance	167, 424, 656				52
	pecific purpose fund			D		53
00 Do	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - unrestricted			0		55
	overning body created - endowment fund balance			0		56
	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement,				0	58
	eplacement, and expansion	1/7 404 /5/			-	
	otal fund balances (sum of lines 52 thru 58)				0	
	otal liabilities and fund balances (sum of lines 51 and	138, 720, 502	1	JI 01	0	60

Heal th	Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		l i	n Lieu of Form CMS	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0001	Period: From 01/01/ To 12/31/	2017 Worksheet G-	1 epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	ł
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balance at end of period per balance		2.00 155, 993, 557 11, 431, 099 167, 424, 656 0 167, 424, 656 0 167, 424, 656	3.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 012.00 13.00 14.00 15.00 16.00
	sheet (line 11 minus line 18)	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) Additions (credit adjustments) (specify)	0	000000000000000000000000000000000000000		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 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 CCN	I: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet G-2 Parts I & II Date/Time Pre 5/25/2018 3:4	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, 975, 0	78	11, 975, 078	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF		1, 818, 84	44	1, 818, 844	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		13, 793, 92	22	13, 793, 922	10.00
	Intensive Care Type Inpatient Hospital Services			1		
11.00	INTENSIVE CARE UNIT		1, 447, 79	75	1, 447, 795	
12.00	CORONARY CARE UNIT					12.00
13.00 14.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
16.00	OTHER SPECIAL CARE (SPECIFY)	Linos	1 447 70	75	1 447 705	
10.00	Total intensive care type inpatient hospital services (sum of 11-15)	TTHES	1, 447, 79	70	1, 447, 795	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		15, 241, 7 [.]	17	15, 241, 717	17.00
18.00	Ancillary services		31, 563, 13		147, 442, 658	•
19.00	Outpatient services		3, 501, 62		37, 633, 581	•
20.00	RURAL HEALTH CLINIC		0,001,0	0 0	0,,000,001	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	•
22.00	HOME HEALTH AGENCY			1, 336, 914	1, 336, 914	•
23.00	AMBULANCE SERVI CES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	NRCC		15, 52	21 11, 025, 269	11, 040, 790	27.00
27.01	PRO FEES		629, 19		2, 367, 672	•
27.02	OTHER		7,00	32, 340	39, 349	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	50, 958, 19	99 164, 144, 482	215, 102, 681	28.00
	G-3, line 1)					_
~~ ~~	PART II - OPERATING EXPENSES			00.050.000		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			83, 353, 930		29.00
30.00 31.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		83, 353, 930		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0001	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prep 5/25/2018 3:43	
				-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Par	t L column 3 line	28)		215, 102, 681	1.00
2.00	Less contractual allowances and discounts of				140, 821, 409	2.00
3.00	Net patient revenues (line 1 minus line 2)				74, 281, 272	3.00
4.00	Less total operating expenses (from Wkst. G	-2. Part II. line 4	13)		83, 353, 930	4.00
5.00	Net income from service to patients (line 3				-9, 072, 658	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellan	eous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00					0	12.00
13.00					0	13.00
14.00		ests			0	14.00
15.00					0	15.00
16.00	5		nan patients		0	16.00
17.00					0	17.00
18.00					0	18.00
	Tuition (fees, sale of textbooks, uniforms,	,			0	19.00
20.00	5	and canteen			0	20.00
21.00	5				0	21.00
22.00	· · ·				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER I NCOME				1, 142, 399	24.00
24.01	NON-OPERATING INCOME				2, 471, 361	24.01
24.02					16, 889, 997	24.02
	Total other income (sum of lines 6-24)				20, 503, 757	25.00
	Total (line 5 plus line 25)				11, 431, 099	26.00
	OTHER EXPENSES (SPECIFY)	hoorinto)			0	27.00
	Total other expenses (sum of line 27 and su				0	28.00
29.00	Net income (or loss) for the period (line 2	o minus iine 28)		I	11, 431, 099	29.00

Extures o </th <th>1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 23. 00 23. 50</th> <th>GENERAL SERVI CE COST CENTERS</th> <th></th> <th></th> <th>HHA CCN:</th> <th>1</th> <th>From 01/01/2017 To 12/31/2017 Home Heal th</th> <th>Date/Time Pre 5/25/2018 3:43</th> <th></th>	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 23. 00 23. 50	GENERAL SERVI CE COST CENTERS			HHA CCN:	1	From 01/01/2017 To 12/31/2017 Home Heal th	Date/Time Pre 5/25/2018 3:43	
Sol and solution Employee Benefit is Instructions) Find open (Services) Home Healt (Services) Home Healt (Services) Total (Services) Total (Services) <thtotal (Services) <thtotal (Services)</thtotal </thtotal 	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$		Sal ari es	Employee		10 7010	Home Health	5/25/2018 3:4	
Salt arries Engl oyee Benefit ts Transport lation/Contracted/Part (See Instructions) Other Cests (See Benefit ts Total (See Instructions) Other Cests (See Benefit ts Total (See Benefit ts 1.00 Capital Related = Bidg. & Fixtures 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$		Sal ari es	Employee				PP5	
Benefits Issue (see 1.00 Chased 2.00 Chased 5.00 Cols.1 5.00 Ithu 5.00 1.00 ENFML FEWICE COST CIVIFIES 1.00 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$		Sal ari es	Empl oyee			Agency I		
Instructions) Services D) 1.00 2.00 3.00 4.00 5.00 6.00 1.01 Capital. Related - Bidg. & Instruct 0 0 0 0 0 2.00 2.00 Plant Related - Movable Equipment 0 0 0 0 0 0 2.00 3.00 Plant Related - Movable Equipment 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$			Renefits			Other Costs		
ENRAL SERVICE COST CENTERS 0 </td <td>$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$</td> <td></td> <td></td> <td></td> <td>instructions)</td> <td>Servi ces</td> <td></td> <td>5)</td> <td></td>	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$				instructions)	Servi ces		5)	
1.00 Capital Related - Bidg. & Fixtures 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$		1.00	2.00	3.00	4.00	5.00	6.00	
2.00 Capital Related - Movable 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50				C		0	0	1.00
Solo Paint Services 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50						0	0	2.00
4.00 Transportation 0	$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ \hline\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$						0	0	2.00
5.00 Administrative and General 195, 663 0 38, 594 0 117, 672 351, 929 5. 6.00 Skilled Nursing Care 243, 370 0 0 0 0 243, 376 6. 7.00 Physical Therapy 166, 862 0 0 0 0 0 165, 862 7. 8.00 Cacupational Therapy 36, 490 0 0 0 0 0 0 0 0 0 65, 490 0	5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50	•	0	-	0		0		
6.00 Sk11 led Mursing Care 243,370 0 0 0 243,370 0 0 0 243,370 0 0 0 243,370 0 0 0 166,862 7. 8.00 Cocupational Therapy 65,490 0 0 0 0 66,490 0 0 3537 0 0 0 0 3537 0 0 0 0 3533 0 0 0 0 0 3533 0	$\begin{array}{c} 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$		195, 663	-			-	-	•
7.00 Physical Therapy 165.862 0 0 0 166.862 0 0 0 166.862 0 0 0 0 166.862 0 <td>$\begin{array}{c} 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$</td> <td></td> <td>0.40, 0.70</td> <td></td> <td></td> <td></td> <td></td> <td>0.40, 0.70</td> <td></td>	$\begin{array}{c} 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 50\\ \end{array}$		0.40, 0.70					0.40, 0.70	
8.00 Occupational Therapy 65,490 0 0 66,490 8.6 9.00 Specch Pathology 3,537 0 0 0 533 10 11.00 Home Healt h Aide 0 0 0 0 0 10.727	$\begin{array}{c} 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 23.\ 50\\ \end{array}$								•
10.00 Medical Social Services 503 0 0 0 503 0 0 0 503 0	10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50						0 0		•
11:00 Home Heal th Ai de 0 <td>11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 23. 50</td> <td></td> <td></td> <td>-</td> <td>C</td> <td></td> <td>0 0</td> <td></td> <td></td>	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 23. 50			-	C		0 0		
12:00 Supplies (see instructions) 0 0 0 0 10,727<	12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50				0		0		
13.00 Drügs 0	13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50		-	-			10 727		•
HA NONEE INBURSABLE SERVICES Image: Content of C	15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 23. 50		-	0	0				
15.00 Home Dial ysis Aide Services 0	15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 23.50		0	0	0		00	0	14.00
16.00 Respiratory Therapy 0	16.00 17.00 18.00 20.00 21.00 22.00 23.00 23.50		0	0				0	15.00
17.00 Private Duty Nursing 0 0 0 0 0 0 0 0 17.00 18.00 Clinic 0 <td>17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50</td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>	17.00 18.00 19.00 20.00 21.00 22.00 23.00 23.50			-					
19.00 Heal th Promotion Activities 0	19.00 20.00 21.00 22.00 23.00 23.50		0	0	0)	0 0	0	
20.00 Day Care Program 0	20. 00 21. 00 22. 00 23. 00 23. 50		0	0	0		0		
21.00 Home Deliverad Meals Program 0 <	21. 00 22. 00 23. 00 23. 50		0	0					
22.00 Homemaker Service 0	22. 00 23. 00 23. 50		0	0				-	
23. 50 Tel emedicine 0 128, 399 841, 418 24. Image: the start of the start o	23.50	Homemaker Service	0	0	0) (0 0	0	
24.00 Total (sum of lines 1-23) 674,425 0 38,594 0 128,399 841,418 24. Adjustments Net Expenses For Allocation Net Expenses For Allocation For Allocation<			0	0	0		0	0	
Recl assi fi cati onRecl assi fi cati onRecl assi fi cati onAdj ustments for Al location (col. 6 + col. 7)Net Expenses for Al location (col. 8 + col. 9)1.00Capi tal Rel ated - Bldg. & Fixtures000010.002.00Capi tal Rel ated - Movable000022.00Capi tal Rel ated - Movable000022.00Capi tal Rel ated - Movable000023.00Pl ant Operation & Maintenance000034.00Transportation000045.00Admin istrative and General0351, 929351, 92956.00Skilled Nursing Care0243, 3700243, 37067.00Physical Therapy0165, 8620165, 86278.00Occupational Therapy0353703, 53799.00Speech Pathology00001110.00Medical Social Services00001111.00Home Heal th Aide00001112.00Supplies (see instructions)00001313.00Drugs00001314.MORE IMBURSABLE SERVICES1010, 7271010, 72713.00Drugs000013<			674, 425	-	38, 594		128, 399	841, 418	23.50 24.00
$\begin{tabular}{ c c c c c c c c c c c c c c c c c c c$			Recl assi fi cati	Recl assi fi ed		Net Expenses			
Image: Coll 7) 9) 7.00 8.00 9.00 10.00 Capital Related - Bldg. & 0 0 0 0 1.00 Capital Related - Movable 0 0 0 0 2.00 Capital Related - Movable 0 0 0 0 2.00 Capital Related - Movable 0 0 0 0 2.00 Capital Related - Movable 0 0 0 0 0 2.00 Capital Related - Movable 0 0 0 0 2.00 Capital Related - Movable 0 0 0 0 0 0 2.00 Capital Related - Movable 0 0 0 0 2.00 Capital Related - Movable 2.00 0 0 0 0 2.00 Capital Related - Movable 2.00 0 0 0 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.0			on						
GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. 0 0 0 0 1. 2.00 Capital Related - Movable 0 0 0 0 2. 2.00 Capital Related - Movable 0 0 0 0 2. 2.00 Capital Related - Movable 0 0 0 0 2. 4.00 Transportation 0 0 0 0 4. 5.00 Administrative and General 0 351, 929 0 351, 929 5. HHA REI MBURSABLE SERVICES 6.00 Skilled Nursing 6. 7.00 Physical Therapy 0 165, 862 0 165, 862 7. 8.00 Occupational Therapy 0 10, 533 0 3, 537 9. 9.00 Speech Pathology 0 3, 537 0 3, 533 10.				col . 7)		9)			
1.00 Capital Related - Bldg. & 0 0 0 0 1. 2.00 Capital Related - Movable 0 0 0 0 2. 2.00 Capital Related - Movable 0 0 0 0 2. 2.00 Plant Operation & Maintenance 0 0 0 0 3. 3.00 Plant Operation & Maintenance 0 0 0 0 4. 5.00 Administrative and General 0 351, 929 0 351, 929 4. 4.00 Transportation 0 0 0 0 4. 5.00 Administrative and General 0 351, 929 0 351, 929 HHA REIMBUSABLE SERVICES 5 6.0 Skilled Nursing Care 0 243, 370 6. 7.00 Physical Therapy 0 165, 862 0 165, 862 7. 8.00 Occupational Therapy 0 6.5, 490 0 65, 490 8. 9.00 Speech Pathology 0 3, 537 0 3, 537 9. <		GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00			
2.00 Capital Related - Movable 0 0 0 0 2. 3.00 Plant Operation & Maintenance 0 0 0 0 3. 3. 4.00 Transportation 0 0 0 0 4. 3. 5.00 Administrative and General 0 351,929 0 351,929 5. HHA REI MBURSABLE SERVICES			0	0	C				1.00
Equipment Image: Constraint of the second seco									
3.00 Plant Operation & Maintenance 0 0 0 0 0 3. 4.00 Transportation 0 0 0 0 0 4. 5.00 Administrative and General 0 351,929 0 351,929 5. HHA REIMBURSABLE SERVICES HHA REIMBURSABLE SERVICES HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 0 243,370 0 243,370 6. 7.00 Physical Therapy 0 165,862 0 165,862 7. 8.00 Occupational Therapy 0 65,490 0 65,490 8. 9.00 Speech Pathology 0 3,537 0 3,537 9. 10.00 Medical Social Services 0 0 0 10. 11.00 Home Heal th Aide 0 0 0 11. 12.00 Supplies (see instructions) 0 10,727 12. 13.00 Drugs 0 0 0 0 13.	2.00		0	0	C				2.00
5.00 Administrative and General 0 351,929 0 351,929 5. HHA REI MBURSABLE SERVI CES	3.00		0	0	C		D		3.00
HHA REIMBURSABLE SERVICES 6.00 Skilled Nursing Care 0 243, 370 0 243, 370 6. 7.00 Physical Therapy 0 165, 862 0 165, 862 7. 8.00 Occupational Therapy 0 65, 490 0 65, 490 8. 9.00 Speech Pathology 0 3, 537 0 3, 537 9. 10.00 Medical Social Services 0 503 0 503 10. 11.00 Home Heal th Aide 0 0 0 0 11. 12.00 Supplies (see instructions) 0 10, 727 0 10, 727 12. 13.00 Drugs 0 0 0 0 13. 14.00 DME 0 0 0 14. HHA NONREI MBURSABLE SERVICES 0 0 0 15. 15.00 Home Dial ysis Aide Services 0 0 0 15. 16.00 0 0							D		4.00
6.00 Skilled Nursing Care 0 243, 370 0 243, 370 6. 7.00 Physical Therapy 0 165, 862 0 165, 862 7. 8.00 Occupational Therapy 0 65, 490 0 65, 490 8. 9.00 Speech Pathology 0 3, 537 0 3, 537 9. 10.00 Medical Social Services 0 503 0 503 10. 11.00 Home Heal th Aide 0 0 0 0 11. 12.00 Supplies (see instructions) 0 10, 727 0 10, 727 12. 13.00 Drugs 0 0 0 0 0 13. 14.00 DME 0 0 0 0 14. HHA NONREL MBURSABLE SERVICES 0 0 0 15. 15. 15.00 Home Dial ysis Aide Services 0 0 0 0 15. 16.00 Respiratory Therapy 0 0 0 0 16. 17. 1			0	351, 929		<u>351, 920</u>	7		5.00
8.00 Occupational Therapy 0 65,490 0 65,490 8. 9.00 Speech Pathology 0 3,537 0 3,537 9. 10.00 Medical Social Services 0 503 0 503 10. 11.00 Home Heal th Ai de 0 0 0 0 11. 12.00 Supplies (see instructions) 0 10,727 0 10,727 12. 13.00 Drugs 0 0 0 0 13. 14.00 DME 0 0 0 14. HHA NONRELIMBURSABLE SERVICES 15.00 Home Dial ysis Ai de Services 0 0 0 15. 16.00 Respiratory Therapy 0 0 0 16. 17. 17.00 Private Duty Nursing 0 0 0 0 17.			0	243, 370	C	243, 370)		6.00
9.00 Speech Pathology 0 3,537 0 3,537 9. 10.00 Medical Social Services 0 503 0 503 10. 11.00 Home Heal th Ai de 0 0 0 0 11. 12.00 Supplies (see instructions) 0 10,727 0 10,727 12. 13.00 Drugs 0 0 0 0 13. 14.00 DME 0 0 0 14. HHA NONREI MBURSABLE SERVI CES 15.00 Home Di al ysis Ai de Services 0 0 0 15. 16.00 Respi ratory Therapy 0 0 0 16. 17. 0 0 17.			0						7.00
10.00 Medical Social Services 0 503 0 503 10. 11.00 Home Health Aide 0 0 0 0 11. 12.00 Supplies (see instructions) 0 10,727 0 10,727 12. 13.00 Drugs 0 0 0 0 13. 14.00 ME 0 0 0 14. HHA NONREI MBURSABLE SERVICES HHA NONREI MBURSABLE SERVICES 15.00 Home Dial ysis Aide Services 0 0 0 15. 16.00 Respiratory Therapy 0 0 0 16. 17. 17.			0		0				8.00 9.00
11.00 Home Heal th Ai de 0 0 0 11. 12.00 Supplies (see instructions) 0 10,727 0 10,727 12. 13.00 Drugs 0 0 0 0 13. 14.00 DME 0 0 0 0 14. HHA NONREI MBURSABLE SERVICES HHA NONREI MBURSABLE SERVICES 15.00 Home Di al ysis Ai de Services 0 0 0 15. 16.00 Respiratory Therapy 0 0 0 16. 16. 17.00 Private Duty Nursing 0 0 0 0 17.			0						10.00
13.00 Drugs 0 0 0 0 13. 14.00 DME 0 0 0 0 14. HHA NONREI MBURSABLE SERVI CES 14. 14. 14. 14. 14. 15.00 Home Di al ysis Ai de Servi ces 0 0 0 0 15. 16.00 Respiratory Therapy 0 0 0 16. 16. 17.00 Private Duty Nursing 0 0 0 17.			0) ()	2		11.00
14.00 DME 0 0 0 14. HHA NONREI MBURSABLE SERVI CES 14. 15. 15. 15. 16. 15. 16. 16. 16. 16. 17. 17. 17. 17. 17. 14. 14. 14. 14. 14. 14. 14. 14. 14. 14. 15. 15. <td></td> <td></td> <td>0</td> <td></td> <td>C</td> <td></td> <td>7</td> <td></td> <td>12.00</td>			0		C		7		12.00
HHA NONREI MBURSABLE SERVI CES15. 00Home Di al ysi s Ai de Servi ces00015.16. 00Respi ratory Therapy00016.17. 00Pri vate Duty Nursi ng000017.				-					13.00 14.00
15.00 Home Dialysis Aide Services 0 0 0 15. 16.00 Respiratory Therapy 0 0 0 16. 17.00 Private Duty Nursing 0 0 0 0 17.			0	0		/			14.00
17.00 Private Duty Nursing 0 0 0 0 17.	15.00	Home Dialysis Aide Services							15.00
5 5			0	-					16.00
		<u> </u>	0						17.00 18.00
			0	0			Ď		19.00
20.00 Day Care Program 0 0 0 0 20.	20.00	Day Care Program	0	-	0		ס	I	20.00
5									21.00
		5	0	-				1	
23.50 Telemedicine 0 0 0 0 23.	23.50	Homemaker Service	0	0	0				22.00
24.00 Total (sum of lines 1-23) 0 841,418 0 841,418 24.	24.00	Homemaker Service All Others (specify) Telemedicine	0	0 0 0	C C C		D		22.00 23.00 23.50

	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 01/01/2017	Worksheet H-1 Part I	
				HHA CCN:		To 12/31/2017		
						Home Health	PPS	s pili
						Agency I		
			Capital Rela	ited Costs				
		Net Expenses	BIdgs &	Movabl e	Plant	Transportati on		1
		for Cost Allocation	Fixtures	Equi pment	Operation & Maintenance		(cols. 0-4)	
		(from Wkst. H,			Marmenance			
		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
2 00	Fixtures			0			0	2 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	251 020	4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	351, 929	0	0		0 0	351, 929	5.00
6.00	Skilled Nursing Care	243, 370	0	0		0 0	243, 370	•
7.00	Physical Therapy Occupational Therapy	165, 862	0	0		0 0	165, 862	
8.00 9.00	Speech Pathology	65, 490 3, 537	0	0		0 0	65, 490 3, 537	
10.00	Medical Social Services	503	Ö	0		0 0	503	
11.00	Home Health Aide	0	0	0		0 0	0	
12.00 13.00	Supplies (see instructions) Drugs	10, 727 0	0	0		0 0	10, 727 0	1
14.00	DME	0	0	0		0 0		
45 00	HHA NONREI MBURSABLE SERVI CES							1 4 5 00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0 0 0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
23.00 23.50	All Others (specify) Telemedicine	0	0	0		0 0 0 0	0	
	Total (sum of lines 1-23)	841, 418	0	0		0 0	841, 418	
		Admi ni strati ve	· ·					
		& General 5.00	<u>4A + 5)</u> 6.00					+
	GENERAL SERVICE COST CENTERS	0.00	0.00		•			
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable							2.00
	Equi pment							
3.00 4.00	Plant Operation & Maintenance Transportation							3.00
5.00	Administrative and General	351, 929						5.00
	HHA REIMBURSABLE SERVICES							
6.00 7.00	Skilled Nursing Care Physical Therapy	174, 977 119, 250	418, 347 285, 112					6.00 7.00
8.00	Occupational Therapy	47,085	112, 575					8.00
9.00	Speech Pathol ogy	2, 543	6, 080					9.00
10.00 11.00	Medical Social Services Home Health Aide	362	865 0					10.00
12.00	Supplies (see instructions)	7, 712	18, 439					12.00
13.00	Drugs	0	0					13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00 18.00	Private Duty Nursing	0	0					17.00
18 00	Clinic Health Promotion Activities	0	0					18.00 19.00
			0					20.00
19. 00 20. 00	Day Care Program	0	0					
19.00 20.00 21.00	Home Delivered Meals Program	0	0					21.00
19.00 20.00 21.00 22.00	Home Delivered Meals Program Homemaker Service		0 0					22.00
19.00 20.00 21.00 22.00	Home Delivered Meals Program		0					•

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0001 15-7510	Period: From 01/01/2017 To 12/31/2017	Worksheet H-1 Part II Date/Time Pre 5/25/2018 3:4	
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	Transportati (MI LEAGE)	onReconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	C		0		3.00
4.00	Transportation (see	0	0	C		0		4.00
	instructions)							
5.00	Administrative and General	0	0	C)	0 -351, 929	489, 489	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	C		0 0	243, 370	6.00
7.00	Physical Therapy	0	0	C		0 0	165, 862	
8.00	Occupational Therapy	0	0	C		0 0	65, 490	
9.00	Speech Pathol ogy	0	0	C)	0 0	3, 537	
10.00	Medical Social Services	0	0)	0 0	503	
11.00	Home Heal th Ai de	0	0			0 0	0	11.00
12.00	Supplies (see instructions)	0	0			0 0	10, 727	
13.00 14.00	Drugs DME		0			0 0	0	
14.00	HHA NONREI MBURSABLE SERVICES	0	0	L C	/	0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	C	1	0 0	0	15.00
16.00	Respiratory Therapy		0				0	16.00
17.00	Private Duty Nursing		0				0	
18.00	Clinic		0				0	
19.00	Health Promotion Activities		0				0	
20,00	Day Care Program		0				0	20.00
20.00	Home Delivered Meals Program		0				0	21.00
22.00	Homemaker Service		0				0	22.00
23.00	All Others (specify)		0				0	
23.50	Tel emedi ci ne		0				0	
24.00	Total (sum of lines 1-23)		0	c c		0 -351,929	-	
24.00	Cost To Be Allocated (per		0			0	351, 929	
20.00	Worksheet H-1, Part I)	l	0			~	001,727	
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0.0000	00	0. 718972	26.00

LOCATION OF GENERAL SERVICE COSTS TO) HHA COST CENT	FERS	Provider CC HHA CCN:	F	eriod: rom 01/01/2017 o 12/31/2017 Home Health	Worksheet H-2 Part I Date/Time Prep 5/25/2018 3:43 PPS	pared
		CAPI	TAL RELATED CC)STS	Agency I		
Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
	0	1.00	1.01	2.00	4. 00	4.01	
00Administrative and General00Skilled Nursing Care00Physical Therapy00Occupational Therapy00Speech Pathology00Medical Social Services00Medical Social Services00Medical Social Services00Medical Social Services00Durgs00Drugs00DME1.00Home Dialysis Aide Services2.00Respiratory Therapy3.00Private Duty Nursing4.00Clinic5.00Day Care Program7.00Home Delivered Meals Program8.00Hohers (specify)9.50Telemedicine0.00Total (sum of lines 1-19) (2)1.00Unit Cost Multiplier: column26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0 418, 347 285, 112 112, 575 6, 080 865 0 18, 439 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9, 581 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		699 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	141, 487 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 598 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14. (15. (16. (17. (18. (19. (19. <u></u>
Cost Center Description	DATA PROCESSI NG	MATERI ALS MANAGEMENT	ADMI TTI NG	PATI ENT ACCOUNTI NG		ADMI NI STRATI VE & GENERAL	
00Administrative and General00Skilled Nursing Care00Physical Therapy00Occupational Therapy00Speech Pathology00Medical Social Services00Home Health Aide00Supplies (see instructions)00Drugs0.00DME1.00Home Dialysis Aide Services2.00Respiratory Therapy3.00Private Duty Nursing4.00Clinic5.00Day Care Program7.00Home Delivered Meals Program3.00Homeaker Service9.00All Others (specify)9.50Telemedicine0.00Total (sum of lines 1-19) (2)	4.02 60,159 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.03 2,134 0 0 0 0 0 0 0 0 0 0 0 0 0	4.04 6,138 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		418, 347 285, 112 112, 575 6, 080 865 0 18, 439 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 12,396 21,490 14,645 5,782 312 44 0 947 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 19.

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

LLOCAT	ION OF GENERAL SERVICE COSTS	U HHA COST CEN	IERS	Provider CC		Period: From 01/01/2017	Worksheet H-2 Part I	
				HHA CCN:		To 12/31/2017		pared 3 pm
						Home Health	PPS	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	Agency I CAFETERI A	NURSI NG	
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	ADMI NI STRATI ON 13. 00	
. 00 /	Administrative and General	18, 448	0.00	6, 902	10.00			1.0
	Skilled Nursing Care	0	0	0	(
	Physical Therapy	0	0	0	(-	
	Occupational Therapy	0	0	0	(0	
	Speech Pathology Medical Social Services	0	0	0	(0	
	Home Heal th Aide	0	0	0	(0	
00	Supplies (see instructions)	0	0	0	(0 0	0	8.
	Drugs	0	0	0	(-	
		0	0	0	(0	
	Home Dialysis Aide Services Respiratory Therapy	0	0	0	(-	
	Private Duty Nursing	0	0	0	(-	
	Clinic	0	0	0	(0	
	Health Promotion Activities	0	0	0	(0	
	Day Care Program Home Delivered Meals Program	0	0	0	(0	
	Homemaker Service	0	0	0	(0	
	All Others (specify)	0	0	0	(0	-
	Tel emedi ci ne	0	0	0	(0	0	
	Total (sum of lines 1-19) (2)	18, 448	0	6, 902	(14, 972	0	
	Jnit Cost Multiplier: column							21.
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
(6 decimal places.	CENTRAL	DUADMACY	MEDLOAL	Culture	Luctore 0	Cultate	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	Subtotal	Intern & Residents Cost	Subtotal	
		SUPPLY		LIBRARY		& Post		
						Stepdown		
		14.00	15.00	16.00	24.00	Adjustments 25.00	26.00	
00 /	Administrative and General	0	0	8, 025	302, 082			1.
	Skilled Nursing Care	0	0	0	439, 83		439, 837	
	Physical Therapy Occupational Therapy	0	0	0	299, 757 118, 357		299, 757 118, 357	
	Speech Pathol ogy	0	0	0	6, 392			
	Medical Social Services	0	0	0	909		909	
	Home Health Aide	0	0	0	(0 0	0	7.
	Supplies (see instructions)	0	0	0	19, 386		19, 386	
] 00] 00)rugs	0	0	0	(0	
	Home Dialysis Aide Services	0	0	0	(-	0	
00 1	Respiratory Therapy	0	0	0	(0	
	Private Duty Nursing	0	0	0	(0 0	0	
	Clinic	0	0	0	(0	
	Health Promotion Activities Day Care Program	0	0	0	(0	
	Home Delivered Meals Program	0	0	0	(0	
	Homemaker Service	0	0	0	(-	0	
	All Others (specify)	0	0	0	(-	0	
	Telemedicine	0	0	0	(0	
	Total (sum of lines 1–19) (2) Jnit Cost Multiplier: column	0	0	8, 025	1, 186, 720	0 0	1, 186, 720	20. 21.
								21.
. 00 l	26. line 1 divided by the sum							
. 00 l	26, line 1 divided by the sum of column 26, line 20 minus							

(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 CCI HHA CCN:	N: 15-0001 15-7510	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part I Date/Time Pre	
							5/25/2018 3:4	3 pm
						Home Health	PPS	
						Agency I		
	Cost Center Description	Allocated HHA	Total HHA					
		A&G (see Part	Costs					
)				-		
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	150, 193	590, 030					2.00
3.00	Physical Therapy	102, 360	402, 117					3.00
4.00	Occupational Therapy	40, 416	158, 773					4.00
5.00	Speech Pathology	2, 183	8, 575					5.00
6.00	Medical Social Services	310	1, 219					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	6, 620	26, 006					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
19.50	Tel emedi ci ne	0	0					19.50
20.00	Total (sum of lines 1-19) (2)	302, 082	1, 186, 720					20.00
21.00	Unit Cost Multiplier: column	0. 341475						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-	
ALLUCA BASI S	TION OF GENERAL SERVICE COSTS T	U HHA CUSI CEN	TERS STATISTICAL	- Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Pre 5/25/2018 3:4	pared:
						Home Health	PPS	
		CAPI	TAL RELATED COS	STS		Agency I		
							5474	-
	Cost Center Description	NEW BLDG & FIXT	BLDG & FIXT - TOWER (MVBLE EQUIP DOLLAR VALUE)	EMPLOYEE BENEFI TS	COMMUNI CATI ONS	DATA PROCESSING	
		(TOTAL FEET)	(SQUARE FEET)		DEPARTMENT (GROSS SALARI ES)	(# NON PT PHONES)	(WORK ORDERS)	
		1.00	1.01	2.00	4.00	4. 01	4. 02	
1.00	Administrative and General	1, 305	0	56	674, 42		78	1
2.00 3.00	Skilled Nursing Care Physical Therapy	0	0	0		0 0 0 0	0	1
4.00	Occupational Therapy	0	0	0		0 0	0	
5.00	Speech Pathology	0	0	0		0 0	0	5.00
6.00	Medical Social Services	0	0	0		0 0	0	
7.00	Home Heal th Aide	0	0	0		0 0	0	
8.00 9.00	Supplies (see instructions) Drugs	0	0	0		0 0	0	
10.00	DME	0	0	0		0 0	0	
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy	0	0	0		0 0	0	12.00
13.00	Private Duty Nursing	0	0	0		0 0	0	13.00
14.00	Clinic	0	0	0		0 0	0	
15.00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
16.00 17.00	Home Delivered Meals Program	0	0	0			0	
18.00	Homemaker Service	0	0	0		0 0	0	1
	All Others (specify)	0	0	0		0 0	0	1
19.50	Tel emedi ci ne	0	0	0		0 0	0	19.50
20.00	Total (sum of lines 1-19)	1, 305	0	56	674, 42		78	
21.00	Total cost to be allocated	9, 581	0	69				
22.00	Unit cost multiplier Cost Center Description	7. 341762 MATERI ALS	0. 000000 ADMI TTI NG	1. 232143 PATI ENT	0.20978 Reconciliatio	9 286. 869565 nADMI NI STRATI VE		22.00
	cost center bescription	MANAGEMENT	(GROSS	ACCOUNTING	Reconciliatio	& GENERAL	PLANT	
		(SUPPLY	REVENUE)	(GROSS		(ACCUM.	(TOTAL	
		USAGE)		REVENUE)	-	COST)	FEET)	
1.00	Administrative and General	4.03 13,972	4.04	4.05	5A	5.00 0 241,339	7.00 1,305	1.00
2.00	Skilled Nursing Care	13,772	1, 330, 714	1, 330, 714 N		0 241, 339	1, 303	1
3.00	Physical Therapy	0	0	0		0 285, 112	0	
4.00	Occupational Therapy	0	0	0		0 112, 575	0	4.00
5.00	Speech Pathol ogy	0	0	0		0 6, 080		
6.00	Medical Social Services	0	0	0		0 865	0	
7.00 8.00	Home Health Aide Supplies (see instructions)	0	0	0		0 0 0 18, 439	0	1
9.00	Drugs	0	0	0		0 10, 439		
10.00	DME	0	0	0		0 0	0	1
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy	0	0	0		0 0	0	1
13.00	Private Duty Nursing	0	0	0		0 0	0	1
14.00 15.00	Clinic Health Promotion Activities	0	0	0			0	
16.00	Day Care Program	0	0	0		o 0	0	1
17.00	Home Delivered Meals Program	0	o	0		0 0	0	1
18.00	Homemaker Service	0	0	0		0 0	0	18.00
	All Others (specify)	0	0	0		0 0	0	
19.00								
19. 00 19. 50	Telemedicine	10 070		1 224 014			0	
19. 00 19. 50	Telemedicine Total (sum of lines 1–19) Total cost to be allocated	0 13, 972 2, 134		0 1, 336, 914 15, 173		0 0 1, 082, 757 55, 616	1, 305	19.50 20.00 21.00

Health Financial Systems		JOHNSON MEMORIAL				u of Form CMS-2	
ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	TERS STATISTICAL	Provider CC HHA CCN:	CN: 15-0001 15-7510	Period: From 01/01/2017 To 12/31/2017	Worksheet H-2 Part II Date/Time Pre	pared:
					Home Health	5/25/2018 3:4 PPS	<u>3 pm</u>
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (TOTAL FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS PAI D)	Agency I NURSI NG ADMI NI STRATI ON (DI RECT	CENTRAL SERVI CES & SUPPLY (COSTED	
	8.00	9.00	10.00	11.00	NRSI NG HRS) 13.00	REQUIS.) 14.00	
1.00Administrative and General2.00Skilled Nursing Care3.00Physical Therapy4.00Occupational Therapy5.00Speech Pathology6.00Medical Social Services7.00Home Health Aide8.00Supplies (see instructions)9.00Drugs10.00DME11.00Home Dialysis Aide Services12.00Respiratory Therapy13.00Private Duty Nursing14.00Clinic15.00Health Promotion Activities16.00Day Care Program17.00Home Delivered Meals Program18.00Homemaker Service19.00All Others (specify)19.50Telemedicine20.00Total (sum of lines 1-19)21.00Total cost to be allocated22.00Unit cost multiplierCost Center Description	0.000 0 0 0 0 0 0 0 0 0 0 0 0	1, 305 1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0		17, 9 17, 9 14, 9	18 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 18 0 72 0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
 Administrative and General O Skilled Nursing Care O Physical Therapy O Occupational Therapy O Speech Pathology O Medical Social Services O Home Heal th Aide O Supplies (see instructions) O Drugs O Respiratory Therapy O Clinic O Had th Promotion Activities O Bay Care Program O Home Belivered Meals Program O Clinic O Home Belivered Meals Program O Clinic (specify) So Telemedicine O Total (sum of lines 1-19) O Total cost multiplier 	(COSTED REQUIS.) 15.00 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY (GROSS REVENUE) 16.00 1,336,914 0 0 0 0 0 0 0 0 0 0 0 0 0					1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 15. 00 15. 00 15. 00 10. 00 15. 00 10. 00 11. 00 15. 00 14. 00 15.

Heal th	n Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST	S			CN: 15-0001	Peri od:	Worksheet H-3	
				HHA CCN:	15-7510	From 01/01/2017 To 12/31/2017		
				Title	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		$(col \cdot 3 \div col \cdot$	
		0	1.00	Part II) 2.00	3.00	4.00	4) 5.00	
	PART I - COMPUTATION OF LESSER							
	BENEFICIARY COST LIMITATION							
1 00	Cost Per Visit Computation Skilled Nursing Care	2.00	F00.020		500.0	20 2.252	2/2.00	1 00
1.00 2.00	Physical Therapy	2.00 3.00			590, 0 402, 1			1.00 2.00
3.00	Occupational Therapy	4.00						•
4.00	Speech Pathol ogy	5.00			8,5			•
5.00	Medical Social Services	6.00	1, 219		1, 2	19 4	304. 75	5.00
6.00	Home Health Aide	7.00				0 0		
7.00	Total (sum of lines 1-6)		1, 160, 714	(<u>1, 160, 7</u>			7.00
			L		Program Visi	<u>ts</u> art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	p				Deducti bl es			
					Coinsurance		5.00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		18020	(b	42		8.00
8.01	Skilled Nursing Care		26900		1,0			8.01
9.00	Physical Therapy		18020	(49		9.00
9.01	Physical Therapy		26900	0		50		9.01
10.00	Occupational Therapy		18020			44		10.00
10. 01 11. 00	Occupational Therapy Speech Pathology		26900 18020			15		10. 01 11. 00
11.00	Speech Pathology		26900			12 35		11.00
12.00	Medical Social Services		18020			0		12.00
12.01	Medical Social Services		26900	(b	2		12.01
13.00	Home Health Aide		18020		D	0		13.00
13.01	Home Health Aide		26900	(0		13.01
14.00		From What 11 2	Facility Costa	() 2,6 Total HHA	11 Total Charges	Datio (ad. 2	14.00
	Cost Center Description	Part I, col.	Facility Costs (from Wkst.	Shared Ancillary	Costs (col s.		Ratio (col. 3 ÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
				Part II)				
	Current i and Drawn Const. Comput	0	1.00	2.00	3.00	4.00	5.00	
15.00	Supplies and Drugs Cost Comput Cost of Medical Supplies	8. 00	26, 006	(26,0	06 C	0. 000000	15 00
16.00		9.00			20,0	0 0		
			Program Visits		Cost of			
					Servi ces			
	Cost Center Description	Part A	Not Subject to	t B Subject to	Part A	Part B Not Subject to	Subject to	
	cost center bescription	Part A	Deductibles &			Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LI	MITATION COST, O	R	
1.00	Cost Per Visit Computation Skilled Nursing Care	0	1, 104		1	0 289, 248		1.00
2.00	Physical Therapy	0				0 208, 361		2.00
3.00	Occupational Therapy	0			1	0 98, 289		3.00
4.00	Speech Pathology	0				0 10, 893		4.00
5.00	Medical Social Services	0				0 610		5.00
6.00	Home Heal th Ai de	0				0 0		6.00
7.00	Total (sum of lines 1-6)	0	2, 611	l	I	0 607, 401		7.00

PPORTIONMENT OF PATIENT SERVICE COST	S		Provider CC	CN: 15-0001	Peri od:	Worksheet H-3	3
			HHA CCN:	15-7510	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/25/2018 3:4	
			Ti tl e	XVIII	Home Health Agency I	PPS	+ <u>5 pili</u>
Cost Center Description		7.00		0.00		11.00	
Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
. 00 Skilled Nursing Care							8.0
.01 Skilled Nursing Care							8.
.00 Physical Therapy							9.
01 Physical Therapy							9.
0.00 Occupational Therapy							10.
0.01 Occupational Therapy							10.
1.00 Speech Pathology							11.
1.01 Speech Pathology							11.
2.00 Medical Social Services							12.
2.01 Medical Social Services							12.
3.00 Home Health Aide							13.
3.01 Home Health Aide							13.
4.00 Total (sum of lines 8-13)							14.
	Prog	ram Covered Cha	rges	Cost of Servi ces			
		-		Jei vi ces			
		Part			Part B		
Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
		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 Comput		7.00	0.00	7.00	10.00	11.00	
5.00 Cost of Medical Supplies	0	0	0		0 0	C	15.
6.00 Cost of Drugs		0	0		0	C	16.
Cost Center Description	Total Program						
	Cost (sum of						
	col s. 9-10)	-					-
	12.00	DOCDAM COCT A				,	-
PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	RUGRAM CUST, AU	GREGATE OF TH	E PRUGRAM LI	MITATION COST, OF	<	
Cost Per Visit Computation							
.00 Skilled Nursing Care	289, 248						1 1.
.00 Physical Therapy	208, 361						2.
.00 Occupational Therapy	98, 289						3.
.00 Speech Pathology	10, 893						4.
.00 Medical Social Services	610						5.
.00 Home Health Aide	0						6.
.00 Total (sum of lines 1-6)	607, 401						7.
Cost Center Description							
	12.00						
Limitation Cost Computation	1						8.
00 Skilled Nursing Care							8.
00 Skilled Nursing Care 01 Skilled Nursing Care							
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy							
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy							9.
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy0.00Occupational Therapy							9. 10.
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy0.00Occupational Therapy0.01Occupational Therapy							9. 10. 10.
 Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology 							9. 10. 10. 11.
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy0.00Occupational Therapy0.01Occupational Therapy1.00Speech Pathology1.01Speech Pathology							9. 10. 10. 11. 11.
 00 Skilled Nursing Care 01 Skilled Nursing Care 00 Physical Therapy 01 Physical Therapy 01 Occupational Therapy 0.01 Occupational Therapy 0.00 Speech Pathology 1.01 Speech Pathology 2.00 Medical Social Services 							9. 10. 10. 11. 11. 12.
 Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services 							9. 10. 10. 11. 11. 12. 12.
 .00 Skilled Nursing Care .01 Skilled Nursing Care .00 Physical Therapy .01 Physical Therapy .01 Physical Therapy .00 Occupational Therapy .01 Occupational Therapy .02 Speech Pathology .03 Speech Pathology .04 Medical Social Services .05 Home Health Aide 							9. 9. 10. 11. 11. 12. 12. 13.
 Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services 							9. 10. 10. 11. 11. 12. 12.

Health Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	ΓS		Provider C	CN: 15-0001	Peri od:	Worksheet H-3	
			HHA CCN:	15-7510	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/25/2018 3:4	pared: 3 pm
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	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. 410143	C)	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 209508	C		Ocol. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 351700	C		Ocol. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 324932	C		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 418422	C		0 col. 2, line 1	6. 00	5.00

Heal th	Financial Systems JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-0001	Peri od:	Worksheet H-4	
		HHA CCN:	15-7510	From 01/01/2017 To 12/31/2017	Part I-II Date/Time Pre 5/25/2018 3:43	
		Title	XVIII	Home Health	PPS	<u> </u>
				Agency I	t B	
			Part A	Not Subject to		
				Coi nsurance	Coi nsurance	
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST(Reasonable Cost of Part A & Part B Services	MARY CHARGE	5			
1.00	Reasonable cost of services (see instructions)			0 0	0	1.00
2.00	Total charges			0 0		2.00
	Customary Charges					
3.00	Amount actually collected from patients liable for payment for	r services		0 0	0	3.00
4.00	on a charge basis (from your records) Amount that would have been realized from patients liable for	navment		0 0	0	4.00
4.00	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0 0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	5.00
6.00	Total customary charges (see instructions)			0 0	0	6.00
7.00	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)	(complete		0 0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0 0	0	8.00
9.00	Primary payer amounts			0 0	-	9.00
				Part A	Part B	
				Services 1.00	Services 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				2100	
10.00	Total reasonable cost (see instructions)			0		
11.00	Total PPS Reimbursement - Full Episodes without Outliers			0	456, 730	
12.00 13.00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0	23, 039 1, 910	
14.00	Total PPS Reimbursement - PEP Episodes			0	598	
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0		15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	16.00
17.00	Total Other Payments			0	0	17.00
18.00	DME Payments			0	0	18.00
19.00	Oxygen Payments			0	0	19.00
20.00	Prosthetic and Orthotic Payments			0	0	20.00
21.00 22.00	Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)	urance)		0	0 486, 104	21.00 22.00
22.00	Excess reasonable cost (from line 8)			0	480, 104	22.00
24.00	Subtotal (line 22 minus line 23)			0		
25.00	Coinsurance billed to program patients (from your records)			-	0	25.00
26.00	Net cost (line 24 minus line 25)			0	486, 104	26.00
27.00	Reimbursable bad debts (from your records)					27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see in	nstructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line	e 27)		0		29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	-	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions	>)		0		30. 50 30. 99
30. 99 31. 00	Demonstration payment adjustment amount before sequestration Subtotal (see instructions)			0	-	
31.00	Sequestration adjustment (see instructions)			0		
31.02	Demonstration payment adjustment amount after sequestration			0		31.02
32.00	Interim payments (see instructions)			0		32.00
33.00	Tentative settlement (for contractor use only)			0		33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, a			0		34.00
35.00	Protested amounts (nonallowable cost report items) in accordant	nce with CMS	Pub. 15-2,	0	0	35.00
	chapter 1, §115.2			I		I

	Financial Systems JOHNSON MEMORIA S OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-0001		eri od:	u of Form CMS-2 Worksheet H-5	
PROGI	RAM BENEFI CI ARI ES	HHA CCN:	15-7510	Fr Tc	rom 01/01/2017 p 12/31/2017	Date/Time Prep	bared
				+	Home Health	5/25/2018 3:43 PPS	3 pm
					Agency I		
		Inpatien	t Part A		Par	tВ	
	-	mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
00 1	Total interim normante peid te provider	1.00	2.00	0	3.00	4.00	1
00 5	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		476, 381 0	1. 2.
a f	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.
D1				0		0	3.
02				0		0	3.
)3				0		0	3
)4				0		0	3
5	Dravidar to Dragram			0		0	3
0	Provider to Program			0		0	3
1				0		0	3
2				0		0	3
3				0		0	3
54				0		0	3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	3
r 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		476, 381	4
	O BE COMPLETED BY CONTRACTOR						
c v	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			0			_
1				0		0	5 5
3				0		0	5
Ρ	Provider to Program						
0				0		0	5
1				0		0	5 5
2	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	5 5
5	5. 50-5. 98)			0		0	
1	Determined net settlement amount (balance due) based on the cost report. (1)						6
	SETTLEMENT TO PROVIDER			0		0	6
	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)			0		0 476, 381	6 7
				0	Contractor	NPR Date	/
					Number	(Mo/Day/Yr)	
		()		1.00	2.00	

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0001	Period: From 01/01/2017	Worksheet L	
		To 12/31/2017	Parts I-III Date/Time Pre 5/25/2018 3:43	
	Title XVIII	Hospi tal	PPS	5 piii
			1.00	
PART I - FULLY PROSPECTIVE METHOD			1.00	
CAPITAL FEDERAL AMOUNT				1
00 Capital DRG other than outlier			430, 835	1 1.
01 Model 4 BPCI Capital DRG other than outlier			000,000	
00 Capital DRG outlier payments			2, 454	
01 Model 4 BPCI Capital DRG outlier payments			0	
00 Total inpatient days divided by number of days in the o	cost reporting period (see inst	ructions)	17.34	
00 Number of interns & residents (see instructions)		0.00		
00 Indirect medical education percentage (see instructions		0.00	5.	
00 Indirect medical education adjustment (multiply line 5 1.01) (see instructions)	by the sum of lines 1 and 1.01	, columns 1 and	0	6.
00 Percentage of SSI recipient patient days to Medicare Pa 30) (see instructions)	art A patient days (Worksheet E	, part A line	0.00	
00 Percentage of Medicaid patient days to total days (see	instructions)		0.00	
00 Sum of lines 7 and 8			0.00	
.00 Allowable disproportionate share percentage (see instru	uctions)		0.00	
.00 Disproportionate share adjustment (see instructions)			0	
. 00 Total prospective capital payments (see instructions)			433, 289	12
			1.00	-
PART II - PAYMENT UNDER REASONABLE COST				
00 Program inpatient routine capital cost (see instruction	ns)		0	1
00 Program inpatient ancillary capital cost (see instructi	ons)		0	2.
00 Total inpatient program capital cost (line 1 plus line	2)		0	-
00 Capital cost payment factor (see instructions)			0	
00 Total inpatient program capital cost (line 3 x line 4)			0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	
00 Program inpatient capital costs for extraordinary circu			0	-
00 Net program inpatient capital costs (line 1 minus line 00 Applicable exception percentage (see instructions)	2)		0.00	
00 Capital cost for comparison to payments (line 3 x line	1)		0.00	
00 Percentage adjustment for extraordinary circumstances			0, 00	
00 Adjustment to capital minimum payment level for extraor		line 6)	0.00	
00 Capital minimum payment level (line 5 plus line 7)			0	
00 Current year capital payments (from Part I, line 12, as	s applicable)		0	
00 Current year comparison of capital minimum payment leve		less line 9)	0	
.00 Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)			0	
	ital payments (line 10 plus lir	ne 11)	0	12.
2.00 Net comparison of capital minimum payment level to capi			0	
				14
 00 Current year exception payment (if line 12 is positive, 00 Carryover of accumulated capital minimum payment level 	over capital payment for the f	following period	0	14
 B. 00 Current year exception payment (if line 12 is positive, Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line) 	over capital payment for the f)	ollowing period	-	
3.00 Current year exception payment (if line 12 is positive, 4.00 Carryover of accumulated capital minimum payment level	over capital payment for the f) see instructions)	ollowing period	0	15