icai tii i i iaiici	ar bystems	SOTHISON WEMOTH THE	HOOF I TAL	111	3 01 101111 01110 2002 1V	-
This report is	required by law (42 USC 1395g	; 42 CFR 413.20(b)). Fail	lure to report can res	sult in all interim	FORM APPROVED	
payments made	since the beginning of the cos	t reporting period being	deemed overpayments ((42 USC 1395g).	OMB NO. 0938-0050	
					EXPIRES 05-31-2019	
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX CC SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 15-0001	Peri od: From 01/01/2018 To 12/31/2018		
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically filed of	cost report		Date: 5/29/20	19 Time: 11:55 am	n
use only	2. [] Manually submitted cos	st report				
	3. [0] If this is an amended 4. [F] Medicare Utilization.			resubmitted this co	ost report	
Contractor use only	(2) Settled without Audit	7. Contractor No.	11 or this Provider CCN 12			

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHNSON MEMORIAL HOSPITAL (15-0001) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl e	
Here	
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	146, 465	-57, 987	0	-63, 556	1.00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	-4, 459	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	142, 006	-57, 987	0	-63, 556	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.

Health Financial Systems JOHNSON MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0001 Period: Worksheet S-2

From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 11:55 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1125 WEST JEFFERSON STREET 1.00 PO Box: 1.00 State: IN 2.00 City: FRANKLIN Zip Code: 46131-County: **JOHNSON** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 JOHNSON MEMORIAL 150001 26900 07/01/1966 Ν 0 3.00 1 HOSPI TAI Subprovi der - IPF 4 00 4 00 TODD ALKENS REHAB 5.00 Subprovider - IRF 15T001 26900 5 01/01/2005 Ν Р 0 5.00 CENTER 6.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 JOHNSON MEMORIAL HOME 12.00 Hospi tal -Based HHA 157510 26900 07/01/1997 Ν Ρ Ν 12.00 HEALTH Separately Certified ASC 13.00 14.00 14.00 Hospi tal -Based Hospi ce 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospi tal -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20 00 21.00 Type of Control (see instructions) 21.00 9 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care N N 22 02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22 03 Ν N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0001 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 11:55 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 922 421 0 24.00 63 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state 0 0 0 0 42 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4. Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1. 00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39. 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν N Ν 46,00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Ν Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes Ν 56.00 or "N" for no.

If line 56 is yes, is this the first cost reporting period during which residents in approved

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is

57.00

58.00

59.00

Ν

Health Financial Systems JOHNSON	MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider Co		eriod: rom 01/01/2018	Worksheet S-2 Part I Date/Time Prep 5/29/2019 11:5	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1. 00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (N			60.00
garry programs that meet the ori terra ander 3116.00.	Y/N	I ME	Direct GME	I ME	Direct GME	
(1.00 Did your bootists receive FTF elete under ACA	1.00	2. 00	3. 00	4. 00	5.00	(1.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61. 00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
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. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05
61.06 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
	Pr	ogram Name	Program Code	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				0.00	0.00	61. 10
FTE unweighted count. 61.20 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 62.00 Enter the number of FTE residents that your hospital				ad for which		62. 00
your hospital received HRSA PCRE funding (see instruction 62.01 Enter the number of FTE residents that rotated from a	ctions) a Teachi	ing Health Cen	ter (THC) into			62. 01
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 63.00 Has your facility trained residents in nonprovider se	er Sett ettings	ings during this c	ost reporting p		N	63. 00
"Y" for yes or "N" for no in column 1. If yes, comple	ete lin	es 64 through	67. (see instru Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 1/ (col. 1 + col. 2))	
Cootion EEOA of the ACA Dage Very ETE Decidents in No	nnra /	dor Cottings	1. 00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor 64.00 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	re June Ty train n-priman all non n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	O. 00			64. 00

Health Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0001 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 11:55 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

10.00 Schis a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		rom 01/01/2018	Date/Time Pre	pared:
10.00 st this a long term care hospital (LTQL)? Enter "" for yes, and "N" for no. N 80.0				
State Stat			N	80.00
Statis a new hospital under 42 CFR Section \$413.40(f)(1) (1) TEFRA? Enter "Y" for yes or "N" for no.	1.00 Is 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		81. 00
1886(d) (1) (1) (1) (1) (1) (1) (1) (1) (1) (1	5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes 6.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		N	85. 00 86. 00
Title V and XIX Services	7.00 Is this hospital an extended neoplastic disease care hospital classified under section		N	87. 00
	1000(d) (1) (b) (v1). Enter 1 101 yes of 1 10 110.	V	XI X	
00.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 10.00 Is this hospital relembursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 10.00 Are title XIX.NP patients occupying title XVIII SMF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 10.00 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. 10.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 10.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 10.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 10.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 10.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10.00 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Y Y 98.0 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Y Y 98.0 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10.00 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 10.00 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for	E	1. 00	2. 00	
yes or "N" for no in the applicable column. 10. Ois this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 20. OAre title XIX NP patients occupying title XVIII SNP beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 30. Obes this facility operate an IcfVIII of Sacility for purposes of title V and XIX7 Enter "Y" for yes or "N" for no in the applicable column. 40. Obes title V or XIX reduce operated column. 50. OI If line 94 is "V", enter the reduction percentage in the applicable column. 50. OI If line 94 is "V", enter the reduction percentage in the applicable column. 50. OI If line 94 is "V", enter the reduction percentage in the applicable column. 50. OI Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 50. OI Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 60. Oo. Oo. Oo. Oo. Oo. Oo. Oo. Oo. Oo. Oo		N	V	90.00
Full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.00 Are title XIX MF patients occupying title XVIII SMF beds (dual certification)? (see Instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 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. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 5.00 If Time 94 is "Y", enter the reduction percentage in the applicable column. 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes, or "N" for no in the applicable column. 7.00 If Time 94 is "Y", enter the reduction percentage in the applicable column. 8.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 9.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 9.00 Does title V or XIX roll ow Medicare (title XVIII) for the Interns and residents post septiments of the providence of the column 2 for title XIX. 9.01 Does title V or XIX foll ow Medicare (title XVIII) for the reporting of charges on Wist. 9.02 Does title V or XIX foll ow Medicare (title XVIII) for the calculation of observation bed costs on Wist. Tol., pt. IV. line 897 Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 9.03 Does title V or XIX foll ow 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 for title V, and in column 1 for title V, and in column 2 for title XIX. 9.03 Does title V or XIX foll ow 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 for title V, and in column 2 for title XIX. 9.04 Does title V or XIX foll ow Medicare (title XVIII) for a column 1 for title V, and in column 2 for title XIX. 9.05	yes or "N" for no in the applicable column.	IN .	1	90.00
22.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see Instructions) Enter "Y" for yes or "N" for no in the applicable column. 73.00 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. 7.40 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 7.50 If I line 94 is "Y", enter the reduction percentage in the applicable column. 7.50 If I line 94 is "Y", enter the reduction percentage in the applicable column. 7.50 If I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 If I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 If I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 If I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 If I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 If I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 I line 96 is "Y", enter the reduction percentage in the applicable column. 7.50 I line 97 98.0 98	1.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	N	91.00
Instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 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. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 5.00 If I ine 94 is "", enter the reduction percentage in the applicable column. 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 7.00 If I ine 94 is "", enter the reduction percentage in the applicable column. 8.01 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Mkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 8.02 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title VXIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relimbursed 101% of inpatient services cost? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relimbursed 101% of inpatient services cost? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "V" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) when cost reimburseed for Wkst. D, Pts. I through IV? Enter "V" for yes or "N" for no in column 1 for title V,			N	92 00
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15.00 If I in 9.4 is "Y", enter the reduction percentage in the applicable column. 0.00	4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94. 00
Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	' '	0.00	0.00	95. 00
17.00 If line 96 is "", enter the reduction percentage in the applicable column. 0.00	6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	1		96. 00
No. 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 column 1 for title V, and in column 2 for title XIX. No. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Y Y Y Y Y Y Y Y Y	' '	0.00	0.00	97 00
No. 00 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C. Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. No. 00 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. No. 01 No. 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 for title V, and in column 2 for title XIX. No. 01 No. XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. No. 01 No. XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. No. 02 No. 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 column 2 for title XIX. No. 02 No. XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D. Pts. I through IN? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. No. 02 No. XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D. Pts. I through IN? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. No. 00 No. XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D. Pts. I through IN? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. No. 00	8.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	1		98. 00
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Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in 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 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. Rural Providers 105.00 Does this hospital qualifies as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&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 reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1		N	98. 03
Description 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 column 2 for title XIX. Description 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.	8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and	N	N	98. 04
P8. 06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105. 00 Does this hospital qualify as a CAH? 106. 00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107. 00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&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 reimbursed. If yes complete Wkst. D-2, Pt. II. 108. 00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108. 0 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109. 00 If this hospital qualifies as a CAH or a cost provider, are thereapy services provided by outside supplier? Enter "Y"	8.05 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		Υ	98. 05
Rural Providers 105.00 Does this hospital qualify as a CAH? N 105.00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R N 107.00 107.01 This facility qualifies as a CAH, is it eligible for cost reimbursement for L&R N 107.00 107.02 Training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If 107.01 Yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 108.00 Is this hospital qualifies as a CAH or a cost provider, are N N N N N 109.00 109.00 If this hospital qualifies as a CAH or a cost provider, are N N N N 109.00 109.00 It this hospital qualifies as a CAH or a cost provider, are N N N N N N N N N	8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in	Y	Υ	98. 06
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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 reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 For Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory			106. 00	
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" N N N 109.00 109.00 N N N N N N N N N	07.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&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		107. 00	
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109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	Physical Occupational	<u> </u>		
therapy services provided by outside supplier? Enter "Y"			4 ()()	
	1.00 2.00			109. 00

	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110.00
Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.		

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	CN: 15-0001	Peri od:		Form CM ksheet S	
FIGURE OF THE PENETT OFFICE OF THE PENETT OF	5.1. 15 0001	From 01/01/2 To 12/31/2	018 Par 018 Dat		repared
		1. 00		2. 00	
11.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N		2.00	111.
			1.00 2.	00 3.0	00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no i is yes, enter the method used (A, B, or E only) in column 2. If column 2 a either "93" percent for short term hospital or "98" percent for long te psychiatric, rehabilitation and long term hospitals providers) based on t Pub. 15-1, chapter 22, §2208.1.	is "E", enter rm care (incl he definition	in column udes	N	0	
16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N 17.00 Is this facility legally-required to carry malpractice insurance? Enter "no.		"N" for	N Y		116. 117.
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy	is	2		118.
jordini mada. Erres. Erresta perrey re decarrones.	Premi ums	Losses	11	nsurance	
	1. 00	2. 00		3.00	
18.01 List amounts of malpractice premiums and paid losses:	326, 1	54	0		0 118.
18.02 Are malpractice premiums and paid losses reported in a cost center other		1. 00 N		2.00	118.
Administrative and General? If yes, submit supporting schedule listing c and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA \$3121 and applicable amendments? (see inst	ost centers vision in ACA " for yes or he Outpatient			N	119. 120.
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implantable device	s charged to	Υ			121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ente the Worksheet A line number where these taxes are included.					122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no lf	N			125.
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2.					126.
27.00 f this is a Medicare certified heart transplant center, enter the certif	ication date				127.
in column 1 and termination date, if applicable, in column 2. 8.00 f this is a Medicare certified liver transplant center, enter the certif	ication date				128.
in column 1 and termination date, if applicable, in column 2. 19.00 If this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.	cation date i	n			129.
0.00 If this is a Medicare certified pancreas transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2.	ti fi cati on				130.
(1.00) If this is a Medicare certified intestinal transplant center, enter the condate in column 1 and termination date, if applicable, in column 2.	erti fi cati on				131.
12.00 f this is a Medicare certified islet transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2.	ication date				132.
in column 1 and termination date, if applicable, in column 2. 3.00 f this is a Medicare certified other transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2.	ication date				133.
34.00 If this is an organ procurement organization (OPO), enter the OPO number and termination date, if applicable, in column 2.	in column 1				134.
All Providers 40.00 Are there any related organization or home office costs as defined in CMS	Pub. 15-1	N			140.
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home					1.10.

Health Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0001 Peri od: Worksheet S-2 From 01/01/2018 Part I То 12/31/2018 Date/Time Prepared: 5/29/2019 11:55 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 of costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 N Ν 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν Ν 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 5.00 0 1.00 2.00 3.00 4.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in

		1. 00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act			
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00	
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the		0168.00	
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168. 01		
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				
	Begi nni ng	Endi ng		
	1. 00	2. 00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	170. 00	
	1. 00	2.00	7	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0 171. 00	

column 5 (see instructions)

Heal th	Financial Systems JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II	epared:
		<u> </u>		Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	l for all NO re	sponses. Ente	r all dates in t	he	
1. 00	Has the provider changed ownership immediately prior to the	e beainnina of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in o					
			Y/N	Date	V/I	
	In		1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2. 00
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
	(See That dot one)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.00
5.00	Are the cost report total expenses and total revenues diffe		N			5. 00
	those on the filed financial statements? If yes, submit rec	conciliation.		V (0)		
				Y/N 1. 00	Legal Oper.	
	Approved Educational Activities			1.00	2. 00	_
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	e provider is	N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in t	he current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
					1. 00	_
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s soo instruct	Long		Y	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,	yes, see inst t A		N t B	15. 00
		Y/N	Date	Y/N	Date	
	loos a	1.00	2. 00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	04/18/2019	Y	04/18/2019	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 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 information? If yes, see instructions.	N		N		19. 00

near th	Financial Systems JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0001	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S- Part II Date/Time Pr 5/29/2019 11	epared:
		Descr	pti on	Y/N	Y/N	1.00 am
)	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:			N	N	20. 00
	nopolit data for other. Beson be the other day astments.	Y/N	Date	Y/N	Date	
21 00	Was the seek seems as a selection the seek deals	1.00	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 (EXCE	PT CHILDRENS H	OSPI TALS)	'		
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see					22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost		23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	d into during	this cost re	porting period?		24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	'If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportir	g period? If	yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	hand funds (De	ht Service R	Peserve Fund)		29. 00
	treated as a funded depreciation account? If yes, see instr	ucti ons		ŕ		
30. 00	Has existing debt been replaced prior to its scheduled matu instructions.					30.00
31. 00	Has debt been recalled before scheduled maturity without is instructions. Purchased Services	suance or new	dept? IT yes	s, see		31.00
32. 00	Have changes or new agreements occurred in patient care ser		d through co	ntractual		32. 00
33. 00	arrangements with suppliers of services? If yes, see instru- If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	provi der-ba	sed physicians?		34. 00
35. 00	If line 34 is yes, were there new agreements or amended exis		ts with the	provi der-based		35. 00
	physicians during the cost reporting period? If yes, see in	STRUCTIONS.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36. 00
37. 00	If line 36 is yes, has a home office cost statement been prolef yes, see instructions.	epared by the	home office?	'		37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end					38. 00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.			i,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
		1	00	2.0	00	
	Cost Report Preparer Contact Information	1.		2.1		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41. 00
42. 00		BLUE & CO				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANI	OCO. COM	43. 00

Health Financial Systems JOHNSON MEN	ORIAL HOSPITAL	In Lie	u of Form CMS-2552-10	0
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-0001	Peri od: From 01/01/2018 To 12/31/2018		_
		10 12/31/2010	5/29/2019 11:55 am	_
	3. 00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	MANAGER		41.00	C
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
42.00 Enter the employer/company name of the cost report			42.00	C
preparer.				
43.00 Enter the telephone number and email address of the cost			43.00	C
report preparer in columns 1 and 2, respectively.				

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:
 Heal th Financial
 Systems
 JOHNSON

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-0001

						To 12/31/2018	B Date/Time Pre 5/29/2019 11:	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		77	28, 10	5 0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
0.00	for the portion of LDP room available beds)							0.00
2.00	HMO and other (see instructions)							2. 00 3. 00
3.00	HMO I PF Subprovi der							4.00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF						0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			77	28, 10	5 0.00		7.00
7.00	beds) (see instructions)			, ,	20, 10	0.00	1	7.00
8.00	INTENSIVE CARE UNIT	31. 00		6	2, 19	0. 00	0	8. 00
9. 00	CORONARY CARE UNIT	01.00		Ö	2, 17	0.00	1	9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	•
14.00	Total (see instructions)			83	30, 29	5 0.00	ol o	14. 00
15. 00	CAH visits						0	15. 00
16.00	SUBPROVIDER - IPF							16. 00
17.00	SUBPROVI DER - I RF	41. 00		11	4, 01	5	0	17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			94				27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF			0				31.00
32.00	Labor & delivery days (see instructions)			0		0		32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)							32. 01
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 00
55. 51	2. S. S. ES Houti di days and di Sonai gos		1		ı	1	1	30.01

Health Financial Systems JOHNSON HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0001

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared:

				'	0 12/31/2010	5/29/2019 11:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	00 4
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	odiiiporierre	I tro xviii	TI CI O XIX	Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 298	55	5, 455			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	475	1, 340				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	42	_			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	2, 298	55	5, 455			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	208	0	496			8. 00
9. 00	CORONARY CARE UNIT	200	U	490			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		7	731			13. 00
14. 00	Total (see instructions)	2, 506	62	6, 682		581. 14	1
15. 00	CAH visits	2,000	0	0, 002	0.00	001.11	15. 00
16. 00	SUBPROVI DER - I PF	J	Ŭ	O			16. 00
17. 00	SUBPROVIDER - I RF	118	0	449	0.00	0.00	1
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	2, 532	0	5, 549	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			44			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.00	
27. 00	Total (sum of lines 14-26)				0.00	581. 14	•
28. 00	Observation Bed Days	_	0	229			28. 00
29. 00	Ambul ance Tri ps	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	4	51			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
33. 00	outpatient days (see instructions)	o					33. 00
	LTCH non-covered days LTCH site neutral days and discharges						33.00
33. UI	TETOTI SI LE MEULLAL MAYS AND ULSCHALGES	ı					J 33. UT

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0001

				To	12/31/2018	Date/Time Prep 5/29/2019 11:	
		Full Time		Di sch	arges		
		Equi val ents		1			
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
1 00	Usersited Adulte a Dada (calcumate 5 / 7 and	11.00	12. 00	13.00	14.00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		(705	19	1, 917	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			113	360		2. 00
3.00	HMO IPF Subprovider			113	0		3. 00
4. 00	HMO IRF Subprovider				2		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				-		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	(705	19	1, 917	14.00
15. 00	CAH visits						15.00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0. 00	(10	0	30	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00 26. 25	RURAL HEALTH CLINIC	0. 00					26. 00 26. 25
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25 27. 00
28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see l'istruction)						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 00
52. 51	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
				. '	'	•	

| Period: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0001

					T-	12/31/2018	Date/Time Pre	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	,		5/29/2019 11: Average Hourly Wage (col. 4 ÷	os alli
			.,	(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1. 00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							
1.00	Total salaries (see	200. 00	40, 263, 393	-63, 798	40, 199, 595	1, 175, 940. 00	34. 19	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	О	О	0.00	0. 00	2. 00
3.00	A Non-physician anesthetist Part		0	0	0	0. 00	0.00	3. 00
4. 00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 1, 121, 598	0		0. 00 12, 061. 00		4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for		0	0		0. 00		6. 00
7 00	hospital-based RHC and FQHC services	21. 00	0	0		0.00	0.00	7 00
7. 00 7. 01	Interns & residents (in an approved program) Contracted interns and	21.00	0	0	0	0.00		7. 00 7. 01
,, ,,	residents (in an approved programs)		Š			0.00	0.00	,, ,,
8.00	Home office and/or related organization personnel	44.00	603, 208	0		17, 715. 00		
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	12, 742, 663	-141, 443	0 12, 601, 220	0. 00 232, 955. 00		9. 00 10. 00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		77, 376	0	77, 376	1, 017. 00	76. 08	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		430, 767	0	430, 767	1, 837. 00	234. 49	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		0	0	0	0.00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0.00		16. 00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		7, 529, 340	0	7, 529, 340			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 496, 581 0	0	2, 496, 581 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01	Physician Part A - Teaching		140, 407	0	0			22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		148, 486 0	0	148, 486 0			23. 00 24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
25. 50	Home office wage-related (core)		0	0				25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		0	0	0			25. 53
	wage-related (core) OVERHEAD COSTS - DIRECT SALARIE	ES .						
26. 00	Employee Benefits Department	4. 00	3, 292, 822					
27.00	Administrative & General	5. 00	1, 566, 329	-51, 006	1, 515, 323	65, 068. 00	23. 29	27. 00

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0001

					11	0 12/31/2018	5/29/2019 11:	
		Wkst. A Line	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		1, 917, 819	0	1, 917, 819	15, 001. 00	127. 85	28.00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	619, 650		619, 650			
31. 00	Laundry & Linen Service	8. 00	107, 874		107, 874	7, 882. 00	13. 69	31. 00
32. 00	Housekeepi ng	9. 00	709, 799	0	709, 799	51, 054. 00		32.00
33. 00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	744, 065	-481, 321	262, 744	18, 876. 00		34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	481, 321	481, 321	27, 207. 00	17. 69	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37.00
38. 00	Nursing Administration	13. 00	1, 467, 049	0	1, 467, 049	24, 881. 00	58. 96	38.00
39. 00	Central Services and Supply	14. 00	90, 212	0	90, 212	4, 596. 00	19. 63	39.00
40.00	Pharmacy	15. 00	496, 731	0	496, 731	12, 938. 00	38. 39	40.00
41.00	Medical Records & Medical	16. 00	543, 399	0	543, 399	26, 031. 00	20. 88	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

Provider CCN: 15-0001

					''	J 12/31/2010	5/29/2019 11:	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		40, 456, 406	-63, 798	40, 392, 608	1, 161, 165. 00	34. 79	1.00
	instructions)							
2.00	Excluded area salaries (see		12, 742, 663	-141, 443	12, 601, 220	232, 955. 00	54. 09	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		27, 713, 743	77, 645	27, 791, 388	928, 210. 00	29. 94	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		508, 143	0	508, 143	2, 854. 00	178. 05	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		7, 529, 340	0	7, 529, 340	0.00	27. 09	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		35, 751, 226	77, 645	35, 828, 871	931, 064. 00	38. 48	6. 00
7.00	Total overhead cost (see		11, 555, 749	84, 514	11, 640, 263	441, 698. 00	26. 35	7. 00
	instructions)							

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0001	Peri od: Worksheet S-3	
		From 01/01/2018 Part IV	

PART I V - WAGE RELATED COSTS 1.00		To 12/31/2018	Date/Time Pre 5/29/2019 11:	
PART IV - WAGE RELATED COSTS			1'	
PART I V - WAGE RELATED COSTS Part A - Core Ist RETIREMINT COST 401K Employer Contributions 0.2.00 Contributions 0.2.00 Contributions 0.2.00 Contributions 0.3.00 Contributions 0.3.00 Contributions 0.3.00 Contribution 0.3.00 Contribu			Reported	
Part A - Core List RETIREMENT COST			1. 00	
RETIREMENT COST				
1.00				
2.00		RETI REMENT COST		
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 0.00	1.00		934, 063	
A. 00 Qualified Defined Benefit Plan Cost (see instructions)	2.00		0	
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Pl an Administration fees 0 5.00 6.00 Legal/Accounting/Management fees-Pension Pl an 0 6.00 Employee Managed Care Program Administration fees 0 7.00 Employee Managed Care Program Administration fees 0 7.00 Employee Managed Care Program Administration fees 0 7.00 HEALTH AND INSURANCE COST			0	
5.00	4.00		0	4.00
Column C				1
The color of the				
HEALTH AND INSURANCE COST			_	
Heal th Insurance (Purchased or Self Funded) Heal th Insurance (Self Funded without a Third Party Administrator) 0	7.00		0	7.00
Heal th Insurance (Self Funded without a Third Party Administrator) 0 8. 01				
Heal th Insurance (Self Funded with a Third Party Administrator)	8.00			
8. 03 Heal th Insurance (Purchased) 0 8. 03 9. 00 Prescription Drug Plan 0 9. 00 10.	8. 01		_	
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 26,143 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 118,071 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 234,668 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) 2, 695, 776 17.00 18.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 18,326 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 0THER Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 22.00 Day Care Cost			6, 107, 785	
10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 26,143 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 118,071 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance 234,668 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion 10.00 17.00 FICA-Employers Portion Only 2,695,776 17.00 18.00 Unemployment Insurance 18,326 19.00 19.00 Unemployment Insurance 18,326 19.00 20.00 OTHER 2.00 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21.00 10.62 22.00 23.00 Tuit ion Reimbursement 28,912 23.00 24.00 Part B - Other than Core Related Cost 24.00 24.00 Part B - Other than Core Related Cost 20.00 25.00 Part B - Other than Core Related Cost 20.00 26.143 11.00 12.00 12.00 26.143 11.00 12.00 27.00 18.00 18.00 28.01 28.01 28.01 29.01 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 29.00 20.00 29.00 2	8. 03		0	
11.00			1	
12.00	10.00		_	
13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only 18.00 Medicare Taxes - Employers Portion Only 19.00 Unemployment Insurance 20.00 State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 23.00 Tuition Reimbursement 24.00 Part B - Other than Core Related Cost			26, 143	11. 00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 15.00 'Workers' Compensation Insurance Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES 17.00 FICA-Employers Portion Only Medicare Taxes - Employers Portion Only Unemployment Insurance State or Federal Unemployment Taxes 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) Day Care Cost and Allowances Tuition Reimbursement Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost	12.00			
15.00 'Workers' Compensation Insurance Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost and No. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 17.00 18.00 Wedicare Taxes - Employers Portion Only 19.00 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 on the province of the			118, 071	
Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES				
Non cumulative portion TAXES			234, 668	
TAXES 17. 00 FI CA-Employers Portion Only 2, 695, 776 17. 00 18. 00 Medicare Taxes - Employers Portion Only 0 18. 00 19. 00 Unemployment Insurance 18, 326 19. 00 20. 00 OTHER 21. 00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 21. 00 21. 00 22. 00 23. 00 Tuition Reimbursement 28, 912 23. 00 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 24. 00 Part B - Other than Core Related Cost 24. 00 25. 00	16. 00		0	16. 00
17. 00				l
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 18,326 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 22.00 Day Care Cost and Allowances 10,662 22.00 23.00 Tuition Reimbursement 28,912 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 10,174,406 24.00 Part B - Other than Core Related Cost				
19.00 Unemployment Insurance 18,326 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 OTHER				
20.00 State or Federal Unemployment Taxes 0 0 OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances 10,662 22.00 Tuition Reimbursement 28,912 23.00 Total Wage Related cost (Sum of Lines 1 -23) 10,174,406 Part B - Other than Core Related Cost				
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost 21.00 2			18, 326	
21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 28,912 24.00 Part B - Other than Core Related Cost	20. 00		0	20.00
instructions)) 22.00 Day Care Cost and Allowances Tuition Reimbursement 24.00 Part B - Other than Core Related Cost instructions)) 22.00 22.00 10,662 22.00 23.00 10,174,406 24.00				
22. 00 Day Care Cost and Allowances 10, 662 22. 00 23. 00 Tuition Reimbursement 28, 912 23. 00 24. 00 Total Wage Related cost (Sum of lines 1 -23) 10, 174, 406 24. 00 Part B - Other than Core Related Cost	21. 00		0	21. 00
23. 00 Tuition Reimbursement 28, 912 23. 00 24. 00 Part B - Other than Core Related Cost (Sum of lines 1 -23) 24. 00				1
24.00 Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost 24.00				
Part B - Other than Core Related Cost				
	24. 00		10, 174, 406	24. 00
25. 00 O HER WAGE RELATED COSTS 0 25. 00				
	25. 00	UTHER WAGE RELATED COSTS	0	25.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0001	Peri od: Worksheet S-3 From 01/01/2018 Part V To 12/31/2018 Date/Time Prepared:

	l.	0 12/31/2010	5/29/2019 11:	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	77, 376	10, 174, 406	1. 00
2.00	Hospi tal	77, 376	10, 174, 406	2. 00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (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	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s			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
	HEALTH AGENCY STATISTICAL DATA		Provi der C	CN: 15-0001	Peri od: From 01/01/2018	Worksheet S-4	
			Component	CCN: 15-7510	To 12/31/2018		
					Home Health	PPS	<u> </u>
					Agency I		
0.00	County				1.	. 00	0.00
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0.00
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2. 00	3.00	4. 00	5. 00	
1.00	Home Health Aide Hours	0	0	1	0 0		
2. 00	Unduplicated Census Count (see instructions)	0.00	0.00		0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		2. 00
		Enter the number		Staff	Contract	Total	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	0		1.00	2. 00	3. 00	
3.00	Administrator and Assistant Administrator(s)		40.00	1		1	1
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.			1
6.00	Direct Nursing Service			2	42 0.00	2. 42	6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			0. (1	1
9.00	Physical Therapy Supervisor			0.		1	1
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			0. 0		1	1
12.00	Speech Pathology Service			0.			
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. (1	1
15. 00 16. 00	Medical Social Service Supervisor Home Health Aide			0. (1
17. 00	Home Health Aide Supervisor			0.		1	1
18. 00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.	0.00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where				2		19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			18020			20. 00
	contains the first code).						
20. 01		Full Epi	i sodes	26900			20. 01
		Wi thout	With Outliers	LUPA Epi sode		Total (cols.	
		0utliers 1.00	2. 00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21 00	PPS ACTIVITY DATA Skilled Nursing Visits	1, 054	0		10 0		21. 00
21. 00 22. 00	Skilled Nursing Visit Charges	252, 960	0	2, 4		255, 360	22. 00
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	880 228, 800	0	1	3 C 80 C		1
25. 00	Occupational Therapy Visits	559	O	i	0 0		1
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	145, 340 24	0	l .			1
28. 00	Speech Pathology Visit Charges	6, 240	0		0 0	6, 240	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	0	0	l .	0 0	ή	1
31. 00	Home Health Aide Visits	2	0		0 0	2	31. 00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	210 2, 519	0	1	0 C 13 C		1
	29, and 31)						
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	633, 550	0	1	0 0 80 0		
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	133			5 0		
	outlier)	133					
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	3, 405	0	1	36 0		37. 00 38. 00
	The state of the s	0,.00			1	3, 111	,

	Financial Systems JOHNSON MEMORIAL HOSPITA			u of Form CMS-2		
JJFII	AL UNCOMPENSATED AND INDIGENT CARE DATA Provide	r CCN: 15-0001	Peri od: From 01/01/2018	Worksheet S-1	U	
			To 12/31/2018		pared 55 am	
				1. 00		
	Uncompensated and indigent care cost computation			1.00		
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	line 202 colum	nn 8)	0. 265004	1. (
	Medicaid (see instructions for each line)		,			
00	Net revenue from Medicaid			5, 288, 808	2. (
00	Did you receive DSH or supplemental payments from Medicaid?				3. (
00	If line 3 is yes, does line 2 include all DSH and/or supplemental pays		cai d?	0	4. (5. (
00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid					
00	Medicaid charges Medicaid cost (line 1 times line 6)	25, 157, 224 6, 666, 765				
00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if					
00	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions for each	line)				
00	Net revenue from stand-alone CHIP	,		0	9. (
0. 00	Stand-alone CHIP charges			0	10.	
1. 00	Stand-alone CHIP cost (line 1 times line 10)			0		
2. 00	Difference between net revenue and costs for stand-alone CHIP (line 1	minus line 9;	if < zero then	0	12.	
	enter zero) Other state or lecal government indigent care program (see instruction	s for each line	\)			
3. 00	Other state or local government indigent care program (see instruction Net revenue from state or local indigent care program (Not included or			0	13.	
1. 00	Charges for patients covered under state or local indigent care program			l e	14.	
00	10)	iii (Not Theradec	2 111 111103 0 01			
5. 00	State or local indigent care program cost (line 1 times line 14)			0	15.	
5. 00	Difference between net revenue and costs for state or local indigent	are program (li	ne 15 minus line	0	16.	
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sinstructions for each line)	tate/local indi	gent care program	ns (see		
7. 00	Private grants, donations, or endowment income restricted to funding of	harity care		0	17.	
3. 00	Government grants, appropriations or transfers for support of hospital			0		
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigonal 8, 12 and 16)	nt care program	ns (sum of lines	1, 377, 957	19.	
	12 and 10)	Uni nsured	Insured	Total (col. 1		
		pati ents		+ col . 2)		
			2 00	1 001. 2)		
		1.00	2. 00	3. 00		
	Uncompensated Care (see instructions for each line)			3.00		
0. 00	Charity care charges and uninsured discounts for the entire facility	2, 750, 1		3.00	20.	
	Charity care charges and uninsured discounts for the entire facility (see instructions)	2, 750, 1	904, 569	3, 654, 691		
0. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see	2, 750, 1	904, 569	3, 654, 691		
	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (seinstructions)	2, 750, 1	904, 569	3. 00 3, 654, 691 1, 633, 362	21.	
1. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see	2, 750, 1	904, 569 904, 569	3. 00 3, 654, 691 1, 633, 362	21.	
1. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	2, 750, 1	904, 569 0 0	3, 00 3, 654, 691 1, 633, 362	21.	
1. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	2, 750, 7 se 728, 7	904, 569 0 0	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362	21. 22.	
1. 00 2. 00 3. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	2, 750, 7 re 728, 7	904, 569 904, 569	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362 1. 00	21. · · · · · · · · · · · · · · · · · · ·	
1. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days	2, 750, 7ee 728, 7	904, 569 904, 569	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362	21. 22. 23.	
1. 00 2. 00 3. 00 4. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care prograf of line 24 is yes, enter the charges for patient days beyond the indigent care prografications.	2, 750, 728, 728, 728, 728, 728, 728, 728, 728	904, 569 904, 569 0 0 793 904, 569	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362 1. 00	21. 22. 23. 24.	
1. 00 2. 00 3. 00 4. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program If line 24 is yes, enter the charges for patient days beyond the indigstay limit	2,750,7 2,750,7 728,7 beyond a length ? ent care progra	904, 569 904, 569 0 0 793 904, 569	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362 1. 00 N	21. 22. 23. 24. 25.	
1. 00 2. 00 3. 00 4. 00 5. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (so instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Total bad debt expense for the entire hospital complex (see instruction)	beyond a length? ent care programs)	904, 569 904, 569 0 0 793 904, 569	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362 1. 00 N 0 5, 665, 453	21. 22. 23. 24. 25. 26.	
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (so instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care reimbursable bad debts for the entire hospital complex (see instruction)	beyond a length? ent care programs) nstructions)	904, 569 904, 569 0 0 793 904, 569	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362 1. 00 N 0 5, 665, 453 114, 098	21. 22. 23. 24. 25. 26. 27.	
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 7. 01	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (so instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care reimbursable bad debts for the entire hospital complex (see instruction Medicare allowable bad debts for the entire hospital complex (see instructions)	beyond a length? ent care programs) nstructions)	904, 569 904, 569 0 0 793 904, 569	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362 1. 00 N 0 5, 665, 453 114, 098 175, 535	21. 22. 23. 24. 25. 26. 27. 27.	
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (so instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care program of the charges for patient days beyond the indigent care reimbursable bad debts for the entire hospital complex (see instruction)	beyond a length? ent care programs) nstructions)	122 904, 569 0 0 793 904, 569 0 904, 569 n of stay limit	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362 1. 00 N 0 5, 665, 453 114, 098 175, 535 5, 489, 918	21. 22. 23. 24. 25. 26. 27. 27. 28.	
1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 7. 01 3. 00	Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care program of line 24 is yes, enter the charges for patient days beyond the indigent care indicated limit. Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see instructions)	beyond a length? ent care programs) nstructions)	904, 569 904, 569 0 904, 569 904, 569 904, 569 n of stay limit	3. 00 3, 654, 691 1, 633, 362 0 1, 633, 362 1. 00 N 0 5, 665, 453 114, 098 175, 535	21. 1 22. 1 23. 1 24. 1 25. 1 26. 1 27. 1 28. 1 29. 1	

Health Financial Systems	JOHNSON MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider C	CN: 15-0001	Peri od:	Worksheet A	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	nared:
				10 12/31/2010	5/29/2019 11:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
OFNEDAL CEDILIOS COCT CENTEDO	1. 00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS 1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT		233, 374	233, 37	4 0	222 274	1.00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP		4, 753, 571	1		233, 374 4, 753, 571	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	312, 491	9, 034, 263			9, 578, 746	4. 00
4. 01 00401 COMMUNI CATI ONS	86, 368	239, 162			325, 494	4. 01
4. 02 00402 DATA PROCESSING	782, 484	1, 940, 511			2, 722, 956	4. 02
4. 03 00403 MATERIALS MANAGEMENT	321, 857	45, 956			367, 386	4. 03
4. 04 00404 ADMI TTI NG	743, 258	8, 066	751, 32	4 -271	751, 053	4. 04
4.05 O0405 PATIENT ACCOUNTING	1, 046, 364	646, 985	1, 693, 34	9 0	1, 693, 349	4. 05
5.00 00500 ADMINISTRATIVE & GENERAL	1, 566, 329	4, 374, 332			5, 885, 889	5. 00
7. 00 00700 OPERATION OF PLANT	619, 650	1, 870, 047			2, 489, 601	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	107, 874	89, 283	•		196, 626	8. 00
9. 00 00900 HOUSEKEEPI NG	709, 799	106, 073			812, 515	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	744, 065	348, 515 0		0 -707, 000 0 706, 768	385, 580 706, 768	10. 00 11. 00
13. 00 O1300 NURSI NG ADMI NI STRATI ON	1, 467, 049	204, 756	1		1, 671, 759	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	90, 212	132, 662			163, 899	14.00
15. 00 01500 PHARMACY	496, 731	4, 627, 807			1, 417, 241	
16. 00 01600 MEDICAL RECORDS & LIBRARY	543, 399	87, 553			630, 952	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 237, 294	615, 636	4, 852, 93	0 -321, 890	4, 531, 040	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 197, 447	107, 097	1, 304, 54	4 -47, 500	1, 257, 044	31. 00
41. 00 04100 SUBPROVI DER - RF	267, 599	56, 603	324, 20	2 -44, 993	279, 209	41. 00
43. 00 04300 NURSERY	0	0)	0 180, 150	180, 150	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 868, 927	446, 546			2, 102, 086	50.00
53. 00 05300 ANESTHESI OLOGY	0 000 417	27, 428	1			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	2, 030, 417 1, 761, 381	686, 078 2, 203, 994			2, 641, 240 3, 794, 447	54. 00 60. 00
65. 00 06500 RESPI RATORY THERAPY	964, 235	2, 203, 994 175, 188			1, 070, 199	65. 00
66. 00 06600 PHYSI CAL THERAPY	746, 962	41, 477			812, 306	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	253, 582	25	1		253, 607	67. 00
68. 00 06800 SPEECH PATHOLOGY	138, 700	649			139, 349	68. 00
69. 00 06900 ELECTROCARDI OLOGY	278, 766	135, 880	1		407, 974	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	49, 335	8, 551	57, 88	6 -1, 550	56, 336	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 872, 585	3, 872, 58	5 -610, 287	3, 262, 298	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1	0 1, 684, 761	1, 684, 761	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 4, 250, 199	4, 250, 199	73. 00
76. 00 03020 0NCOLOGY	262, 852	194, 984	•			76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	128, 438	170, 539	298, 97	7 -6, 360	292, 617	76. 97
90. 00 09000 CLINIC	699, 614	2, 104, 167	2, 803, 78	1 -183, 381	2, 620, 400	90.00
91. 00 09100 EMERGENCY	3, 264, 850	1, 009, 278				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,201,000	., 00,, 2,0	1,2,1,12	0,7220	1, 200, 700	92. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			'		
101.00 10100 HOME HEALTH AGENCY	628, 642	85, 231	713, 87	3 -5, 148	708, 725	101. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE		0		0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	28, 416, 971	40, 684, 852	69, 101, 82	3 755, 625	69, 857, 448	118. 00
NONREI MBURSABLE COST CENTERS	40,000	00.470	70.07	4 400	70.040	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	49, 892	29, 179	1		78, 942	
192.00 19200 PHYSICIANS PRIVATE OFFICES 192.01 19201 SOUTH CLINIC	11, 261, 737	4, 871, 477	16, 133, 21	4 -567, 486		192. 00
192. 01 19201 3001H CLINIC		0				192. 01
192. 03 19203 DI ABETES CENTER	78, 615	6, 202	84, 81	7 -6,000		
193. 00 19300 NONPALD WORKERS	70,010	0, 202	01,01	0,000		193. 00
193. 01 19301 ADULT/CHI LD CARE	386, 597	129, 699	516, 29	6 -182,009	334, 287	
193.02 19302 PHYSICIAN OFFICE BUILDING	0	0		o o		193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON	o	0		o o		193. 03
194. 00 07950 PARTNERSHI P HFC	21, 676	35, 127	56, 80	3 -1	56, 802	
194. 01 07951 TRAFALGAR CLI NI C	0	0		0 0		194. 01
194. 02 07952 EDI NBURGH	0	0		이		194. 02
194. 03 07953 JAI L	47, 905	0	47, 90	5 0	47, 905	
194. 04 07954 ATHLETI C TRAINERS	0	0 45 357 507	0/ 010 00	U 0		194. 04
200.00 TOTAL (SUM OF LINES 118 through 199)	40, 263, 393	45, 756, 536	86, 019, 92	9 0	86, 019, 929	200. 00

Provider CCN: 15-0001

Peri od: Worksheet A From 01/01/2018 Date/Time Prepared: 5/20/2019 11:55 am

				5/29/2019 11:	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation	<u>1</u>	
	T	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS		000 540	, I	4 00
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	66, 139 0		l .	1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT	-173, 294	4, 753, 571 9, 405, 452	1	2. 00 4. 00
4. 00	00400 EMPLOTEE BENEFITS DEPARTMENT	-173, 294	310, 212	1	4. 00
4. 01	00401 COMMON CATTONS 00402 DATA PROCESSING	-15, 262	2, 722, 956	1	4. 01
4. 03	00403 MATERI ALS MANAGEMENT	0	367, 386	1	4. 03
4. 04	00404 ADMITTING	0	751, 053	l .	4. 04
4. 05	00405 PATIENT ACCOUNTING	-4, 521	1, 688, 828		4. 05
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 453, 973		1	5. 00
7.00	00700 OPERATION OF PLANT	-38, 578			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	196, 626		8. 00
9.00	00900 HOUSEKEEPI NG	0	812, 515	5	9. 00
10.00	01000 DI ETARY	0	385, 580		10. 00
11. 00	01100 CAFETERI A	-299, 512	407, 256	b	11. 00
13.00	01300 NURSING ADMINISTRATION	-525		·	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	163, 899	·	14. 00
15. 00	01500 PHARMACY	-1, 351	1, 415, 890	•	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-36, 523	594, 429	}	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 404 000	2 12/ 222		20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	-1, 404, 808		•	30.00
41. 00	04100 SUBPROVI DER – I RF	-7, 683 0	1, 249, 361 279, 209	•	41.00
43. 00	04300 NURSERY	0		1	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	0	100, 130)	43.00
50. 00	05000 OPERATING ROOM	0	2, 102, 086	5	50.00
53. 00	05300 ANESTHESI OLOGY	0		1	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 641, 240	1	54.00
60.00	06000 LABORATORY	0	3, 794, 447	1	60.00
65.00	06500 RESPI RATORY THERAPY	0	1, 070, 199		65. 00
66.00	06600 PHYSI CAL THERAPY	-10, 842	801, 464	1	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	253, 607	l .	67. 00
68. 00	06800 SPEECH PATHOLOGY	-625	1	l .	68. 00
69. 00	06900 ELECTROCARDI OLOGY	-91, 111	316, 863	1	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	56, 336	1	70.00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	3, 262, 298		71. 00
72.00	O7200 IMPL. DEV. CHARGED TO PATIENT O7300 DRUGS CHARGED TO PATIENTS	0	1, 684, 761	l .	72. 00
73. 00 76. 00	03020 ONCOLOGY	0 -130, 613	4, 250, 199 322, 728	l .	73. 00 76. 00
76. 00	07697 CARDI AC REHABI LI TATI ON	-130, 613		l .	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	-127,730	104, 007	1	1 70. 77
90. 00	09000 CLINIC	-718, 104	1, 902, 296	5	90.00
91. 00	09100 EMERGENCY	-2, 113, 754	2, 093, 151	l control of the cont	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,	,		92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0	708, 725	5	101. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 NTEREST EXPENSE	0			113. 00
118.00		-8, 562, 710	61, 294, 738	3	118. 00
400.00	NONREI MBURSABLE COST CENTERS		70.040	, I	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 SOUTH CLINIC	0			192. 00 192. 01
	19201 SOUTH CLINIC	0			192. 01
	19203 DI ABETES CENTER	0	78, 817	7	192. 02
	19300 NONPALD WORKERS	0	70,017		193. 00
	19301 ADULT/CHI LD CARE	0	334, 287	7	193. 01
	19302 PHYSICIAN OFFICE BUILDING	0	0		193. 02
	19303 OPTI FAST/FOUNDATI ON	Ö			193. 03
	07950 PARTNERSHI P HFC	0	56, 802	2	194. 00
	07951 TRAFALGAR CLINIC	0	0		194. 01
	07952 EDI NBURGH	0	0		194. 02
	07953 JAI L	0	47, 905	5	194. 03
	07954 ATHLETIC TRAINERS	0	0		194. 04
200.00	TOTAL (SUM OF LINES 118 through 199)	-8, 562, 710	77, 457, 219	9	200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0001 Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					To 12/31/2018 Date/Time Pro 5/29/2019 11:	
		Increases				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - NURSERY RECLASS	3.00	4.00	3.00		
1.00	NURSERY	43.00	165, 622	14, 528		1. 00
	TOTALS		165, 622	14, 528		
1. 00	B - I MPLANTABLE RECLASS I MPL. DEV. CHARGED TO	72. 00	O	1, 684, 761		1. 00
1.00	PATIENT	72.00	٩	1,004,701		1.00
	TOTALS			1, 684, 761		
	C - CAFETERIA RECLASS					
1. 00	CAFETERI A	<u>11.</u> 00	481, 321	225, 447		1. 00
	TOTALS D - DAY CARE RECLASS		481, 321	225, 447		-
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	135, 520	45, 466		1. 00
	TOTALS		135, 520	45, 466		
	G - STD RECLASS					
1.00	INTENSIVE CARE UNIT	31. 00	0	6, 869		1. 00
2.00	PHYSICIANS' PRIVATE OFFICES TOTALS	1 <u>92.</u> 00	0	_ <u>5, 923</u> 12, 792		2. 00
	H - EMPLOYEE WELLNESS RECLASS		<u> </u>	12, 192		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	51, 006		1. 00
	TOTALS			51, 006]
	J - PART A RECLASS					
1.00	ADULTS & PEDIATRICS PHYSICAL THERAPY	30.00	0	19, 083 39, 160		1.00
2. 00 3. 00	ANESTHESI OLOGY	66. 00 53. 00	ol Ol	39, 180		2. 00 3. 00
0.00	TOTALS		- — 	97, 282		0.00
	K - MEDICAL SUPPLIES RECLASS		,			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 074, 518		1. 00
2 00	PATI ENTS	0. 00	o	0		2 00
2. 00 3. 00		0.00	0	0		2. 00 3. 00
4. 00		0.00	Ö	o		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	o	0		10.00
11. 00		0.00	o	Ö		11. 00
12.00		0.00	o	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	ō	Ō		18. 00
19.00		0. 00	o	0		19. 00
20. 00		0. 00	0	0		20. 00
21.00		0.00	0	0		21. 00
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
24. 00		0.00	o	0		24. 00
25. 00		0.00	o	0		25. 00
26.00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00 29. 00		0. 00 0. 00	0	0		28. 00 29. 00
30.00		0.00	O O	0		30.00
31. 00		0.00	Ö	o		31.00
32.00		0.00	O	0		32. 00
	TOTALS		0	1, 074, 518]
1 00	L - DRUGS CHARGEABLE RECLASS	70.00	al	4 050 105		1
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4, 250, 199		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0.00	o	0		4. 00
5. 00		0.00	ō	ō		5. 00
6.00		0.00	О	0		6. 00
7. 00		0. 00	o	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	O	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	o	Ō		13. 00
				· · · · · · · · · · · · · · · · · · ·		

Heal th Financial Systems

| Provider CCN: 15-001 | Period: From CMS-2552-10 | Provider CCN: 15-001 | Period: From 01/01/2018 | To 12/31/2018 | Prepared:

						5/29/2019 11:	55 am_
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3. 00	4. 00	5. 00			
14.00		0.00	0	0			14. 00
15.00		0.00	0	0			15. 00
16.00		0.00	0	0			16. 00
	TOTALS		0	4, 250, 199			
500.00	Grand Total: Increases		782, 463	7, 455, 999			500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 | 11:55 am Provider CCN: 15-0001

						5/29/2	019 11:55 am
		Decreases					
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.		
	6. 00 A - NURSERY RECLASS	7. 00	8. 00	9. 00	10. 00		
1. 00	A - NURSERY RECLASS ADULTS & PEDIATRICS	30.00	165, 622	14, 528	0		1. 00
1.00	TOTALS		165, 622	14, 528			1.00
	B - IMPLANTABLE RECLASS		103, 022	14, 320			
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 684, 761	O		1.00
	PATIENTS			.,,			
	TOTALS		0	1, 684, 761			
	C - CAFETERIA RECLASS						
1. 00	DI ETARY	1000	481, 321	22 <u>5, 4</u> 47			1. 00
	TOTALS		481, 321	225, 447			
4 00	D - DAY CARE RECLASS	100.04	405 500	45 477			4.00
1. 00	ADULT/CHI LD CARE TOTALS	1 <u>93.</u> 01	135, 520	4 <u>5, 4</u> 66			1. 00
	G - STD RECLASS		135, 520	45, 466			
1. 00	INTENSIVE CARE UNIT	31.00	6, 869	0	O		1.00
2. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	5, 923	0	-		2. 00
	TOTALS		12, 792				
	H - EMPLOYEE WELLNESS RECLASS	;					
1.00	ADMINISTRATIVE & GENERAL	5. 00	51, 006	0	0		1. 00
	TOTALS		51, 006	0			
	J - PART A RECLASS						
1.00	SUBPROVI DER - I RF	41.00	0	39, 160	l I		1. 00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	52, 122	0		2.00
3. 00	DI ABETES CENTER	1 <u>92.</u> 03	0	<u>6, 000</u>	9		3. 00
	TOTALS K - MEDICAL SUPPLIES RECLASS		U	97, 282			
1. 00	COMMUNI CATIONS	4. 01	0	36	O		1. 00
2. 00	DATA PROCESSING	4. 02	o	39			2. 00
3.00	MATERIALS MANAGEMENT	4. 03	o	157	ol		3. 00
4.00	ADMI TTI NG	4.04	O	271	O		4. 00
5.00	ADMINISTRATIVE & GENERAL	5. 00	O	213	o		5. 00
6.00	OPERATION OF PLANT	7. 00	0	96	0		6. 00
7.00	LAUNDRY & LINEN SERVICE	8. 00	0	531	0		7. 00
8. 00	HOUSEKEEPI NG	9. 00	0	3, 357	0		8. 00
9.00	DIETARY	10.00	0	232	0		9.00
10.00	NURSING ADMINISTRATION	13.00	0	46	0		10.00
11. 00 12. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	58, 975 6, 011	0		11. 00 12. 00
13. 00	ADULTS & PEDIATRICS	30.00	0	159, 162			13. 00
14. 00	INTENSIVE CARE UNIT	31. 00	0	46, 613			14. 00
15. 00	SUBPROVI DER - I RF	41.00	o	5, 740	ol		15. 00
16.00	OPERATING ROOM	50.00	O	202, 603	o		16. 00
17.00	ANESTHESI OLOGY	53.00	o	11	o		17. 00
18. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	62, 795	0		18. 00
19. 00	LABORATORY	60.00	0	168, 820	0		19. 00
20. 00	RESPI RATORY THERAPY	65.00	0	59, 780	0		20. 00
21. 00	PHYSI CAL THERAPY	66.00	0	15, 271	0		21.00
22. 00	ELECTROCARDI OLOGY	69.00	0	6, 642			22.00
23. 00 24. 00	ELECTROENCEPHALOGRAPHY ONCOLOGY	70. 00 76. 00	0	1, 550 3, 996			23. 00 24. 00
25. 00	CARDI AC REHABI LI TATI ON	76. 97	0	6, 360			25. 00
26. 00	CLINIC	90.00	o	82, 752	o o		26. 00
27. 00	EMERGENCY	91. 00	o	67, 223	o		27. 00
28. 00	HOME HEALTH AGENCY	101.00	O	5, 148			28. 00
29.00	GIFT, FLOWER, COFFEE SHOP &	190.00	O	129	o		29. 00
	CANTEEN						
30.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	108, 935	0		30. 00
31. 00	ADULT/CHI LD CARE	193. 01	0	1, 023	0		31. 00
32. 00	PARTNERSHIP HFC	1 <u>94.</u> 00		1	┛		32. 00
	TOTALS		0	1, 074, 518			
1 00	L - DRUGS CHARGEABLE RECLASS	4 02	ol	270			1 00
1. 00 2. 00	MATERIALS MANAGEMENT ADMINISTRATIVE & GENERAL	4. 03 5. 00	0	270 3, 553	l I		1. 00 2. 00
3. 00	PHARMACY	15. 00	0	3, 553 3, 701, 286			3. 00
4. 00	ADULTS & PEDIATRICS	30.00	o	1, 661	o		4. 00
5. 00	INTENSIVE CARE UNIT	31. 00	Ö	887	o o		5. 00
6. 00	SUBPROVI DER - I RF	41.00	O	93	o		6. 00
7.00	OPERATING ROOM	50.00	o	10, 784	o		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	12, 460	0		8. 00
9. 00	LABORATORY	60.00	0	2, 108	l I		9. 00
10.00	RESPIRATORY THERAPY	65.00	0	9, 444	l I		10.00
11. 00	PHYSI CAL THERAPY	66.00	0	22			11.00
12. 00	ELECTROCARDI OLOGY	69. 00	0	30	0		12. 00

Health Financial Systems

JOHNSON MEMORIAL HOSPITAL

RECLASSIFICATIONS

Provider CCN: 15-0001 Period: Worksheet A-6

O01 Period: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

						5/29/2019 11:55	5 am_
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
13.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	44	(13.00
	PATI ENTS						
14.00	ONCOLOGY	76.00	0	499	(14.00
15.00	CLINIC	90.00	0	100, 629	(15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	406, 429)		16.00
	TOTALS			4, 250, 199			
500.00	Grand Total: Decreases		846, 261	7, 392, 201		5	500.00
300.00	Jordina Total . Decreases		040, 201	7, 372, 201	ļ	1	,00. 00

Provider CCN: 15-0001

					o 12/31/2018	Date/Time Pre	pared:
				Acqui si ti ons		5/29/2019 11:	55 am
		Begi nni ng	Purchases	Donation	Total	Disposals and	
		Bal ances	Pui Cliases	טטוומנו טוו	TOTAL	Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	3.00	4.00	3.00	
1.00	Land	4, 743, 426	O	0	0	0	1.00
2.00	Land Improvements	2, 807, 066	82, 220	0	82, 220	0	2. 00
3.00	Buildings and Fixtures	0	02,220	0	02,220	0	3. 00
4. 00	Building Improvements	72, 464, 758	6, 124, 333	0	6, 124, 333	8, 964, 372	4. 00
5.00	Fi xed Equi pment	13, 007, 605	53, 616	0	53, 616		5. 00
6.00	Movable Equipment	39, 151, 763	15, 227, 531	0	15, 227, 531	1, 120, 054	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	132, 174, 618	21, 487, 700	0	21, 487, 700	10, 084, 426	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	132, 174, 618	21, 487, 700	0	21, 487, 700	10, 084, 426	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			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, 889, 286	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	69, 624, 719	0				4. 00
5.00	Fixed Equipment	13, 061, 221	0				5. 00
6.00	Movable Equipment	53, 259, 240	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	143, 577, 892	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	143, 577, 892	0				10. 00

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-0001	Peri od:	Worksheet A-7	,
					From 01/01/2018 To 12/31/2018		narod:
					10 12/31/2010	5/29/2019 11:	55 am
			<u> </u>	SUMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
						instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	226, 129		0 7, 2	15 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 753, 571		0	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 979, 700		0 7, 2	15 0	0	3. 00
		SUMMARY OF	F CAPITAL				
	Cost Center Description		Total (1) (sı	um			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)		_			
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	233, 3	74			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4, 753, 5				2. 00
3.00	Total (sum of lines 1-2)	0	4, 986, 9	45			3. 00

Heal th	Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018		
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col 2)	instructions)		
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	C	1	0. 000000		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	53, 259, 240		53, 259, 24			2.00
3.00	Total (sum of lines 1-2)	53, 259, 240		53, 259, 24			3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CE				000 545		4 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	2	0 309, 515		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2	0 4, 753, 571		2.00
3. 00	Total (sum of lines 1-2)	U		<u>'I</u> JMMARY OF CAPI	5, 063, 086	0	3. 00
			50	JIMIMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)		Capi tal -Rel ate	of cols. 9	
			ŕ		d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-10, 002	l	1	0	299, 513	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1		0	.,	2. 00
3.00	Total (sum of lines 1-2)	-10, 002	0)	0 0	5, 053, 084	3. 00

					rom 01/01/2018 o 12/31/2018		
				Expense Classification on	Worksheet A	5/29/2019 11:	55 am
			Т	To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
4 00	J. NEW CAR	1.00	2. 00	3.00	4. 00	5. 00	4 00
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	A		EW CAP REL COSTS-BLDG &	1.00	11	1. 00
0.00	2)			AD DEL COCTO MUDI E FOLLID	0.00		0.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		UC	AP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time		О		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		О		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-4, 604, 186			0	10. 00
11. 00	1 3		O		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
	transactions (chapter 10)	,, , ,					
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	
15. 00	Rental of quarters to employee	1	Ö		0.00	0	
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		О		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						40.04
19. 01	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 01
20.00	books, etc.)		0		0.00	0	20.00
	Vending machines Income from imposition of		0		0. 00 0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	OR	ESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0 P	HYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0 *	** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			EW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	Depreciation - CAP REL		1	AP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 *	** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant	400	O		0.00	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	00	CCUPATI ONAL THERAPY	67.00		30. 00
30 00	limitation (chapter 14) Hospice (non-distinct) (see			DULTS & PEDIATRICS	30.00		30. 99
JU. 77	instructions)		UA	DULIS & FLUINIKIUS	30.00		30. 99

Health Financial Systems		JOHNSON MEMOR	I AL HOSPI TAL	In Lie	In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8		
				From 01/01/2018			
				To 12/31/2018	Date/Time Prep 5/29/2019 11:		
			3/29/2019 11.	oo alii			
			Expense Classification or To/From Which the Amount is				
			To Troil will cir the Amount 13	to be haj astea			
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.		
	1.00	2.00	3.00	4. 00	5. 00		
31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00	
pathology costs in excess of							
limitation (chapter 14)							
32.00 CAH HIT Adjustment for		0		0.00	0	32.00	
Depreciation and Interest							
33.00 CAFETERIA CANTEEN VENDING	В	-296, 137	CAFETERI A	11. 00	0	33. 00	
REVENUE							
33. 01 CAFETERI A CANTEEN VENDING	В	-3, 375	CAFETERI A	11.00	0	33. 01	
REVENUE							
33. 02 MI SC OTHER REVENUE	В		PATIENT ACCOUNTING	4. 05	0	00.02	
33. 03 MISC OTHER REVENUE	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03	
33. 04 MISC OTHER REVENUE	В		NURSING ADMINISTRATION	13. 00	0	33. 04	
33. 05 MISC OTHER REVENUE	В	·	PHARMACY	15. 00	0	33. 05	
33.06 MISC OTHER REVENUE	В	·	MEDICAL RECORDS & LIBRARY	16.00	0	33. 06	
33. 07 MI SC OTHER REVENUE	В		CLINIC	90.00	0	33. 07	
33. 08 CABLE SERVICES	A	·	OPERATION OF PLANT	7.00	0	33. 08	
33. 09 TELEPHONE SERVICES	A	·	NEW CAP REL COSTS-BLDG &	1.00	9	33. 09	
			FIXT		_		
33. 10 TELEPHONE SERVICES	A		ADMINISTRATIVE & GENERAL	5. 00	0	000	
33. 11 COMMUNI CATI ONS	A	·	COMMUNICATIONS	4. 01	0	33. 11	
33. 12 ADVERTISING EXP - A&G	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12	
33. 13 ADVERTISING EXP - WOUND CARE	A		CLINIC	90.00	0	33. 13	

-8, 562, 710

-180, 986 EMPLOYEE BENEFITS DEPARTMENT

-1, 969 ADMINI STRATI VE & GENERAL

84, 563 NEW CAP REL COSTS-BLDG &

FIXT
-3, 031, 664 ADMINISTRATIVE & GENERAL

-14, 156 OPERATION OF PLANT

10, 662 EMPLOYEE BENEFITS DEPARTMENT

-2, 970 EMPLOYEE BENEFITS DEPARTMENT

4.00

4.00

5.00

7.00

4.00

0.00

1.00

5.00

33. 14

33. 15

33. 16

33. 17

33. 18

33. 19

33. 20

33. 21

50.00

В

Α

Α

Α

Α

Α

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

OTHER ADJUSTMENTS (SPECIFY)

33. 14

33. 15

33. 17

33. 19

33. 20

33. 21

50.00

DAYCARE

33. 18 PROF - BUILDING

DAYCARE DISCOUNT

33. 16 LOBBYING EXPENSE - I HHA

PROF - BUILDING

1933 AHA LIFE

HAF EXPENSE

⁽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.

| Period: | Worksheet A-8-2 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0001

					1	o 12/31/2018	Date/Time Pre 5/29/2019 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	oo aiii
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	30. 00	ADULTS & PEDIATRICS	1, 404, 808	1, 404, 808	0	0	0	1. 00
2.00	31. 00	INTENSIVE CARE UNIT	7, 683	7, 683	0	0	0	2.00
3.00	60.00	LABORATORY	136, 962	0	136, 962	211, 500	1, 961	3.00
4.00	66. 00	PHYSI CAL THERAPY	10, 842	10, 842	0	0	0	4.00
5.00	68. 00	SPEECH PATHOLOGY	625	625	0	0	0	5.00
6.00	69. 00	ELECTROCARDI OLOGY	124, 158	59, 085	65, 073	211, 500	325	6. 00
7.00	76. 00	ONCOLOGY	163, 863	0	163, 863	211, 500	327	7. 00
8.00	76. 97	CARDIAC REHABILITATION	127, 750	127, 750	0	0	0	8. 00
9.00	90. 00	CLINIC	717, 000	717, 000	0	0	0	9. 00
10.00	91. 00	EMERGENCY	2, 113, 754	2, 113, 754	0	0	0	10.00
200.00			4, 807, 445	4, 441, 547	365, 898		2, 613	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00		ADULTS & PEDIATRICS	0	0	0		0	1. 00
2.00		INTENSIVE CARE UNIT	0	0	0	0	"	2.00
3.00		LABORATORY	199, 400		0	0	0	3. 00
4.00		PHYSI CAL THERAPY	0	0	0	0	0	4. 00
5.00		SPEECH PATHOLOGY	0	0	0	0	0	5. 00
6.00		ELECTROCARDI OLOGY	33, 047	,	0	0	0	6. 00
7.00		ONCOLOGY	33, 250	1, 663	0	0	0	7. 00
8.00		CARDIAC REHABILITATION	0	0	0	0	0	8. 00
9.00		CLI NI C	0	0	0	0	0	9. 00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00	WI+ A I : "	C+ C+ /Dh -	265, 697 Provi der		RCE	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician		Adjusted RCE		Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00	30. 00	ADULTS & PEDIATRICS	0	0	0	1, 404, 808		1. 00
2.00	31. 00	INTENSIVE CARE UNIT	0	0	0	7, 683		2. 00
3.00	60.00	LABORATORY	0	199, 400	0	0	1	3.00
4.00	66. 00	PHYSI CAL THERAPY	0	0	0	10, 842		4.00
5.00		SPEECH PATHOLOGY	0	0	0	625		5. 00
6.00	69. 00	ELECTROCARDI OLOGY	0	33, 047	32, 026	91, 111		6. 00
7. 00		ONCOLOGY	l o	33, 250	130, 613			7. 00
8. 00		CARDI AC REHABI LI TATI ON	l	0	0	127, 750		8. 00
9. 00		CLI NI C	l o	Ö	0			9. 00
10.00		EMERGENCY	0	0	0	2, 113, 754		10.00
200.00			Ö	265, 697	162, 639			200. 00
			•	•	•			

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0001

						o 12/31/2018		
				CAPI TAL REI	ATED COSTS		5/29/2019 11:	os am
						EMDLOVEE	COMMUNICATIONS	
		Cost Center Description	Net Expenses for Cost	NEW BLDG & FLXT	MVBLE EQUIP	EMPLOYEE BENEFITS	COMMUNI CATI ONS	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2. 00	4. 00	4. 01	
		AL SERVICE COST CENTERS						
1.00	4	NEW CAP REL COSTS-BLDG & FIXT	299, 513	299, 513				1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	4, 753, 571 9, 405, 452	3, 231	4, 753, 571 2, 117			2. 00 4. 00
4. 01		COMMUNI CATI ONS	310, 212	426			339, 109	4. 01
4.02		DATA PROCESSING	2, 722, 956	6, 778			33, 736	4. 02
4. 03 4. 04		MATERIALS MANAGEMENT ADMITTING	367, 386 751, 053	4, 143 2, 424			7, 247 8, 496	4. 03 4. 04
4. 05	4	PATIENT ACCOUNTING	1, 688, 828	7, 200			21, 991	4. 05
5.00	1	ADMINISTRATIVE & GENERAL	2, 431, 916	10, 315			19, 242	5. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	2, 451, 023 196, 626	31, 298 2, 603			12, 245 1, 249	7. 00 8. 00
9. 00		HOUSEKEEPI NG	812, 515	2, 022			3, 499	9. 00
10.00	4	DIETARY	385, 580	4, 241			6, 497	10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	407, 256 1, 671, 234	4, 516 10, 684			0 11, 495	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	163, 899	1, 840			0	14. 00
15. 00		PHARMACY	1, 415, 890	2, 215			5, 748	15. 00
16. 00		MEDICAL RECORDS & LIBRARY LENT ROUTINE SERVICE COST CENTERS	594, 429	4, 200	12, 846	179, 131	9, 246	16. 00
30. 00		ADULTS & PEDIATRICS	3, 126, 232	29, 860	207, 679	1, 348, 506	26, 239	30. 00
31.00		INTENSIVE CARE UNIT	1, 249, 361	8, 539			6, 997	31. 00
41. 00 43. 00		SUBPROVIDER - IRF NURSERY	279, 209 180, 150	3, 051 677			4, 498 0	41. 00 43. 00
43.00		LARY SERVICE COST CENTERS	160, 150	677		54, 597	0	43.00
50.00	05000	OPERATING ROOM	2, 102, 086	49, 549			21, 991	50. 00
53.00	4	ANESTHESI OLOGY	66, 456	427			12.005	53. 00
54. 00 60. 00		RADI OLOGY-DI AGNOSTI C LABORATORY	2, 641, 240 3, 794, 447	17, 900 8, 715			12, 995 16, 993	54. 00 60. 00
65. 00	4	RESPI RATORY THERAPY	1, 070, 199	405			4, 498	65. 00
66.00	4	PHYSI CAL THERAPY	801, 464	6, 863			6, 247	66.00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	253, 607 138, 724	1, 446 90			1, 499 1, 499	67. 00 68. 00
69.00		ELECTROCARDI OLOGY	316, 863	1, 169		1	10, 746	
70. 00		ELECTROENCEPHALOGRAPHY	56, 336	197			500	70. 00
71. 00 72. 00	4	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	3, 262, 298 1, 684, 761	0			0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	4, 250, 199	0		Ö	Ö	73. 00
76. 00		ONCOLOGY	322, 728	7, 578			9, 246	
76. 97		CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	164, 867	2, 719	16, 464	42, 340	0	76. 97
90. 00		CLINIC	1, 902, 296	12, 469	26, 329	230, 628	5, 248	90. 00
		EMERGENCY	2, 093, 151	10, 756	49, 567	1, 076, 258	14, 744	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92. 00
101.00		HOME HEALTH AGENCY	708, 725	1, 413	103	207, 232	5, 748	101. 00
440.00		AL PURPOSE COST CENTERS				ı		
113. 00 118. 00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	61, 294, 738	261, 959	4, 574, 831	9, 264, 710	290, 379	113. 00 118. 00
110.00		IMBURSABLE COST CENTERS	01, 274, 730	201, 737	4, 374, 031	7, 204, 710	270, 317	110.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	78, 942	1, 404				190. 00
		PHYSICIANS' PRIVATE OFFICES SOUTH CLINIC	15, 565, 728	28, 071 0	1		40, 984	192. 00 192. 01
		WEST CLINIC	0	0		0		192. 01
	4	DI ABETES CENTER	78, 817	435	866	23, 938		192. 03
		NONPALD WORKERS ADULT/CHILD CARE	0 334, 287	0 5, 232		0 82, 768		193. 00 193. 01
	4	PHYSICIAN OFFICE BUILDING	334, 267	0, 232	1	02, 700	·	193. 01
193. 03	19303	OPTI FAST/FOUNDATI ON	0	0	1	0		193. 03
	1	PARTNERSHIP HFC TRAFALGAR CLINIC	56, 802	2, 412 0	1	7, 145		194. 00 194. 01
		EDI NBURGH	0	0	· ·	0		194. 01
194. 03	07953	JAI L	47, 905	0		15, 792	0	194. 03
		ATHLETIC TRAINERS	0	0	C	0	0	194. 04
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers		0	(0	n	200. 00 201. 00
202. 00	1	TOTAL (sum lines 118 through 201)	77, 457, 219	299, 513	4, 753, 571	9, 410, 800		

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0001

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

5/29/2019 11:55 am Cost Center Description DATA MATERI ALS ADMITTI NG PATI ENT Subtotal PROCESSI NG MANAGEMENT ACCOUNTI NG 4.04 4A. 05 4.02 4.03 4.05 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00401 COMMUNI CATLONS 4 01 4 01 4.02 00402 DATA PROCESSING 5, 249, 937 4.02 00403 MATERIALS MANAGEMENT 119,800 615, 234 4.03 4.03 4.04 00404 ADMITTING 156, 748 872 1, 164, 608 4. 04 00405 PATIENT ACCOUNTING 2, 421, 386 4.05 338, 128 1, 671 C 4 05 5.00 00500 ADMINISTRATIVE & GENERAL 550, 857 11, 124 3, 569, 752 5.00 7.00 00700 OPERATION OF PLANT 31, 350 201 0 0 2, 802, 126 7 00 00800 LAUNDRY & LINEN SERVICE 77 0 0 264, 169 8 00 8 00 20, 153 9.00 00900 HOUSEKEEPI NG 626 0 0 1, 059, 755 9.00 10.00 01000 DI ETARY 87, 331 34, 857 0 0 638, 205 10.00 0 01100 CAFETERI A 11.00 0 622, 588 11.00 01300 NURSING ADMINISTRATION 6, 033 0 2, 284, 945 13.00 101, 886 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 8, 576 0 0 256, 652 14.00 01500 PHARMACY 54 862 0 15 00 1, 651, 353 15.00 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 160, 107 16.00 0 16.00 216 960, 175 03000 ADULTS & PEDIATRICS 387, 391 68, 059 30.00 31, 559 135, 683 5, 361, 208 30.00 31.00 03100 INTENSIVE CARE UNIT 130, 997 10,608 7, 305 14, 562 1, 877, 582 31.00 04100 SUBPROVIDER - IRF 6,717 417, 593 41.00 0 1, 268 3.369 41.00 43.00 04300 NURSERY 3, 631 7.238 246, 293 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 176, 696 352, 262 4, 668, 617 50.00 606, 839 32, 609 05300 ANESTHESI OLOGY 53.00 251 25, 481 50.800 178, 907 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 195, 935 25, 511 236, 133 470, 801 4, 817, 343 54.00 06000 LABORATORY 5, 555, 290 60.00 237, 361 181, 936 170, 396 339, 702 60.00 1, 647, 313 06500 RESPIRATORY THERAPY 14, 922 30, 221 65.00 124, 279 60.248 65.00 06600 PHYSI CAL THERAPY 103.006 1, 249, 136 66.00 3, 061 22, 101 44.060 66.00 67.00 06700 OCCUPATIONAL THERAPY 17, 914 9, 150 18, 241 389, 254 67.00 06800 SPEECH PATHOLOGY 17, 914 68.00 0 2, 419 4,822 211, 786 68.00 25, 917 69 00 06900 ELECTROCARDI OLOGY 219, 447 51,669 771 810 69 00 C 07000 ELECTROENCEPHALOGRAPHY 70.00 231 554 1, 104 78, 133 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 65, 046 48, 906 97, 498 3, 496, 113 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 26, 869 53, 565 1, 765, 195 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 75,020 149, 560 4, 474, 779 73.00 76.00 03020 ONCOLOGY 64, 938 2,074 4, 167 8, 307 509, 135 76.00 07697 CARDIAC REHABILITATION 76.97 1,741 3, 147 6, 274 237, 552 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 161, 226 56, 515 57, 333 114, 299 2, 566, 343 90.00 4, 017, 347 09100 EMERGENCY 267, 591 21, 014 161, 767 322, 499 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 54, 862 901 5, 967 11, 896 996, 847 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 164, 608 4, 210, 922 513, 500 2, 321, 807 59, 643, 296 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 198, 572 190. 00 88.451 2.467 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 99, 579 16, 888, 118 192. 00 890.104 92.891 0 192. 01 19201 SOUTH CLINIC 0 C 0 0 192 01 192. 02 19202 WEST CLINIC 0 192. 02 192. 03 19203 DI ABETES CENTER 11, 196 10 0 0 116, 012 192. 03 0 193. 00 19300 NONPALD WORKERS 0 0 193, 00 C 0 193. 01 19301 ADULT/CHI LD CARE 22.393 6, 139 452, 068 193. 01 193. 02 19302 PHYSICIAN OFFICE BUILDING 0 0 0 193. 02 C 193. 03 19303 OPTI FAST/FOUNDATI ON 0 0 193. 03 194. 00 07950 PARTNERSHIP HFC 95, 456 194. 00 26, 871 227 0 194. 01 07951 TRAFALGAR CLINIC 0 0 194. 01 0 C 194. 02 07952 EDI NBURGH 0 0 0 0 0 194. 02 0 63, 697 194. 03 194. 03 07953 JAI L 0 0 0 194. 04 07954 ATHLETIC TRAINERS 0 C 0 0 0 194.04 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 5. 249. 937 615, 234 1. 164. 608 2, 421, 386 77, 457, 219 202. 00 202.00 TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0001

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 11:55 am

				'	0 12/31/2016	5/29/2019 11:	
	Cost Center Description		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02 4. 03	00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT						4. 02 4. 03
4.03	00404 ADMITTING						4. 03
4. 05	00405 PATIENT ACCOUNTING						4. 05
5. 00	00500 ADMINISTRATIVE & GENERAL	3, 569, 752					5. 00
7.00	00700 OPERATION OF PLANT	135, 379	2, 937, 505				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	12, 763	32, 719	l			8. 00
9.00	00900 HOUSEKEEPI NG	51, 200	25, 410	l		754 000	9.00
10.00	01000 DI ETARY	30, 834 30, 079	53, 311	l	22, 151	751, 032	1
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	110, 393	56, 768 134, 291	0	23, 587 55, 799	0	1
14. 00	01400 CENTRAL SERVI CES & SUPPLY	12, 400	23, 124	_	9, 608	0	
15. 00	01500 PHARMACY	79, 782	27, 846	1		0	1
16.00	01600 MEDICAL RECORDS & LIBRARY	46, 389	52, 794	1		0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	259, 016	375, 325	1		641, 759	1
31.00	03100 I NTENSI VE CARE UNI T	90, 712	107, 329			57, 354	
41.00	04100 SUBPROVI DER - I RF 04300 NURSERY	20, 175	38, 353			51, 919	
43. 00	ANCI LLARY SERVI CE COST CENTERS	11, 899	8, 506	0	3, 534	0	43. 00
50. 00	05000 OPERATING ROOM	225, 555	622, 810	56, 335	258, 784	0	50.00
53. 00	05300 ANESTHESI OLOGY	8, 644	5, 362	1	2, 228	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	232, 740	225, 002	1	93, 490	0	54.00
60.00	06000 LABORATORY	268, 393	109, 548	0	45, 518	0	60.00
65.00	06500 RESPI RATORY THERAPY	79, 587	5, 090		2, 115	0	
66.00	06600 PHYSI CAL THERAPY	60, 350	86, 261	1, 832		0	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	18, 806	18, 169	1	7, 550 469	0	
69. 00	06900 ELECTROCARDI OLOGY	10, 232 37, 288	1, 130 14, 699	1		0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	3, 775	2, 477	l		0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	168, 908	_,			0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	85, 282	0	0	o	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	216, 190	0	0	0	0	1
76. 00	03020 ONCOLOGY	24, 598	95, 257		,	0	
76. 97	07697 CARDI AC REHABILITATION	11, 477	34, 175	0	14, 200	0	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	123, 988	156, 734	1, 853	65, 124	0	90.00
91. 00	09100 EMERGENCY	194, 090	135, 734	1	56, 178	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	171,070	100, 200	17,001	30, 170	· ·	92.00
	OTHER REIMBURSABLE COST CENTERS	' '					
101.00	10100 HOME HEALTH AGENCY	48, 161	17, 761	0	7, 380	0	101. 00
	SPECIAL PURPOSE COST CENTERS	1		T.	Г		
	11300 INTEREST EXPENSE	2 700 005	2 4/5 454	205 024	1 000 2/1	751 022	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 709, 085	2, 465, 454	305, 034	1, 000, 261	751, 032	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 594	17, 652	0	7, 335	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	815, 938	352, 841	1			192. 00
	1 19201 SOUTH CLINIC	0	0	0	0		192. 01
	2 19202 WEST CLINIC	0	0	0	0		192. 02
	3 19203 DI ABETES CENTER	5, 605	5, 471	0	2, 273		192. 03
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	1 19301 ADULT/CHILD CARE 2 19302 PHYSICIAN OFFICE BUILDING	21, 841	65, 764	0	27, 325		193. 01
	3 19303 OPTI FAST/FOUNDATI ON	0	0	0	0	0	193. 02 193. 03
	07950 PARTNERSHIP HFC	4, 612	30, 323		12, 600		194. 00
	1 07951 TRAFALGAR CLINIC	1,012	00, 020	Ö	0		194. 01
	2 07952 EDI NBURGH		0	ō	ol		194. 02
194. 03	3 07953 JAI L	3, 077	0	0	o	0	194. 03
	4 07954 ATHLETIC TRAINERS	0	0	0	0	0	194. 04
200.00	1 1						200.00
201.00		0	0 007 505	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	3, 569, 752	2, 937, 505	309, 651	1, 196, 402	751, 032	1202.00

Provider CCN: 15-0001

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 |

			То	12/31/2018	Date/Time Pre 5/29/2019 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	00 4111
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
4. 01 00400 EMPLOTEE BENEFIT IS DEPARTMENT						4. 00
4. 02 00402 DATA PROCESSING						4. 01
4. 03 00403 MATERIALS MANAGEMENT						4. 03
4. 04 00404 ADMI TTI NG						4. 04
4. 05 OO405 PATIENT ACCOUNTING						4. 05
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	722 022	,				10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	733, 022 20, 872	1				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	4, 323		349, 123			14.00
15. 00 01500 PHARMACY	13, 312	1	017, 120	1, 783, 863		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	20, 231	1	0	0	1, 101, 525	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	99, 236		0	0	61, 346	30. 00
31. 00 03100 INTENSIVE CARE UNIT	32, 002		0	0	6, 396	31. 00
41. 00 04100 SUBPROVI DER - RF	0 (47	1 -1	0	0	3, 192	41.00
43.00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 647	36, 294	0	0	3, 441	43. 00
50. 00 05000 OPERATING ROOM	56, 045	557, 698	O	0	167, 424	50.00
53. 00 05300 ANESTHESI OLOGY	30, 043		0	0	24, 154	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	53, 401	1	0	ő	223, 704	54. 00
60. 00 06000 LABORATORY	61, 284	1	0	0	161, 517	60.00
65. 00 06500 RESPIRATORY THERAPY	25, 865	o	0	0	28, 646	65. 00
66. 00 06600 PHYSI CAL THERAPY	19, 508	0	0	0	20, 949	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 625	1	0	0	8, 673	67. 00
68. 00 06800 SPEECH PATHOLOGY	3, 101		0	0	2, 293	1
69. 00 06900 ELECTROCARDI OLOGY	9, 799		0	0	22, 233	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 437	1	0 349, 123	0	525 50, 377	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT			349, 123	0	25, 469	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		ol o	0	1, 783, 863	73, 204	73. 00
76. 00 03020 0NC0L0GY	7, 602	o	O	0	3, 950	76. 00
76. 97 07697 CARDIAC REHABILITATION	3, 619	0	0	0	2, 983	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	34, 843	1	0	0	54, 345	90.00
91. 00 09100 EMERGENCY	66, 663	663, 356	0	0	151, 048	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
101.00 10100 HOME HEALTH AGENCY	14, 620	0	0	0	5 656	101. 00
SPECIAL PURPOSE COST CENTERS	14, 020	,	0	O _I	3, 030	1101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	557, 035	2, 606, 300	349, 123	1, 783, 863	1, 101, 525	1
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 180	1	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	140, 647	1	0	0		192. 00
192. 01 19201 SOUTH CLINIC	C		0	0		192. 01
192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER	1 722		0	0		192. 02 192. 03
193. 00 19300 NONPALD WORKERS	1, 722		0	0		192. 03
193. 01 19301 ADULT/CHI LD CARE	16, 233		0	0		193. 01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG	10, 200	ol öl	o	ol		193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON	C	ol ol	O	o		193. 03
194. 00 07950 PARTNERSHI P HFC	233	s o	0	o		194. 00
194. 01 07951 TRAFALGAR CLINIC	C	0	0	0		194. 01
194. 02 07952 EDI NBURGH	C	0	0	0		194. 02
194. 03 07953 JAI L	12.072		0	0		194. 03 194. 04
194. 04 07954 ATHLETIC TRAINERS 200. 00 Cross Foot Adjustments	13, 972		٥	o	0	200. 00
201.00 Negative Cost Centers		ار ار	n	n	n	200.00
202.00 TOTAL (sum lines 118 through 201)	733, 022	2, 606, 300	349, 123	1, 783, 863	1, 101, 525	
	, , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,		91	, , - = 0	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0001

				To 12/31/2018	Date/Time Prepared: 5/29/2019 11:55 am
Cost Center Description	Subtotal	Intern &	Total		3/29/2019 11. 33 aiii
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
GENERAL SERVICE COST CENTERS			ı		1.00
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 2.00 O0200 CAP REL COSTS-MVBLE EQUIP					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
4. 01 00401 COMMUNI CATI ONS					4. 01
4. 02 00402 DATA PROCESSING					4. 02
4. 03 00403 MATERI ALS MANAGEMENT					4. 03
4. 04 00404 ADMI TTI NG					4. 04
4.05 00405 PATIENT ACCOUNTING 5.00 00500 ADMINISTRATIVE & GENERAL					4. 05 5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINISTRATION					11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY					16. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	8, 012, 847	I .			30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	2, 552, 288 560, 801	I .			31. 00 41. 00
43. 00 04300 NURSERY	313, 614	I .			43. 00
ANCILLARY SERVICE COST CENTERS		-			
50. 00 05000 OPERATI NG ROOM	6, 613, 268	I .			50. 00
53. 00 05300 ANESTHESI OLOGY	219, 295	I .			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	5, 671, 611 6, 201, 550	l e			54. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY	1, 788, 616	l e			65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 473, 878	l e	1, 473,		66. 00
67.00 06700 OCCUPATIONAL THERAPY	448, 077	 			67. 00
68. 00 06800 SPEECH PATHOLOGY	229, 011	l .	229,		68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	864, 369 87, 376	l .			69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 064, 521	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 875, 946	1			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 548, 036				73. 00
76. 00 03020 0NCOLOGY	680, 122	 			76.00
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	304, 006	0	304,	006	76. 97
90. 00 09000 CLINIC	3, 003, 230	0	3, 003,	230	90.00
91. 00 09100 EMERGENCY	5, 330, 946	l .			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
OTHER REIMBURSABLE COST CENTERS	4 000 405		1 000	405	101.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 090, 425	5 0	1, 090,	425	101. 00
113. 00 11300 NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	57, 933, 833	0	57, 933,	833	118. 00
NONRE MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	236, 333	I .	236,		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLINI C	18, 348, 769	0	18, 348,	0	192. 00 192. 01
192. 02 19202 WEST CLINIC				0	192. 02
192. 03 19203 DI ABETES CENTER	131, 083	B O	131,	083	192. 03
193. 00 19300 NONPAI D WORKERS	C	0		0	193. 00
193. 01 19301 ADULT/CHI LD CARE	583, 231	0	583,	231	193. 01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON		0		0	193. 02 193. 03
194. 00 07950 PARTNERSHIP HFC	143, 224	, 0	143,	224	194. 00
194. 01 07951 TRAFALGAR CLINIC	0	o o		0	194. 01
194. 02 07952 EDI NBURGH	C	0		0	194. 02
194. 03 07953 JAI L	66, 774		66,		194. 03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	13, 972	0	13,	9/2	194. 04 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers				0	200.00
202.00 TOTAL (sum lines 118 through 201)	77, 457, 219	Ö	77, 457,	219	202. 00
	•	•	•	•	•

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0001

			To	12/31/2018	Date/Time Pre 5/29/2019 11:	
		CAPI TAL REI	LATED COSTS		372972019 11.	33 alli
Cost Center Description	Directly	NEW BLDG &	MVBLE EQUIP	Subtotal	EMPLOYEE	
·	Assi gned New	FLXT			BENEFITS	
	Capital Related Costs				DEPARTMENT	
OFFICE AND OFFICE OFFIC	0	1. 00	2.00	2A	4. 00	
1. 00 GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 231	2, 117	5, 348	5, 348	4. 00
4. 01 00401 COMMUNI CATI ONS 4. 02 00402 DATA PROCESSI NG	0	426 6, 778		426 2, 235, 299	16 146	4. 01 4. 02
4. 03 00403 MATERIALS MANAGEMENT		4, 143		14, 701	60	4. 02
4. 04 00404 ADMI TTI NG	0	2, 424		2, 424	139	4. 04
4. 05 00405 PATIENT ACCOUNTING	0	7, 200		25, 834	196	4. 05
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT	0	10, 315 31, 298		57, 087 103, 039	283 116	5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	o	2, 603		103, 037	20	8.00
9. 00 00900 HOUSEKEEPI NG	0	2, 022		9, 130	133	9. 00
10. 00 01000 DI ETARY	0	4, 241		37, 326	49	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	4, 516 10, 684		56, 665 10, 684	90 274	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	o	1, 840		54, 439	17	14. 00
15. 00 01500 PHARMACY	o	2, 215		11, 106	93	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	4, 200	12, 846	17, 046	102	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	l ol	29, 860	207, 679	237, 539	775	30.00
31. 00 03100 I NTENSI VE CARE UNI T	O	8, 539		65, 278	223	31. 00
41. 00 04100 SUBPROVI DER - RF	0	3, 051	31, 267	34, 318	50	41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	677	0	677	31	43. 00
50. 00 05000 OPERATING ROOM	0	49, 549	710, 493	760, 042	349	50.00
53. 00 05300 ANESTHESI OLOGY	0	427	22, 623	23, 050	7	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	17, 900		565, 401	380	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	8, 715 405	· ·	233, 816 25, 086	329 180	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	Ö	6, 863		22, 961	140	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 446		5, 250	47	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	90		686	26	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1, 169 197		55, 273 3, 145	52 9	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	0		22, 365	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	О	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 03020 ONCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	0	7, 578 2, 719		11, 026 19, 183	49 24	76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>	2, 717	10, 404	17, 103	27	70.77
90. 00 09000 CLI NI C	0	12, 469		38, 798	131	90. 00
91. 00 09100 EMERGENCY	0	10, 756	49, 567	60, 323	611	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	0	1, 413	103	1, 516	118	101. 00
SPECIAL PURPOSE COST CENTERS	T		T	T		
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	261, 959	4, 574, 831	4, 836, 790	5 265	113. 00 118. 00
NONREI MBURSABLE COST CENTERS	<u> </u>	201, 737	4, 374, 031	4, 030, 170	3, 203	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 404				190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLINIC	0	28, 071	170, 761	198, 832		192. 00 192. 01
192. 01 1920 SOUTH CLINIC 192. 02 19202 WEST CLINIC	0	0	0	0		192. 01
192. 03 19203 DI ABETES CENTER	o o	435	866	1, 301		192. 03
193. 00 19300 NONPALD WORKERS	o	0	0	o		193. 00
193. 01 19301 ADULT/CHI LD CARE	0	5, 232	0	5, 232		193. 01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193. 02 193. 03
194. 00 07950 PARTNERSHIP HFC	o o	2, 412	0	2, 412		194. 00
194. 01 07951 TRAFALGAR CLINIC	0	0	0	0		194. 01
194. 02 07952 EDI NBURGH	0	0	0	0		194. 02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C TRAI NERS	0	0	0	0		194. 03 194. 04
200.00 Cross Foot Adjustments		U		ol	U	200.00
201.00 Negative Cost Centers		0	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	299, 513	4, 753, 571	5, 053, 084	5, 348	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0001

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/29/2019 11:55 am Cost Center Description COMMUNICATIONS DATA MATERI ALS ADMITTI NG PATI ENT PROCESSI NG ACCOUNTI NG MANAGEMENT 4.01 4.04 4.02 4.05 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00401 COMMUNI CATI ONS 4 01 4 01 442 4.02 00402 DATA PROCESSING 44 2, 235, 489 4.02 00403 MATERIALS MANAGEMENT 9 4.03 51, 012 65, 782 4.03 4.04 00404 ADMITTING 11 66, 745 93 69, 412 4.04 00405 PATIENT ACCOUNTING 143, 979 29 170, 217 4.05 179 0 4 05 1, 189 5.00 00500 ADMINISTRATIVE & GENERAL 25 234, 562 5.00 0 7.00 00700 OPERATION OF PLANT 16 13, 349 21 0 0 7 00 00800 LAUNDRY & LINEN SERVICE 2 5 8 00 0 8 00 8, 582 8 0 9.00 00900 HOUSEKEEPI NG 0 0 9.00 67 10.00 01000 DI ETARY 8 37, 187 3,727 0 0 10.00 01100 CAFETERI A 0 11.00 11.00 0 C 01300 NURSING ADMINISTRATION 15 13.00 43, 384 645 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 917 0 0 14.00 01500 PHARMACY 15.00 15 00 23, 361 C 0 01600 MEDICAL RECORDS & LIBRARY
INPATIENT ROUTINE SERVICE COST CENTERS 16.00 16.00 68, 176 0 03000 ADULTS & PEDIATRICS 34 164, 956 4, 058 9, 538 30.00 30.00 3, 374 31.00 03100 INTENSIVE CARE UNIT 9 55, 780 1, 134 436 1,024 31.00 04100 SUBPROVIDER - IRF 41.00 6 136 201 472 41.00 43.00 04300 NURSERY 217 509 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 29 258, 399 10, 537 24, 763 50.00 3.487 05300 ANESTHESI OLOGY 53.00 0 27 1.519 3.571 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 17 83, 432 2,728 14,046 33,098 54.00 06000 LABORATORY 19, 455 60.00 22 101, 071 10, 161 23,880 60.00 52, 919 06500 RESPIRATORY THERAPY 1.595 1.802 4. 235 65.00 6 65.00 06600 PHYSI CAL THERAPY 8 66.00 43, 861 327 1, 318 3, 097 66.00 2 1, 282 67.00 06700 OCCUPATIONAL THERAPY 7, 628 C 546 67.00 06800 SPEECH PATHOLOGY 68.00 7,628 0 144 339 68.00 69 00 06900 ELECTROCARDI OLOGY 14 93, 443 Ω 1, 545 3,632 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 C 25 33 78 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 6, 955 2, 916 6,854 71.00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1,602 3.765 72.00 C C 4, 474 07300 DRUGS CHARGED TO PATIENTS 73.00 0 10, 514 73.00 76.00 03020 ONCOLOGY 12 27, 652 222 248 584 76.00 07697 CARDIAC REHABILITATION 76. 97 0 186 188 441 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 68, 652 6,042 3, 419 8,035 90.00 19 09100 EMERGENCY 2, 247 22, 670 91.00 91.00 113, 944 9,646 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 7 23, 361 96 356 836 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 378 1, 793, 063 54, 905 69, 412 163, 217 118. 00 118, 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 37, 663 264 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 7, 000 192. 00 53 379.018 9. 932 192. 01 19201 SOUTH CLINIC 0 C 0 192 01 192. 02 19202 WEST CLINIC 0 0 0 0 192. 02 192. 03 19203 DI ABETES CENTER 1 4, 768 1 0 192. 03 0 193. 00 19300 NONPALD WORKERS 0 193.00 0 2 0 0 3 0 0 193. 01 19301 ADULT/CHI LD CARE 9.535 656 0 193 01 193. 02 19302 PHYSICIAN OFFICE BUILDING 0 0 0 0 193. 02 C 193. 03 19303 OPTI FAST/FOUNDATI ON 0 193. 03 0 194. 00 07950 PARTNERSHIP HFC 0 194, 00 11, 442 24 194. 01 07951 TRAFALGAR CLINIC 0 0 194. 01 C 194. 02 07952 EDI NBURGH 0 Ω 0 0 0 194. 02 0 194. 03 07953 JAI L 0 0 194. 03 0 0 194. 04 07954 ATHLETIC TRAINERS 0 C 0 0 0 194. 04 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 2, 235, 489 69.412 170, 217 202. 00 202.00 442 65, 782

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0001

			T	o 12/31/2018	Date/Time Pre 5/29/2019 11:	
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	JJ alli
· ·	& GENERAL	PLANT	LINEN SERVICE			
GENERAL SERVICE COST CENTERS	5. 00	7. 00	8. 00	9. 00	10. 00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01 00401 COMMUNI CATI ONS						4. 01
4. 02 00402 DATA PROCESSING						4. 02
4. 03 00403 MATERIALS MANAGEMENT						4. 03
4. 04 00404 ADMI TTI NG						4. 04
4. 05 O0405 PATI ENT ACCOUNTI NG						4. 05
5. 00 00500 ADMINISTRATIVE & GENERAL	293, 146	407 (57				5. 00
7. 00 00700 OPERATION OF PLANT	11, 116	127, 657				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING	1, 048	1, 422		10 020		8. 00 9. 00
10. 00 01000 DI ETARY	4, 204 2, 532	1, 104 2, 317		18, 828 349	83, 950	1
11. 00 01100 CAFETERI A	2, 470	2, 317	0	371	03, 430	11.00
13. 00 01300 NURSING ADMINISTRATION	9, 064	5, 836	_	878	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1, 018	1, 005		151	0	14. 00
15. 00 01500 PHARMACY	6, 551	1, 210		182	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	3, 809	2, 294	0	345	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS			,			
30. 00 03000 ADULTS & PEDI ATRI CS	21, 268	16, 311	4, 986		71, 736	
31. 00 03100 INTENSIVE CARE UNIT	7, 448	4, 664		702	6, 411	
41. 00 04100 SUBPROVI DER - RF	1, 657	1, 667		251	5, 803	1
43. 00 04300 NURSERY	977	370	0	56	0	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	10 520	27.042	2 027	4 075		E0 00
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	18, 520 710	27, 063 233		4, 075 35	0	50. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 110	9, 778			0	54.00
60. 00 06000 LABORATORY	22, 038	4, 761	0,000	716	0	60.00
65. 00 06500 RESPIRATORY THERAPY	6, 535	221	0	33	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	4, 955	3, 749	128	564	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 544	790		119	0	67. 00
68.00 06800 SPEECH PATHOLOGY	840	49	0	7	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 062	639		96	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	310	108		16	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 869	0		0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	7, 003	0		0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	17, 751	0	0	(22	0	73.00
76. 00 03020 0NCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	2, 020 942	4, 140 1, 485		623 223	0	76. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	942	1, 400		223	0	70.97
90. 00 09000 CLINIC	10, 181	6, 811	129	1, 025	0	90.00
91. 00 09100 EMERGENCY	15, 937	5, 876		884	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	,	2, 2.2	3, 233			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	3, 954	772	0	116	0	101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	222, 443	107, 142	21, 263	15, 742	83, 950	118. 00
NONREI MBURSABLE COST CENTERS	700	7/7	1 0	115	0	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	788 67, 030	767 15, 334		115 2, 307		190. 00 192. 00
192.00 19200 PHTSI CLANS PRI VATE OFFI CES	07,030	10, 334	0			192. 00
192. 02 19202 WEST CLINIC	0	0	0	0		192. 02
192. 03 19203 DI ABETES CENTER	460	238	_	36		192. 03
193. 00 19300 NONPAI D WORKERS	0	0	Ō	0		193. 00
193. 01 19301 ADULT/CHI LD CARE	1, 793	2, 858	0	430	0	193. 01
193.02 19302 PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0	0	0	193. 03
194. 00 07950 PARTNERSHI P HFC	379	1, 318	0	198		194. 00
194. 01 07951 TRAFALGAR CLINIC	0	0	0	0		194. 01
194. 02 07952 EDI NBURGH	0	0	0	0		194. 02
194. 03 07953 JAI L	253	0] 0	0		194. 03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	0	0	O	0	194. 04 200. 00
201.00 Negative Cost Centers		0	0	0	0	200.00
202.00 TOTAL (sum lines 118 through 201)	293, 146	127, 657	21, 585	18, 828		202.00
	-,	.,	,	-, -==9	2, . 50	

Provider CCN: 15-0001

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Ti

				10	12/31/2018	Date/IIme Pre 5/29/2019 11:	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	JJ alli
		11. 00	13.00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 4. 01 4. 02 4. 03 4. 04	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATIONS 00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT 00404 ADMITTING						1. 00 2. 00 4. 00 4. 01 4. 02 4. 03 4. 04
4. 05 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	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	62, 063 1, 767 366	72, 547	59, 110			4. 05 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	1, 127 1, 713	0	0 0	43, 637 0	93, 520	15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	8, 402		0	0	5, 211	1
31. 00 41. 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF	2, 710 0		0	0	543 271	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	309		0	0	292	1
50. 00	05000 OPERATING ROOM	4, 745	15, 524	O	ol	14, 221	50.00
53. 00	05300 ANESTHESI OLOGY	0		Ö	ō	2, 052	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 521	0	0	0	18, 960	54. 00
60. 00	06000 LABORATORY	5, 189		0	0	13, 719	1
65. 00	06500 RESPIRATORY THERAPY	2, 190		0	0	2, 433	
66.00	06600 PHYSI CAL THERAPY	1, 652		0	0	1, 779	1
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	476 263		0	0	737 195	1
69. 00	06900 ELECTROCARDI OLOGY	830		0	0	1, 888	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	122		0	0	45	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		59, 110	0	4, 279	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	Ö	o o	0	o	2, 163	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	o	Ö	43, 637	6, 218	1
76.00	03020 ONCOLOGY	644	0	0	o	335	1
76. 97	07697 CARDI AC REHABI LI TATI ON	306	0	0	0	253	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	2, 950		0	0	4, 616	1
91.00	09100 EMERGENCY	5, 644	18, 465	0	0	12, 830	
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	1, 238	0	O	ol	490	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	1, 230	U	U _I	<u> </u>	400	1101.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	1 1	47, 164	72, 547	59, 110	43, 637	93, 520	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	269		0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	11, 907		- 1	0		192. 00
	19201 SOUTH CLINIC	0		-	0		192. 01
	19202 WEST CLINIC	0		0	0		192. 02
	19203 DI ABETES CENTER	146		-	0		192. 03
	19300 NONPALD WORKERS 19301 ADULT/CHI LD CARE	0 1, 374	1	0	0		193. 00 193. 01
	19302 PHYSICIAN OFFICE BUILDING	1,374	0	0	0		193. 01
	19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193. 03
	07950 PARTNERSHIP HFC	20		o	ol		194. 00
	07951 TRAFALGAR CLINIC	0		Ō	ō		194. 01
194. 02	07952 EDI NBURGH	0	0	0	О	0	194. 02
	07953 JAI L	0	0	0	0		194. 03
	07954 ATHLETIC TRAINERS	1, 183	0	0	0	0	194. 04
200.00		_	_	_	_	=	200. 00
201. 00 202. 00		62, 063		0 59, 110	0 43, 637		201. 00 202. 00
202. UL	TOTAL (Sum TITIES TTO LIMOUGH ZUT)	02,003	12, 347	39, 110	43, 03/	73, UZU	1202.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0001

				To 12/31/2018	Date/Time Prepared: 5/29/2019 11:55 am
Cost Center Description	Subtotal	Intern &	Total		3/24/2014 11. 33 aiii
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
GENERAL SERVICE COST CENTERS		Г	T		
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT 2.00 O0200 CAP REL COSTS-MVBLE EQUIP					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01 00401 COMMUNI CATI ONS					4. 01
4. 02 00402 DATA PROCESSING					4. 02
4. 03 00403 MATERI ALS MANAGEMENT					4. 03
4. 04					4. 04 4. 05
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A					10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	578, 129	9 0	578, 1	20	30.00
31. 00 03100 NTENSI VE CARE UNI T	156, 471		1		31.00
41. 00 04100 SUBPROVI DER - RF	45, 782	l .			41. 00
43. 00 04300 NURSERY	4, 448	0	4, 4	48	43. 00
ANCILLARY SERVICE COST CENTERS	1 145 (01		1 145 /	0.1	F0.00
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	1, 145, 681 31, 204	l .			50. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	754, 750	l .	1		54.00
60. 00 06000 LABORATORY	435, 157	l .			60.00
65. 00 06500 RESPIRATORY THERAPY	97, 235	l .	–		65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	84, 539	l .			66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	18, 421 10, 179	l .	1		68. 00
69. 00 06900 ELECTROCARDI OLOGY	160, 644	1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 892	l .	-, -		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	116, 348	l .			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	14, 533 82, 594	1	, -		72. 00 73. 00
76. 00 03020 0NC0L0GY	47, 555				76.00
76. 97 07697 CARDIAC REHABILITATION	23, 231				76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	150, 796	1	1		90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	272, 376	0 0	1	70	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS					72.00
101.00 10100 HOME HEALTH AGENCY	32, 850	0	32, 8	50	101. 00
SPECIAL PURPOSE COST CENTERS			1		112.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 266, 815	5 0	4, 266, 8	15	113. 00 118. 00
NONREI MBURSABLE COST CENTERS	1, 200, 010	,	1, 200, 0	10	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	48, 397		48, 3		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	691, 735		691, 7		192. 00
192. 01 19201 SOUTH CLI NI C 192. 02 19202 WEST CLI NI C				0	192. 01 192. 02
192. 03 19203 DI ABETES CENTER	6, 965	-	6, 9	-	192. 02
193. 00 19300 NONPAI D WORKERS	0,755	o o	9, ,	0	193. 00
193. 01 19301 ADULT/CHILD CARE	21, 927	7 0	21, 9	27	193. 01
193. 02 19302 PHYSICIAN OFFICE BUILDING		0		0	193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	15, 800		15, 8	0	193. 03 194. 00
194. 01 07951 TRAFALGAR CLINIC	13,000		15, 6	0	194. 00
194. 02 07952 EDI NBURGH	d	o		0	194. 02
194. 03 07953 JAIL	262			62	194. 03
194. 04 07954 ATHLETIC TRAINERS	1, 183	0	1, 1	83	194. 04
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers					200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	5, 053, 084	-	5, 053, 0	84	202. 00
,	•	•		•	•

	Financial Systems	JOHNSON MEMOR			In Lie	u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider C	F	Period: From 01/01/2018	Worksheet B-1	
					o 12/31/2018	Date/Time Pre 5/29/2019 11:	pared: 55 am
		CAPITAL REI	LATED COSTS				
	Cost Center Description	NEW BLDG & FLXT	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	COMMUNI CATI ONS	DATA PROCESSI NG	
		(TOTAL	(DULLAR VALUE)	DEPARTMENT	(# NON PT	(WORK	
		FEET)		(GROSS	PHONES)	ORDERS)	
		1.00	2.00	4. 00	4. 01	4. 02	
	GENERAL SERVICE COST CENTERS	27/ /1/	T	I			1 00
	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	276, 616	2, 575, 452				1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 984	1, 147	28, 547, 892			4. 00
	00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG	393 6, 260		1,		4, 689	4. 01 4. 02
4. 03	00403 MATERIALS MANAGEMENT	3, 826				107	4. 03
	00404 ADMITTING	2, 239	l .	1,		140	
	00405 PATIENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL	6, 650 9, 526				302 492	4. 05 5. 00
7. 00	00700 OPERATION OF PLANT	28, 905	38, 869	619, 650	49	28	7. 00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	2, 404 1, 867		1		18 0	8. 00 9. 00
	01000 DI ETARY	3, 917		1		78	
	01100 CAFETERI A	4, 171				0	
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	9, 867 1, 699	l .	.,,		91 0	13. 00 14. 00
15. 00	01500 PHARMACY	2, 046	4, 817	496, 731	23	49	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	3, 879	6, 960	543, 399	37	143	16. 00
30. 00	03000 ADULTS & PEDIATRICS	27, 577	112, 519	4, 090, 755	105	346	30.00
	03100 INTENSIVE CARE UNIT	7, 886				117	1
	04100 SUBPROVI DER - I RF 04300 NURSERY	2, 818 625		1		0	
	ANCILLARY SERVICE COST CENTERS	020					10.00
	05000 OPERATING ROOM	45, 761 394				542 0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	16, 532	· ·			175	
60.00	06000 LABORATORY	8, 049	121, 958	1, 761, 381	68	212	60.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	374 6, 338		l		111 92	
	06700 OCCUPATI ONAL THERAPY	1, 335		l		16	
	06800 SPEECH PATHOLOGY	83				16	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 080 182				196 0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 117	(o	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72. 00 73. 00
	03020 ONCOLOGY	6, 999				58	
	07697 CARDI AC REHABI LI TATI ON	2, 511	8, 920	128, 438	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	11, 516	14, 265	699, 614	21	144	90.00
	09100 EMERGENCY	9, 934	26, 855	3, 264, 850	59	239	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00	10100 HOME HEALTH AGENCY	1, 305	56	628, 642	23	49	101. 00
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			1			113. 00
118.00		241, 932	2, 478, 612	28, 104, 727	1, 162	3, 761	118. 00
400.00	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 297 25, 925			15 164		190. 00 192. 00
	19201 SOUTH CLINIC	0		1	0	0	192. 01
	19202 WEST CLINIC	0	_	1	0		192. 02
	19203 DI ABETES CENTER 19300 NONPAI D WORKERS	402		72, 615	0		192. 03 193. 00
193. 01	19301 ADULT/CHILD CARE	4, 832	0	251, 077	5	20	193. 01
	19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION	0	0			0	193. 02 193. 03
	07950 PARTNERSHIP HFC	2, 228	Ö	21, 676	8		194. 00
	07951 TRAFALGAR CLINIC	0	0		0		194. 01
	07952 EDI NBURGH 07953 JAI L	0	0	47, 905) 5		194. 02 194. 03
194. 04	07954 ATHLETI C TRAINERS	Ö	Ö	17,700	o o		194. 04
200.00							200. 00 201. 00
201. 00 202. 00		299, 513	4, 753, 571	9, 410, 800	339, 109	5, 249, 937	
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 082775	1. 845723	0. 329650	249. 896094	1, 119. 628279	<u> </u> 203. 00

Heal th Finar	ncial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
					From 01/01/2018 Fo 12/31/2018		
		CAPITAL REI	LATED COSTS				
	Cost Center Description	NEW BLDG & FIXT	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS	COMMUNI CATI ONS	DATA PROCESSI NG	
		(TOTAL FEET)		DEPARTMENT (GROSS SALARI ES)	(# NON PT PHONES)	(WORK ORDERS)	
		1. 00	2.00	4. 00	4. 01	4. 02	
204. 00	Cost to be allocated (per Wkst. B, Part II)			5, 348	3 442	2, 235, 489	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000187	0. 325718	476. 751759	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

Provider CCN: 15-0001

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 11: 55 am

Cost Center Description	MATERIALS MANAGEMENT (SUPPLY USAGE)	ADMITTING (GROSS CHARGES)	PATI ENT ACCOUNTI NG (GROSS CHARGES)	Reconciliation	5/29/2019 11: ADMI NI STRATI VE & GENERAL (ACCUM. COST)	55 AIII
	4. 03	4.04	4. 05	5A	5. 00	
CENERAL SERVICE COST CENTERS	4, 250, 172 6, 021 11, 547 76, 847 1, 389 531 4, 327 240, 799 0 41, 680 59, 248 0 1, 491	219, 070, 050 0 0 0 0 0 0 0 0 0 0	228, 466, 065 0 0 0 0 0 0 0 0	-3, 569, 752 0 0 0 0 0 0 0 0	2, 802, 126 264, 169 1, 059, 755 638, 205 622, 588 2, 284, 945 256, 652 1, 651, 353	1. 00 2. 00 4. 00 4. 01 4. 02 4. 03 4. 04 4. 05 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
30. 00 03000 ADULTS & PEDIATRICS	218, 014	12, 802, 731	12, 802, 731	0	5, 361, 208	30.00
31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	73, 284 8, 757 0	1, 374, 067 633, 782 682, 972	12, 602, 731 1, 374, 067 633, 782 682, 972	0	1, 877, 582 417, 593	31. 00 41. 00 43. 00
50. 00 05000 OPERATING ROOM	225, 270	33, 238, 564	33, 238, 564	0	4, 668, 617	50.00
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	1, 731 176, 234 1, 256, 853 103, 087 21, 145 0	4, 793, 345 44, 413, 753 32, 053, 440 5, 684, 820 4, 157, 385 1, 721, 165 455, 033 4, 875, 348	4, 793, 345 44, 413, 753 32, 053, 440 5, 684, 820 4, 157, 385 1, 721, 165 455, 033 4, 875, 348	0 0 0 0 0 0	178, 907 4, 817, 343 5, 555, 290 1, 647, 313 1, 249, 136 389, 254 211, 786 771, 810	53. 00 54. 00 60. 00 65. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 0NCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATIENT SERVICE COST CENTERS	1, 598 449, 350 0 0 14, 331 12, 025	104, 166 9, 199, 698 5, 054, 283 14, 112, 110 783, 813 592, 042	104, 166 9, 199, 698 5, 054, 283 14, 112, 110 783, 813 592, 042	0 0 0	78, 133 3, 496, 113 1, 765, 195 4, 474, 779 509, 135 237, 552	71. 00
90. 00 09000 CLI NI C	390, 415	10, 784, 955	10, 784, 955			90. 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	145, 170	30, 430, 139	30, 430, 139	0	4, 017, 347	91.00
101.00 10100 HOME HEALTH AGENCY	6, 226	1, 122, 439	1, 122, 439	0	996, 847	101. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 547, 370	219, 070, 050	219, 070, 050	-3, 569, 752	56, 073, 544	113. 00 118. 00
NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 SOUTH CLINIC	17, 042 641, 714	0	9, 396, 015	0	198, 572 16, 888, 118	1
192. 02 19202 WEST CLINI C 192. 03 19203 DI ABETES CENTER	0 67	0	0	0	0 116, 012	192. 02 192. 03
193.00 19300 NONPALD WORKERS 193.01 19301 ADULT/CHILD CARE 193.02 19302 PHYSICIAN OFFICE BUILDING	0 42, 409	0	0	0	452, 068	193. 00 193. 01 193. 02
193. 02 19302 PHTSI CIAIN OFFICE BUILDING 193. 03 19303 OPTI FAST/FOUNDATION 194. 00 07950 PARTNERSHI PHFC 194. 01 07951 TRAFALGAR CLINI C 194. 02 07952 EDI NBURGH	0 0 1,570 0	0 0	0	0	0 95, 456 0	193. 03
194.03 07953 JAIL 194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	0	0	0	63, 697	
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I)	615, 234	1, 164, 608	2, 421, 386		3, 569, 752	
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II)	0. 144755 65, 782	0. 005316 69, 412	0. 010598 170, 217		0. 048313 293, 146	

Heal th Financ	ial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATI	ON - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
					From 01/01/2018		
					To 12/31/2018		
						5/29/2019 11:	
(Cost Center Description	MATERI ALS	ADMITTING	PATI ENT	Reconciliation		
		MANAGEMENT	(GROSS	ACCOUNTI NG		& GENERAL	
		(SUPPLY	CHARGES)	(GROSS		(ACCUM.	
		USAGE)		CHARGES)		COST)	
		4. 03	4. 04	4. 05	5A	5. 00	
205.00 L	Jnit cost multiplier (Wkst. B, Part	0. 015477	0. 000317	0. 00074	5	0. 003967	205. 00
	1)						
206. 00 N	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
1 1	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
1 1.	arto III and II)				1	l	

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	JOHNSON MEMOR	Provider Co		eriod: rom 01/01/2018	u of Form CMS- Worksheet B-1 Date/Time Pre	pared:
Cost Center Description	OPERATION OF PLANT (TOTAL FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (TOTAL FEET)	DI ETARY (MEALS SERVED)	5/29/2019 11: CAFETERI A (HOURS PAI D)	55 am
	7. 00	8.00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS 1.00	215, 833	l e				1. 00 2. 00 4. 00 4. 01 4. 02 4. 03 4. 04 4. 05 5. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 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 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	2, 404 1, 867 3, 917 4, 171 9, 867 1, 699 2, 046 3, 879	74, 218 8, 074 0 0 0	211, 562 3, 917 4, 171 9, 867 1, 699 2, 046	19, 485 0 0 0 0 0	848, 522 24, 161 5, 004 15, 409 23, 419	13. 00 14. 00 15. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS	27, 577 7, 886 2, 818 625	16, 853	7, 886 2, 818	16, 650 1, 488 1, 347 0	114, 872 37, 045 0 4, 222	31. 00 41. 00
50. 00	45, 761 394 16, 532 8, 049 374 6, 338 1, 335 83 1, 080 182 0	32, 056 0 0 2, 265 0 3, 008 0 0	8, 049 374 6, 338 1, 335 83 1, 080 182 0	0 0 0 0 0 0 0 0 0	64, 876 0 61, 815 70, 940 29, 940 22, 582 6, 511 3, 590 11, 343 1, 663 0	53. 00 54. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 ONCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATIENT SERVI CE COST CENTERS	6, 999 2, 511	0 0	6, 999	0 0 0	0 8, 800 4, 189	76. 00
90. 00	11, 516 9, 934			0	40, 333 77, 167	90. 00 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 305	0	1, 305	0	16, 924	101. 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	181, 149	377, 084	176, 878	19, 485	644, 805	113. 00 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC 192. 03 19203 DIABETES CENTER 193. 00 19300 NONPAID WORKERS 193. 01 19301 ADULT/CHILD CARE 193. 02 19302 PHYSICIAN OFFICE BUILDING 193. 03 19303 OPTIFAST/FOUNDATION 194. 00 197950 PARTNERSHIP HFC 194. 02 197951 TRAFALGAR CLINIC 194. 02 197952 EDINBURGH 194. 04 07954 ATHLETIC TRAINERS 200. 00 201. 00 202. 00 Cost to be allocated (per Wkst. B, Part I)	1, 297 25, 925 0 0 402 0 4, 832 0 0 2, 228 0 0 0 2, 937, 505	5, 707 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 402 0 4, 832 0 0 2, 228 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	162, 808 0 1, 993 0 18, 791 0 270 0 0 16, 174	192. 01 192. 02 192. 03 193. 00 193. 01 193. 02 193. 03 194. 00 194. 01 194. 02 194. 03 194. 04 200. 00 201. 00 202. 00
203.00 204.00 Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	13. 610083 127, 657	ł		38. 544111 83, 950	0. 863881 62, 063	203. 00 204. 00

Health Fin	ancial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der CO		Peri od: From 01/01/2018	Worksheet B-1	
					To 12/31/2018	Date/Time Pre 5/29/2019 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(TOTAL	(MEALS	(HOURS	
		(TOTAL	(POUNDS OF	FEET)	SERVED)	PAI D)	
		FEET)	LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 591462	0. 056388	0. 08899	5 4. 308442	0. 073142	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

				Fr To	com 01/01/2018 12/31/2018	Date/Time Prepared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	5/29/2019 11:55 am
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	
	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT 00404 ADMITTING 00405 PATIENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	303, 186 5, 004	100			1. 00 2. 00 4. 00 4. 01 4. 02 4. 03 4. 04 4. 05 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	0	100 0	218, 614, 547	15. 00 16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		5	51	2.070.17017	10.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	114, 872 37, 045 0 4, 222	0 0 0 0	0 0 0 0	12, 174, 206 1, 269, 232 633, 411 682, 972	30. 00 31. 00 41. 00 43. 00
53. 00 54. 00 60. 00 65. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY	64, 876 0 0 0	0 0 0 0	0 0 0 0	33, 225, 583 4, 793, 345 44, 409, 502 32, 053, 440 5, 684, 820	50. 00 53. 00 54. 00 60. 00 65. 00
69. 00 70. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0 0 0	0 0 0 0 0 100	0 0 0 0 0	4, 157, 385 1, 721, 165 455, 033 4, 412, 092 104, 166 9, 997, 382	66. 00 67. 00 68. 00 69. 00 70. 00 71. 00
72. 00 73. 00 76. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS	0 0 0 0	0 0 0 0	0 100 0 0	5, 054, 283 14, 527, 510 783, 813 592, 042	72. 00 73. 00 76. 00 76. 97
91.00	09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	77, 167	0	0	10, 784, 955 29, 975, 771	90. 00 91. 00 92. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	1, 122, 439	101. 00
113. 00 118. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	303, 186	100	100	218, 614, 547	113. 00 118. 00
192. 00 192. 01 192. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 SOUTH CLINIC 19202 WEST CLINIC 19203 DIABETES CENTER	0 0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03
193. 01 193. 02 193. 03 194. 00	19300 NONPAID WORKERS 19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION 07950 PARTNERSHIP HFC	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	193. 00 193. 01 193. 02 193. 03 194. 00
194. 02 194. 03	, ,	0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	194. 01 194. 02 194. 03 194. 04 200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	2, 606, 300	349, 123	1, 783, 863	1, 101, 525	202. 00
203. 00 204. 00		8. 596373 72, 547	3, 491. 230000 59, 110	17, 838. 630000 43, 637	0. 005039 93, 520	203. 00 204. 00

Heal th Finar	ncial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od: From 01/01/2018	Worksheet B-1	
					To 12/31/2018	Date/Time Pre 5/29/2019 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY		
		(DI RECT	(COSTED		(GROSS		
		NRSING HRS)	REQUIS.)		CHARGES)		
		13. 00	14.00	15. 00	16.00		
205. 00	Unit cost multiplier (Wkst. B, Part	0. 239282	591. 100000	436. 37000	0. 000428		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0001	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 11:55 am
	Title XVIII	Hospi tal	PPS

					10 12/31/2010	5/29/2019 11:	
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 012, 847		8, 012, 84	7 0	8, 012, 847	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 552, 288		2, 552, 28	3 0	2, 552, 288	31. 00
41.00	04100 SUBPROVI DER - I RF	560, 801		560, 80	1 0	560, 801	41. 00
43.00	04300 NURSERY	313, 614		313, 61	4 0	313, 614	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	6, 613, 268		6, 613, 26	3 0	6, 613, 268	
53.00	05300 ANESTHESI OLOGY	219, 295		219, 29	5 0	219, 295	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 671, 611		5, 671, 61	1 0	5, 671, 611	54.00
60.00	06000 LABORATORY	6, 201, 550		6, 201, 55	0	6, 201, 550	60.00
65.00	06500 RESPI RATORY THERAPY	1, 788, 616	0	1, 788, 61	5 0	1, 788, 616	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 473, 878	0	1, 473, 87	3 0	1, 473, 878	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	448, 077	0	448, 07	7 0	448, 077	67. 00
68.00	06800 SPEECH PATHOLOGY	229, 011	0	229, 01	1 0	229, 011	68. 00
69.00	06900 ELECTROCARDI OLOGY	864, 369		864, 36	9 32, 026	896, 395	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	87, 376		87, 37	6 0	87, 376	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 064, 521		4, 064, 52	1 0	4, 064, 521	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 875, 946		1, 875, 94	5 0	1, 875, 946	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 548, 036		6, 548, 03	6 0	6, 548, 036	73. 00
76.00	03020 ONCOLOGY	680, 122		680, 12	2 130, 613	810, 735	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	304, 006		304, 00	6 0	304, 006	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	3, 003, 230		3, 003, 23	0	3, 003, 230	90.00
91.00	09100 EMERGENCY	5, 330, 946		5, 330, 94	5 0	5, 330, 946	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	322, 826		322, 82	5	322, 826	92.00
	OTHER REIMBURSABLE COST CENTERS				_		
101.00	10100 HOME HEALTH AGENCY	1, 090, 425		1, 090, 42	ō	1, 090, 425	101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	58, 256, 659	0	58, 256, 65	9 162, 639	58, 419, 298	200.00
201.00	Less Observation Beds	322, 826		322, 82	5	322, 826	201. 00
202.00	Total (see instructions)	57, 933, 833	0	57, 933, 83	162, 639	58, 096, 472	202. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0001	Peri od:	Worksheet C
		From 01/01/2018	

Title XVIII						To 12/31/2018	Date/Time Pre 5/29/2019 11:	
Inpati ent				Title	XVIII	Hospi tal	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00				Charges				
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	I npati ent	Outpati ent				
INPATIENT ROUTINE SERVICE COST CENTERS 10,872,336 30.00					+ col. 7)	Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10,872,336 10,872,336 30.00 31.00 03100 INTENSI VE CARE UNIT 1,269,232 1,269,232 31.00 41.00 04100 SUBPROVIDER - IRF 633,411 633,411 633,411 41.00 43.00 04100 NURSERY 682,972 682,972 43.00 ANCILLARY SERVICE COST CENTERS								
30.00 3000 ADULTS & PEDIATRICS 10, 872, 336 10, 872, 336 31.00 31.00 1 NTENSI VE CARE UNIT 1, 269, 232 1, 269, 232 31.00 43.00 24.00			6. 00	7. 00	8. 00	9. 00	10. 00	
31. 00								
41. 00							I	
43. 00			1, 269, 232		1, 269, 23	2	I	1
ANCILLARY SERVICE COST CENTERS So. 00 ODDOOD ODDO							I	
50. 00 05000 OPERATI NG ROOM O5000 OPERATI NG ROOM O5000 O50000 O5000 O50000 O5000 O50000 O50000 O50000 O50000 O500000 O50000 O50000 O500000 O500000 O5000000 O5000000 O50000000 O50000000 O500000000 O500000000 O500000000 O500000000 O50000000000	43.00		682, 972		682, 97	2		43. 00
53. 00 05300 ANESTHESI OLOGY 625, 703 4, 167, 642 4, 793, 345 0. 045750 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 570, 984 38, 838, 518 44, 409, 502 0. 127712 0. 000000 54. 00 60. 00 06000 LABORATORY 6, 761, 588 25, 291, 852 32, 053, 440 0. 193475 0. 000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 2, 875, 967 2, 808, 853 5, 684, 820 0. 314630 0. 000000 66. 00 67. 00 06600 PHYSI CAL THERAPY 704, 876 1, 016, 289 1, 721, 165 0. 260334 0. 000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 704, 876 1, 016, 289 1, 721, 165 0. 260334 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 165, 077 289, 956 455, 033 0. 503284 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 035, 079 3, 377, 013 4, 412, 092 0.								
54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 570, 984 38, 838, 518 44, 409, 502 0. 127712 0. 000000 54. 00 60. 00 06000 LABORATORY 6, 761, 588 25, 291, 852 32, 053, 440 0. 193475 0. 000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 2, 875, 967 2, 808, 853 5, 684, 820 0. 314630 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 725, 211 3, 432, 174 4, 157, 385 0. 354520 0. 000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 704, 876 1, 016, 289 1, 721, 165 0. 260334 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 165, 077 289, 956 455, 033 0. 503284 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 035, 079 3, 377, 013 4, 412, 092 0. 195909 0. 000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 31, 544 72, 622 104, 166 0. 838815 0. 000000 70. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 1, 652, 343 3, 401, 940 5, 054, 283	50.00		5, 935, 364	27, 290, 219	33, 225, 58			
60. 00 06000 LABORATORY 6, 761, 588 25, 291, 852 32, 053, 440 0. 193475 0. 000000 60. 00 65. 00 06500 RESPIRATORY THERAPY 2, 875, 967 2, 808, 853 5, 684, 820 0. 314630 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 725, 211 3, 432, 174 4, 157, 385 0. 354520 0. 000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 704, 876 1, 016, 289 1, 721, 165 0. 260334 0. 000000 67. 00 06800 SPEECH PATHOLOGY 165, 077 289, 956 455, 033 0. 503284 0. 000000 69. 00 06900 ELECTROCARDI OLOGY 1, 035, 079 3, 377, 013 4, 412, 092 0. 195909 0. 000000 69. 00 07000 ELECTROENCEPHALOGRAPHY 31, 544 72, 622 104, 166 0. 838815 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3, 149, 651 6, 847, 731 9, 997, 382 0. 406559 0. 000000 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 4, 288, 285 10, 239, 225 14, 527, 510 0. 450734 0. 000000 73. 00 74.	53.00		625, 703	4, 167, 642	4, 793, 34	0. 045750	0. 000000	
65. 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 570, 984	38, 838, 518	44, 409, 50	2 0. 127712	0.000000	54. 00
66. 00 06600 PHYSI CAL THERAPY 725, 211 3, 432, 174 4, 157, 385 0. 354520 0. 000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 704, 876 1, 016, 289 1, 721, 165 0. 260334 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 165, 077 289, 956 455, 033 0. 503284 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 035, 079 3, 377, 013 4, 412, 092 0. 195909 0. 000000 69. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 31, 544 72, 622 104, 166 0. 838815 0. 000000 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3, 149, 651 6, 847, 731 9, 997, 382 0. 406559 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 652, 343 3, 401, 940 5, 054, 283 0. 371160 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 4, 288, 285 10, 239, 225 14, 527, 510 0. 450734 0. 000000 73. 00 76. 00 03020 ONCOLOGY 2, 714 781, 099 783, 813 0. 867710 0. 000000 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 266 591, 776 592, 042 0. 513487 0. 000000 70. 00 91. 00 09100 EMERGENCY 3, 489, 686 26, 486, 085 29, 975, 771 0. 177842 0. 000000 91. 00 91. 00 09100 EMERGENCY 3, 489, 686 26, 486, 085 29, 975, 771 0. 177842 0. 000000 91. 00	60.00	06000 LABORATORY	6, 761, 588	25, 291, 852	32, 053, 44	0. 193475	0.000000	60. 00
67. 00 06700 0CCUPATI ONAL THERAPY 704, 876 1, 016, 289 1, 721, 165 0. 260334 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 165, 077 289, 956 455, 033 0. 503284 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 035, 079 3, 377, 013 4, 412, 092 0. 195909 0. 000000 69. 00 70. 00	65.00	06500 RESPI RATORY THERAPY	2, 875, 967	2, 808, 853	5, 684, 82	0. 314630	0.000000	65.00
68. 00 06800 SPEECH PATHOLOGY 165, 077 289, 956 455, 033 0.503284 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1,035, 079 3,377, 013 4,412,092 0.195909 0.000000 69. 00 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 31,544 72,622 104,166 0.838815 0.000000 70. 00 71. 00 71. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 3,149,651 6,847,731 9,997,382 0.406559 0.000000 71. 00 72. 00 72. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 1,652,343 3,401,940 5,054,283 0.371160 0.000000 72. 00 73.	66.00	06600 PHYSI CAL THERAPY	725, 211	3, 432, 174	4, 157, 38	5 0. 354520	0.000000	66. 00
69. 00 06900 ELECTROCARDI OLOGY 1, 035, 079 3, 377, 013 4, 412, 092 0. 195909 0. 000000 69. 00 70. 00 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 31, 544 72, 622 104, 166 0. 838815 0. 000000 70. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74. 00	67.00	06700 OCCUPATI ONAL THERAPY	704, 876	1, 016, 289	1, 721, 16	5 0. 260334	0.000000	67.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 31, 544 72, 622 104, 166 0. 838815 0. 000000 70. 00 71. 00 71. 00 71. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 3, 149, 651 6, 847, 731 9, 997, 382 0. 406559 0. 000000 71. 00 72. 00 72. 00 MPL. DEV. CHARGED TO PATIENT 1, 652, 343 3, 401, 940 5, 054, 283 0. 371160 0. 000000 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 288, 285 10, 239, 225 14, 527, 510 0. 450734 0. 000000 73. 00 76.	68. 00	06800 SPEECH PATHOLOGY	165, 077	289, 956	455, 03	0. 503284	0.000000	68. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 3, 149, 651 6, 847, 731 9, 997, 382 0. 406559 0. 000000 71. 00 72. 00 72. 00 1MPL. DEV. CHARGED TO PATI ENT 1, 652, 343 3, 401, 940 5, 054, 283 0. 371160 0. 000000 72. 00 73. 00 73. 00 74.	69. 00	06900 ELECTROCARDI OLOGY	1, 035, 079	3, 377, 013	4, 412, 09	0. 195909	0.000000	69.00
72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 1,652,343 3,401,940 5,054,283 0.371160 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 4,288,285 10,239,225 14,527,510 0.450734 0.000000 73.00 76.00 03020 ONCOLOGY 2,714 781,099 783,813 0.867710 0.000000 76.00 76.97 O7697 CARDI AC REHABI LI TATI ON 266 591,776 592,042 0.513487 0.000000 76.97 O7697	70.00	07000 ELECTROENCEPHALOGRAPHY	31, 544	72, 622	104, 16	6 0. 838815	0.000000	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 288, 285 10, 239, 225 14, 527, 510 0. 450734 0. 000000 73. 00 76. 00 76. 00 76. 97 76. 97 07697 CARDI AC REHABI LI TATI ON 266 591, 776 592, 042 0. 513487 0. 000000 76. 97 0000000 76. 97 0000000 76. 97 0000000 000000000000000000000000	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 149, 651	6, 847, 731	9, 997, 38	0. 406559	0.000000	71. 00
76. 00 03020 0NCOLOGY 2, 714 781, 099 783, 813 0. 867710 0. 000000 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 266 591, 776 592, 042 0. 513487 0. 000000 76. 97 0UTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C 9, 866 10, 775, 089 10, 784, 955 0. 278465 0. 000000 90. 00 91. 00 09100 EMERGENCY 3, 489, 686 26, 486, 085 29, 975, 771 0. 177842 0. 000000 91. 00 00000000000000000000000000000000	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 652, 343	3, 401, 940	5, 054, 28	0. 371160	0.000000	72. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 266 591, 776 592, 042 0. 513487 0. 000000 76. 97 0000000 76. 97 0000000 000000000000000000000000	73.00	07300 DRUGS CHARGED TO PATIENTS	4, 288, 285	10, 239, 225	14, 527, 51	0. 450734	0.000000	73. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 9,866 10,775,089 10,784,955 0.278465 0.000000 90.00 91. 00 09100 EMERGENCY 3,489,686 26,486,085 29,975,771 0.177842 0.000000 91.00	76.00	03020 ONCOLOGY	2, 714	781, 099	783, 81	0. 867710	0.000000	76.00
90. 00 09000 CLI NI C 9,866 10,775,089 10,784,955 0.278465 0.000000 91.00 91.00 6MERGENCY 3,489,686 26,486,085 29,975,771 0.177842 0.000000 91.00	76. 97	07697 CARDI AC REHABI LI TATI ON	266	591, 776	592, 04	0. 513487	0.000000	76. 97
91. 00 09100 EMERGENCY 3, 489, 686 26, 486, 085 29, 975, 771 0. 177842 0. 000000 91. 00		OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 3, 489, 686 26, 486, 085 29, 975, 771 0. 177842 0. 000000 91. 00	90.00	09000 CLI NI C	9, 866	10, 775, 089	10, 784, 95	5 0. 278465	0.000000	90.00
								1
	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 ' ' 1	1, 301, 870			0. 000000	1
OTHER REIMBURSABLE COST CENTERS		,	-1	.,,	.,		3, 55555	
101. 00 10100 HOME HEALTH AGENCY 0 1, 122, 439 1, 122, 439 101. 00	101.00		0	1, 122, 439	1, 122, 43	9		101.00
SPECIAL PURPOSE COST CENTERS			-	.,,	.,,	-		
113. 00 11300 INTEREST EXPENSE 113. 00	113 00							113 00
200. 00 Subtotal (see instructions) 50, 482, 155 168, 132, 392 218, 614, 547 200. 00			50 482 155	168 132 392	218 614 54	7	I	
201.00 Less Observation Beds 201.00			00, 102, 100	.00, 102, 072	210, 017, 04		I	
202. 00 Total (see instructions) 50, 482, 155 168, 132, 392 218, 614, 547 202. 00			50, 482, 155	168, 132, 392	218, 614, 54	7	I	

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-	O001 Period: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 5/20/2019 11:55 am

				1	5/29/2019 11:55 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVI DER - I RF				41.00
43.00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 199041			50.00
53.00	05300 ANESTHESI OLOGY	0. 045750			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 127712			54.00
60.00	06000 LABORATORY	0. 193475			60.00
65.00	06500 RESPI RATORY THERAPY	0. 314630			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 354520			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 260334			67. 00
68.00	06800 SPEECH PATHOLOGY	0. 503284			68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 203168			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 838815			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 406559			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 371160			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 450734			73. 00
76.00	03020 ONCOLOGY	1. 034347			76. 00
76. 97	07697 CARDIAC REHABILITATION	0. 513487			76. 97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 278465			90.00
91.00	09100 EMERGENCY	0. 177842			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 247971			92. 00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 I NTEREST EXPENSE				113. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-000	From 01/01/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 11:55 am
	T. 11 VIV	11 * 1	0 1

					10 12/31/2018	5/29/2019 11:	
			Ti tl	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.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 012, 847		8, 012, 84	7 0	8, 012, 847	30.00
31.00	03100 INTENSIVE CARE UNIT	2, 552, 288		2, 552, 28	8 0	2, 552, 288	31.00
41.00	04100 SUBPROVI DER - I RF	560, 801		560, 80	1 0	560, 801	41.00
43.00	04300 NURSERY	313, 614		313, 61	4 0	313, 614	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6, 613, 268		6, 613, 26	8 0	6, 613, 268	50.00
53.00	05300 ANESTHESI OLOGY	219, 295		219, 29	5 0	219, 295	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 671, 611		5, 671, 61	1 0	5, 671, 611	54.00
60.00	06000 LABORATORY	6, 201, 550		6, 201, 55	0	6, 201, 550	60.00
65.00	06500 RESPI RATORY THERAPY	1, 788, 616	0	1, 788, 61	6 0	1, 788, 616	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 473, 878	0	1, 473, 87	8 0	1, 473, 878	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	448, 077	0	448, 07	7 0	448, 077	67. 00
68.00	06800 SPEECH PATHOLOGY	229, 011	0	229, 01	1 0	229, 011	68. 00
69.00	06900 ELECTROCARDI OLOGY	864, 369		864, 36	9 32, 026	896, 395	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	87, 376		87, 37	6 0	87, 376	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 064, 521		4, 064, 52	1 0	4, 064, 521	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 875, 946		1, 875, 94	6 0	1, 875, 946	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 548, 036		6, 548, 03	6 0	6, 548, 036	73. 00
76.00	03020 ONCOLOGY	680, 122		680, 12		810, 735	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	304, 006		304, 00		304, 006	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	3, 003, 230		3, 003, 23	0 0	3, 003, 230	90.00
91.00	09100 EMERGENCY	5, 330, 946		5, 330, 94		5, 330, 946	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	322, 826		322, 82		322, 826	
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 090, 425		1, 090, 42	5	1, 090, 425	101.00
	SPECIAL PURPOSE COST CENTERS			, , , , , , , , , , , , , , , , , , , ,		,	
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	1	58, 256, 659	О	58, 256, 65	9 162, 639	58, 419, 298	
201.00	,	322, 826		322, 82		322, 826	
202.00		57, 933, 833					
							•

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0001	Peri od:	Worksheet C
		From 01/01/2018	

					To 12/31/2018	Date/Time Pre 5/29/2019 11:	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	I NPATIENT ROUTINE SERVICE COST CENTERS						4
30. 00	03000 ADULTS & PEDI ATRI CS	10, 872, 336		10, 872, 33		I	30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 269, 232		1, 269, 23		I	31. 00
41. 00	04100 SUBPROVI DER - I RF	633, 411		633, 41		I	41. 00
43.00	04300 NURSERY	682, 972		682, 97	2		43. 00
	ANCILLARY SERVICE COST CENTERS						4
50. 00	05000 OPERATING ROOM	5, 935, 364	27, 290, 219			0. 000000	
53.00	05300 ANESTHESI OLOGY	625, 703	4, 167, 642	4, 793, 34	0. 045750	0. 000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 570, 984	38, 838, 518	44, 409, 50	0. 127712	0. 000000	54. 00
60.00	06000 LABORATORY	6, 761, 588	25, 291, 852	32, 053, 44	0. 193475	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	2, 875, 967	2, 808, 853	5, 684, 82	0. 314630	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	725, 211	3, 432, 174	4, 157, 38	0. 354520	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	704, 876	1, 016, 289	1, 721, 16	5 0. 260334	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	165, 077	289, 956	455, 03	0. 503284	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 035, 079	3, 377, 013	4, 412, 09	0. 195909	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	31, 544	72, 622	104, 16	6 0. 838815	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 149, 651	6, 847, 731	9, 997, 38	0. 406559	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 652, 343	3, 401, 940	5, 054, 28	0. 371160	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 288, 285	10, 239, 225	14, 527, 51	0. 450734	0. 000000	73. 00
76. 00	03020 ONCOLOGY	2,714	781, 099	783, 81	0. 867710	0. 000000	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	266	591, 776	592, 04	0. 513487	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS		•				1
90.00	09000 CLI NI C	9, 866	10, 775, 089	10, 784, 95	5 0. 278465	0.000000	90.00
91. 00	09100 EMERGENCY	3, 489, 686	26, 486, 085	29, 975, 77	0. 177842	0. 000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 301, 870			0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS	-1	.,	.,,,,,,,		3, 55555	1
101.00	10100 HOME HEALTH AGENCY	0	1, 122, 439	1, 122, 43	9		101. 00
	SPECIAL PURPOSE COST CENTERS	-	.,,	1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1	-		1
113 00	11300 I NTEREST EXPENSE						113. 00
200.00		50, 482, 155	168, 132, 392	218, 614, 54	7	I	200.00
201.00	,	33, 132, 100	.00, .02, 072	2.3, 3, 51		I	201. 00
202.00		50, 482, 155	168, 132, 392	218, 614, 54	7	I	202.00
202.00	Trotal (See Thatiactions)	1 30, 402, 133	100, 132, 372	210,014,34	'		1202.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0001	Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared: 5/29/2019 11:55 am

					5/29/2019 11: 5	.5 am
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00	03020 ONCOLOGY	0. 000000				76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>				
90.00	09000 CLI NI C	0. 000000				90.00
91. 00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>				
101.00	10100 HOME HEALTH AGENCY				1	101. 00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>				
113.00	11300 INTEREST EXPENSE				1	113. 00
200.00					l l	200. 00
201.00					2	201. 00
202.00	Total (see instructions)				2	202. 00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od: From 01/01/2018	Worksheet D Part I	
				To 12/31/2018	Date/Time Pre	
					5/29/2019 11:	55 am_
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col	•		
	26)	2.00	2)	4.00	F 00	
LADATI FAIT DOUTLASE CEDALCE COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F70 100		I 570 10	0 5 (04	101 71	20.00
30. 00 ADULTS & PEDIATRICS	578, 129	0	0,0,12			
31. 00 INTENSIVE CARE UNIT	156, 471	•	156, 47			
41. 00 SUBPROVI DER - I RF	45, 782	Ü	45, 78			
43. 00 NURSERY	4, 448		4, 44			
200. 00 Total (lines 30 through 199)	784, 830		784, 83	0 7, 360		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col. 6)				
	6, 00	7. 00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDI ATRI CS	2, 298	233, 730	J			30.00
31. 00 INTENSIVE CARE UNIT	2, 248	65, 618				31. 00
41. 00 SUBPROVI DER - I RF	118	12, 031				41. 00
43. 00 NURSERY	0	12, 031	1			43.00
200.00 Total (lines 30 through 199)	2, 624	-	1			200. 00
200. 00 Total (Titles 30 till ough 199)	2, 024	311, 3/9	T			₁ 200.00

Health Financial Systems	JOHNSON MEMOR	I AL H	OSPI TAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	_ COSTS	P	Provider CO	CN: 15-0001	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prep 5/29/2019 11:5	
			Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Tota	I Charges	Ratio of Cos	t Inpatient	Capital Costs	

					To 12/31/2018	Date/Time Pre	pared:
-			Ti +Lo	: XVIII	Hospi tal	5/29/2019 11: PPS	55 am_
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	cost center bescription		(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	9	column 4)	
		Part II, col.	8)	2)	. ona. goo	501 a 1)	
		26)	-,				
		1.00	2.00	3.00	4. 00	5. 00	
AN	ICILLARY SERVICE COST CENTERS						
50.00 05	OOOO OPERATING ROOM	1, 145, 681	33, 225, 583	0. 03448	2 1, 888, 091	65, 105	50.00
53. 00 05	300 ANESTHESI OLOGY	31, 204	4, 793, 345	0. 00651	0 226, 750	1, 476	53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	754, 750	44, 409, 502	0. 01699	5 2, 258, 438	38, 382	54. 00
60.00 06	5000 LABORATORY	435, 157	32, 053, 440	0. 01357	6 3, 116, 455	42, 309	60.00
65. 00 06	5500 RESPIRATORY THERAPY	97, 235	5, 684, 820	0. 01710	4 1, 060, 059	18, 131	65. 00
66. 00 06	6600 PHYSI CAL THERAPY	84, 539	4, 157, 385	0. 02033	5 267, 172	5, 433	66. 00
67. 00 06	5700 OCCUPATI ONAL THERAPY	18, 421	1, 721, 165	0. 01070	3 249, 080	2, 666	67. 00
68. 00 06	800 SPEECH PATHOLOGY	10, 179	455, 033	0. 02237	0 62, 001	1, 387	68. 00
69. 00 06	900 ELECTROCARDI OLOGY	160, 644	4, 412, 092	0. 03641	0 866, 784	31, 560	69. 00
70. 00 07	7000 ELECTROENCEPHALOGRAPHY	3, 892	104, 166	0. 03736	11, 496	430	70. 00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	116, 348	9, 997, 382	0. 01163	8 1, 143, 207	13, 305	71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENT	14, 533	5, 054, 283	0. 00287	5 758, 805	2, 182	72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	82, 594	14, 527, 510	0. 00568	5 1, 880, 974	10, 693	73. 00
76. 00 03	3020 ONCOLOGY	47, 555	783, 813	0. 06067	1 556	34	76. 00
76. 97 07	7697 CARDIAC REHABILITATION	23, 231	592, 042	0. 03923	9 0	0	76. 97
	ITPATIENT SERVICE COST CENTERS						
90. 00 09	POOO CLI NI C	150, 796	10, 784, 955	0. 01398	9, 866	138	90. 00
	P100 EMERGENCY	272, 376	29, 975, 771	0. 00908	7 1, 595, 320	14, 497	91. 00
92. 00 09	0200 OBSERVATION BEDS (NON-DISTINCT PART)	23, 292	1, 301, 870	0. 01789	1 0	0	92. 00
200.00	Total (lines 50 through 199)	3, 472, 427	204, 034, 157		15, 395, 054	247, 728	200. 00

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS		F	Period: From 01/01/2018 To 12/31/2018		pared: 55 am
			XVIII	Hospi tal	PPS	
Cost Center Description				Allied Health		
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	(0	0	
31.00 03100 INTENSIVE CARE UNIT	0	0	(0	0	1
41. 00 04100 SUBPROVI DER - I RF	0	0	(0	0	41. 00
43. 00 04300 NURSERY	0	0	(0	0	
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 684			
31.00 03100 INTENSIVE CARE UNIT		0	496			
41. 00 04100 SUBPROVI DER - I RF	0	0	449			
43. 00 04300 NURSERY		0	731	0.00	0	43. 00
200.00 Total (lines 30 through 199)		0	7, 360		2, 624	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
INDATION DOUTING CODYLOG COCT CONTEDC	9. 00					

30. 00 31. 00

41. 00 43. 00 200. 00

30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY Total (lines 30 through 199)

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0001	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

				'		5/29/2019 11:	55 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	C	0	0	50. 00
	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
1	06000 LABORATORY	0	0	(0	0	60. 00
1	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
1	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
1	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 00	03020 ONCOLOGY	0	0	(0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	(0	0	90. 00
91. 00	09100 EMERGENCY	0	0	(0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		()	0	92. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	JOHNSON MEMORIAL	. HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0001	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

				0 12/31/2018	5/29/2019 11:	
		Title	xVIII	Hospi tal	PPS	00 4111
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0) C	33, 225, 583	1	
53. 00 05300 ANESTHESI OLOGY	0	0) C	4, 793, 345		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0) C	44, 409, 502		
60. 00 06000 LABORATORY	0	0	C	32, 053, 440		
65. 00 06500 RESPI RATORY THERAPY	0	0) C	5, 684, 820		
66. 00 06600 PHYSI CAL THERAPY	0	0) C	4, 157, 385		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0) C	1, 721, 165		
68. 00 06800 SPEECH PATHOLOGY	0	0) C	455, 033		
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	4, 412, 092	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	104, 166	0.000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	9, 997, 382	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C	5, 054, 283	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	14, 527, 510	0.000000	73. 00
76. 00 03020 ONCOLOGY	0	0	C	783, 813	0.000000	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	C	592, 042	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0) c	10, 784, 955	0.000000	90. 00
91. 00 09100 EMERGENCY	0	0	(c	29, 975, 771	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(C	1, 301, 870	0. 000000	92. 00
200.00 Total (lines 50 through 199)	0	0	() c	204, 034, 157		200. 00

Health Financial Systems	JOHNSON MEMORIA	NT IDSOL IN		In Lie	eu of Form CMS-2	2552 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provider Co		eri od:	Worksheet D	2552-10
THROUGH COSTS				rom 01/01/2018 o 12/31/2018		nared:
			'	0 12/31/2016	5/29/2019 11:	55 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS				1		
50.00 05000 OPERATING ROOM	0. 000000	1, 888, 091		5, 616, 022	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	226, 750		,		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 258, 438	0	9, 085, 880	0	54.00
60. 00 06000 LABORATORY	0. 000000	3, 116, 455	C	2, 302, 136	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 060, 059	C	617, 617	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	267, 172	C	15, 098	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	249, 080	C	13, 471	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	62, 001	C	1, 423	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	866, 784	C	988, 807	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	11, 496		17, 342	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 143, 207		1, 066, 481	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	758, 805	C	678, 168	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 880, 974		4, 809, 946	0	73. 00
76. 00 03020 ONCOLOGY	0. 000000	556		126, 743	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0			l	76. 97
OUTPATIENT SERVICE COST CENTERS				,		
90. 00 09000 CLINIC	0. 000000	9, 866	C	2, 423, 926	0	90.00
91. 00 09100 EMERGENCY	0. 000000	1, 595, 320			o o	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0			0	1
200.00 Total (lines 50 through 199)		15, 395, 054			1	200. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1		'		,	

Heal th Fina	ncial Systems	JOHNSON MEMOR	TAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				F	From 01/01/2018		
				7	Γo 12/31/2018		
			T' 11	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		5/29/2019 11:	55 am_
			IITIE	XVIII	Hospi tal	PPS	
			DDC D : 1 1	Charges	1 0 1	Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
			Servi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
		1.00	0.00	(see inst.)	(see inst.)		
	LARY OFRIGO COST OFFITERS	1. 00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS					1 117 010	
	O OPERATI NG ROOM	0. 199041			ا ا	1, 117, 819	
	O ANESTHESI OLOGY	0. 045750			0	27, 502	53. 00
	O RADI OLOGY-DI AGNOSTI C	0. 127712			0	1, 160, 376	
	0 LABORATORY	0. 193475			0	445, 406	
	O RESPI RATORY THERAPY	0. 314630			0	194, 321	65. 00
	O PHYSI CAL THERAPY	0. 354520			0	5, 353	
	O OCCUPATIONAL THERAPY	0. 260334			0	3, 507	67. 00
	O SPEECH PATHOLOGY	0. 503284			0	716	
	O ELECTROCARDI OLOGY	0. 195909		(0	193, 716	69. 00
70.00 07000	O ELECTROENCEPHALOGRAPHY	0. 838815	17, 342	(0	14, 547	70. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 406559	1, 066, 481	(0	433, 587	71. 00
72.00 07200	O IMPL. DEV. CHARGED TO PATIENT	0. 371160	678, 168	(0	251, 709	72. 00
	D DRUGS CHARGED TO PATIENTS	0. 450734	4, 809, 946	(20	2, 168, 006	73. 00
76. 00 03020	ONCOLOGY	0. 867710	126, 743	(0	109, 976	76. 00
76. 97 0769	7 CARDIAC REHABILITATION	0. 513487	91, 953	(0	47, 217	76. 97
	ATIENT SERVICE COST CENTERS						
90.00 09000	O CLI NI C	0. 278465	2, 423, 926	3, 968	3 0	674, 979	90. 00
91.00 09100	O EMERGENCY	0. 177842	4, 597, 761	(0	817, 675	91.00
92.00 09200	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 247971	486, 691	(0	120, 685	92.00
200.00	Subtotal (see instructions)		33, 540, 599	3, 968	3 20	7, 787, 097	200. 00
201.00	Less PBP Clinic Lab. Services-Program			(o o		201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)		33, 540, 599	3, 968	20	7, 787, 097	202. 00

Health Financial Systems	JOHNSON MEMO	ORI AL	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Г	Provi der (CCN: 15-0001	From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/29/2019 11:	
			Ti tl	e XVIII	Hospi tal	PPS	
	C	Costs					
Cost Center Description	Cost Reimbursed	Re	Cost eimbursed				

		Title	XVIII	Hospi tal	PPS	aiii
	Cos		7,,,,,	110001 101	1.10	
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			I	54. 00
60. 00 06000 LABORATORY	0	0				50. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				55.00
66. 00 06600 PHYSI CAL THERAPY	0	0				56. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				57. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				58. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				59. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			I	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			I	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9				73. 00
76. 00 03020 0NC0L0GY	0	0			l .	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			7	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 105	0				90. 00
91. 00 09100 EMERGENCY	0	0			l .	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			l .	92.00
200.00 Subtotal (see instructions)	1, 105	9			• • • • • • • • • • • • • • • • • • •	00.00
201.00 Less PBP Clinic Lab. Services-Program	0				20	01. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	1, 105	9			20	02. 00

Health Financial Systems	JOHNSON MEMOR				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0001	Peri od: From 01/01/2018	Worksheet D	
		Component	CCN: 15-T001	To 12/31/2018		pared.
		'			5/29/2019 11:	
		Title	xVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00		4 00		
ANOLULARY OFRICA OF COOT OFFITERS	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4 445 (04	20 005 500	0.0044	1 040		F0 00
50. 00 05000 OPERATING ROOM	1, 145, 681		l .		l	50.00
53. 00 05300 ANESTHESI OLOGY	31, 204		l .		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	754, 750		l .			54. 00
60. 00 06000 LABORATORY	435, 157					60. 00
65. 00 06500 RESPI RATORY THERAPY	97, 235					65. 00
66. 00 06600 PHYSI CAL THERAPY	84, 539		l .			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	18, 421					67. 00
68.00 06800 SPEECH PATHOLOGY	10, 179				l e	68. 00
69. 00 06900 ELECTROCARDI OLOGY	160, 644				ł	
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 892				0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	116, 348		l .	•	17	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT	14, 533		l .		0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	82, 594		l .	•	63	
76. 00 03020 0NCOLOGY	47, 555				0	76. 00
76. 97 O7697 CARDIAC REHABILITATION	23, 231	592, 042	0. 03923	39 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	150, 796	10, 784, 955	0. 01398	32 0	0	90. 00
91. 00 09100 EMERGENCY	272, 376	29, 975, 771	0. 00908	37 0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 301, 870	0.00000	00	0	92. 00
200.00 Total (lines 50 through 199)	3, 449, 135	204, 034, 157		237, 110	3, 794	200. 00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	S Provider CO		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018		
		Component (CCN: 15-T001	To 12/31/2018	Date/Time Pre	oared:
		· ·			5/29/2019 11:	55 am_
		Title	: XVIII	Subprovi der -	PPS	
				IRF		
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adiustments		Adiustments		

	Coot Conton Decemintion	Non Dhysisian	Nussing Cohool	Nussing Cobool	Allied Heelth	Alliad Haal+b	
	Cost Center Description		Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	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	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	l 0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	l 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
	07200 I MPL. 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
	03020 ONCOLOGY	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS						70.77
90. 00	09000 CLINI C	0	0		0	0	90.00
91. 00	09100 EMERGENCY				0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	· · · · · · · · · · · · · · · · · · ·						•
200.00	Total (lines 50 through 199)	1	ıl O	ıl O	ıl O	l 0	200. 00

Health Financial Systems	JOHNSON MEMORI				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provi der C		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2018 To 12/31/2018		nared:
		Component	CCN. 13-1001	10 12/31/2010	5/29/2019 11:	55 am
		Title	: XVIII	Subprovi der -	PPS	
				. I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)	7.00	0.00	
ANOLILARY OFRIGO OCCUPANTED	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				22 225 502	0.000000	FO 00
50. 00 05000 OPERATI NG ROOM	0	0		33, 225, 583		
53. 00 05300 ANESTHESI OLOGY	0	0		0 4, 793, 345		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 44, 409, 502	1	
60. 00 06000 LABORATORY	0	0		32, 053, 440		
65. 00 06500 RESPI RATORY THERAPY	0	0		5, 684, 820		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 157, 385		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		1, 721, 165		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 455, 033		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 4, 412, 092		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 104, 166		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		9, 997, 382		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		5, 054, 283		
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 ONCOLOGY	0	0		14, 527, 510		
	0	0		783, 813 592, 042		
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS		0	1	592, 042	0.000000	76. 97
90. 00 09000 CLINIC	0	0	1	10, 784, 955	0. 000000	90. 00
91. 00 09100 ELI NI C 91. 00 09100 EMERGENCY	0	0	1			90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1	29, 975, 771 1 301 870		
200.00 Total (lines 50 through 199)				1, 301, 870 204, 034, 157		200. 00
200.00 Total (Titles 50 tillough 199)	0	ı	1	J ₁ 204, 034, 157		200.00

	inancial Systems	JOHNSON MEMORIAL				eu of Form CMS-2	<u> 2552-10</u>
	NMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co	CN: 15-0001	Peri od:	Worksheet D	
THROUGH	COSTS		Component (CCN: 15-T001	From 01/01/2018 To 12/31/2018		narod:
			Component	CCN. 15-1001	10 12/31/2010	5/29/2019 11:	55 am
			Title	XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Outpati ent	I npati ent	Inpatient	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)		x col. 12)	
		9.00	10. 00	11. 00	12. 00	13. 00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0. 000000	1, 848		0	0	
53. 00 05	5300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000	14, 458		0	0	54.00
60.00 06	6000 LABORATORY	0. 000000	56, 909		0	0	60.00
65. 00 06	6500 RESPI RATORY THERAPY	0.000000	6, 432		0 0	0	65. 00
66.00 06	6600 PHYSI CAL THERAPY	0. 000000	59, 628		0 0	0	66. 00
67. 00 06	6700 OCCUPATI ONAL THERAPY	0. 000000	60, 861		0 0	0	67. 00
68. 00 06	6800 SPEECH PATHOLOGY	0. 000000	16, 598		0 0	0	68. 00
69. 00 06	6900 ELECTROCARDI OLOGY	0. 000000	7, 863		0 0	0	69.00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 461		0 0	0	71. 00
72. 00 07	7200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72. 00
73. 00 07	7300 DRUGS CHARGED TO PATIENTS	0. 000000	11, 052		0 0	0	73.00
	3020 ONCOLOGY	0. 000000	0		0 0	0	76. 00
76, 97 07	7697 CARDIAC REHABILITATION	0. 000000	0		0 0	l 0	76. 97
OL	UTPATIENT SERVICE COST CENTERS				-		
90.00 09	9000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00 09	9100 EMERGENCY	0. 000000	0		0 0	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		ol o	0	
200.00	Total (lines 50 through 199)		237, 110		o o	0	200. 00
	1	1	,	1	-1	,	

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der	CCN: 15-0001	Peri od: From 01/01/2018	Worksheet D-1
			To 12/31/2018	Date/Time Prepared: 5/29/2019 11:55 am
	Ti 1	TE XVIII	Hosni tal	DDS

		Title XVIII	Hospi tal	5/29/2019 11: PPS	55 am
	Cost Center Description	I tie XVIII	nospi tai	113	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		5, 684	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed days			5, 684	2.00
3.00	Private room days (excluding swing-bed and observation bed day	3 /	vate room days,	0	3. 00
	do not complete this line.	, , ,	,		
4.00	Semi-private room days (excluding swing-bed and observation be			5, 455	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (R1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember .	or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 298	9. 00
7. 00	newborn days)	o the riegram (exertaining	oming sou and	2,270	7.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instruct			0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	dir (exertaining swring beart	adys)	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	arter becomber or or	1110 0031	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20.00	reporting period	a after December 21 of th		0.00	20. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after beceiliber 31 of the	ie cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		8, 012, 847	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
22.00	5 x line 17)	21 of the east reporting	nominal (line (0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		8, 012, 847	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	, , , , , , , , , , , , , , , , , , , ,		., ,	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	FII ne 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	ous line 22)(see instruct	tions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		11 0115)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	8, 012, 847	37. 00
	27 minus line 36)	,		-, -, -, -, -, -, -, -, -, -, -, -, -, -	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00.05	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 .00 ==	00.00
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 409. 72	38. 00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			3, 239, 537 0	39. 00 40. 00
41. 00		,		3, 239, 537	
00	,		ı	-,, , 55,	

	Financial Systems	JOHNSON MEMORI		CN: 1F 0004		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-0001	Peri od: From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/29/2019 11:	
	Cost Contar Decement on	Total		XVIII	Hospi tal	PPS Program Cost	
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1	9	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	2, 552, 288	496	5, 145.	74 208	1, 070, 314	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00							46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ne)		3, 868, 881 8, 178, 732	
49.00	PASS THROUGH COST ADJUSTMENTS	41 tili ougii 46) (s	see mstructro	JIIS)		0, 170, 732	49.00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, su	m of Parts I and	299, 348	50.00
51. 00	<pre> </pre>	atient ancillary	/ services (fr	om Wkst. D. :	sum of Parts II	247, 728	51. 00
	and IV)	-	, (
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated non nhy	veician ancet	hotist and	547, 076 7, 631, 656	
33.00	medical education costs (line 49 minus line		atea, non-pny	731 Ci ali allesti	netrst, and	7, 031, 030	33.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						1 54 00
	Program discharges Target amount per discharge					0.00	54. 00 55. 00
56.00	Target amount (line 54 x line 55)					l e	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	rget amount (I	ine 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996, ເ	updated and co	ompounded by the		59. 00
40.00	market basket	cost roport un	datad by the n	narkat backat		0.00	60.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line					0.00	
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% o	f the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instrud	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decer	mher 31 of the	cost report	ing period (See	0	64.00
0 00	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	55)(title XVI	II only). For	0	66. 00
47.00	CAH (see instructions)		Dogombon 21 a	ef the cost o	onorting noried	0	47.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 C	or the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70.00
72. 00	Program routine service cost (line 9 x line	71)					72. 00
73.00	Medically necessary private room cost application. Total Program general inpatient routine serv						73.00
74. 00 75. 00	Capital -related cost allocated to inpatient	•			Part II, column		74. 00 75. 00
	26, line 45)		•				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.				nus Lino 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		ost irimitatifUl	. (11116 /6 IIII)	1116 /7)		81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00
87. 00	Total observation bed days (see instructions					229	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 409. 72	88. 00
89. UU	Observation bed cost (line 87 x line 88) (se	e instructions)				322, 826	δ9. UU

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2018	Worksheet D-1	
				To 12/31/2018	Date/Time Prep 5/29/2019 11:	pared: 55 am
		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	1
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	578, 129	8, 012, 847	0. 07215	0 322, 826	23, 292	90. 00
91.00 Nursing School cost	0	8, 012, 847	0.00000	0 322, 826	0	91.00
92.00 Allied health cost	0	8, 012, 847	0.00000	0 322, 826	0	92. 00
93.00 All other Medical Education	0	8, 012, 847	0.00000	0 322, 826	0	93. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0001	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T001		
	Title XVIII	Subprovi der -	PPS
		IRF	

		II the Aviii	I RF	FF3	
	Cost Center Description			I	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			449	1. 00
2.00	Inpatient days (including private room days, excluding swing-			449	
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		449	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period	om dava) aftar Dagombar 3	11 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	118	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en		Join days) ares	· ·	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including private	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	(only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			O	13.00
14.00	Medically necessary private room days applicable to the Progra			0	
15.00	Total nursery days (title V or XIX only)		-	0	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of t	the cost	0.00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	3			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	3)		560, 801	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
	7 x line 19)	•			
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		560, 801	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		\ \ \		00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	irges)	0	28. 00 29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	i ons)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)		1 0113)	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	560, 801	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 249. 00	
39.00	Program general inpatient routine service cost (line 9 x line			147, 382	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 147, 382	40. 00 41. 00
	1	,	ı	, 302	

	Financial Systems	JOHNSON MEMORIA		ou 15 0001		eu of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co		Peri od: From 01/01/2018	Worksheet D-1		
			· ·	CCN: 15-T001	To 12/31/2018	5/29/2019 11:		
			Title	e XVIII	Subprovi der - I RF	PPS		
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3. 00	4. 00	5. 00		
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. C	00 0	0	42.00	
43. 00	INTENSIVE CARE UNIT	0	0	0.0	00 0	0		
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00	
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00	
	·					1. 00		
48. 00 49. 00				ons)		67, 759 215, 141	1	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	ervices (from	n Wkst. D, sum	of Parts I and	12, 031	50. 00	
51. 00	<pre> </pre>	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	3, 794	51. 00	
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				15, 825	52. 00	
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line !	ding capital rel	ated, non-phy	sician anesth	etist, and	199, 316	•	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00	
55.00	Target amount per discharge					0.00	•	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	0		
58.00	Bonus payment (see instructions)					0 0.00	58. 00 59. 00	
59. 00	00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							
60. 00 61. 00								
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							
63. 00	0	63. 00						
64. 00	9	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00	
65. 00	,	ts after Decembe	r 31 of the c	cost reporting	period (See	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	0	66. 00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	porting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	rting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (routine costs (I	ine 67 + line	e 68)		0	69. 00	
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70. 00	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(lino 14 v li	no 25)			72. 00 73. 00	
74. 00	Total Program general inpatient routine servi		•				74.00	
75. 00	Capital-related cost allocated to inpatient (26, line 45)		costs (from W	lorksheet B, P	art II, column		75. 00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00	
78. 00	Inpatient routine service cost (line 74 minus	.*					78. 00	
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				us line 79)		79. 00 80. 00	
81. 00	Inpatient routine service cost per diem limi	tati on			,		81. 00	
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (82. 00 83. 00	
84.00	Program inpatient ancillary services (see in	structions)					84. 00	
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00	
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u> </u>					
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			0.00	87. 00 88. 00	
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00	

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-T001	From 01/01/2018 To 12/31/2018		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
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	45, 782	560, 801	0. 08163	7 0	0	90. 00
91.00 Nursing School cost	O	560, 801	0. 00000	0	0	91. 00
92.00 Allied health cost	O	560, 801	0. 00000	0	0	92. 00
93.00 All other Medical Education	o	560, 801	0. 00000	o o	0	93. 00

Health Financial Systems	JOHNSON MEMORIAL H	IOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	P		From 01/01/2018 To 12/31/2018	Date/Time Prepared:
				5/29/2019 11:55 am
		Title XIX	Hospi tal	Cost

NAME - ALL PROVIDER CONVINENTS 1.09 1.00				10 12,01,2010	5/29/2019 11:	55 am
MART 1 - ALL PROVIDER CRIPONENTS			Title XIX	Hospi tal	Cost	
Next I. ALL PROVIDER COMPONENTS Next		Cost Center Description				
MEATLEST DAYS					1. 00	
Impatient days (including private room days and seing-bed days, excluding newborn) 5.684 2.00 Private room days (excluding seing-bed and bendam days) 5.684 2.00 7.						
Inpatient days (Including private room days, excluding saing-bed and newborn days) 5,684 2,00				-		
Private room days (excluding swing-bed and observation bed days) 1 ry you have only private room days 0 3.00						
do not complete this line. 4. 00 Selle-private room days (excluding swing-bed and observation bed days) through Becember 31 of the cost 1. Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 2. 00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 2. 00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost 2. 01 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 2. 02 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 3. 03 Total inpatient days (including private room days) after December 31 of the cost 3. 04 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost 3. 05 Swing-bed SW type inpatient days applicable to the SW type inpatient days applicable to the Program (excluding private room days) 3. 08 Ing-bed SW type inpatient days applicable to the SW type inpatient days applicable to SW type inpatient days a						
5.455 d. 0. 5.456 Total swing-bed SRF type inpatient days (including private room days) after December 31 of the cost reporting period or the private room days) after December 31 of the cost of 5.00 Total swing-bed SRF type inpatient days (including private room days) after December 31 of the cost or 5.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private room days) after December 31 of the cost reporting period (if calleding private	3.00		ys). If you have only pr	ivate room days,	0	3. 00
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10 10 10 10 10 10 10 10	7.00		ii days) tili ougii beceiibei	31 OF THE COST	U	7.00
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34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 012, 847) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 77, 535 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, , , , , , , , , , , , , , , , , , , ,				
35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8, 012, 847) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 77, 535 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						
36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 8,012,847 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 77,535 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 36.00 37.						
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 409. 72 38. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00		, , , , , , , , , , , , , , , , , , , ,				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 409. 72 38.00 Program general inpatient routine service cost (line 9 x line 38) 77, 535 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,409.72 38.00 Program general inpatient routine service cost (line 9 x line 38) 77,535 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		and private room cost di	rrerentiai (iine	8, 012, 847	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,409.72 38.00 Program general inpatient routine service cost (line 9 x line 38) 77,535 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,409.7238.0039.00Program general inpatient routine service cost (line 9 x line 38)77,53539.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00			ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 77,535 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38 00				1 400 72	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	,			
		, , , , , , , , , , , , , , , , , , , ,	*			
77, 330 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	- 1. 00	Trotal Trogram general impatrent routine service cost (Tine 37		ı	11, 555	- 1.00

Heal th	Financial Systems JOHNSON MEMORIAL HOSPITAL In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0001 Period: From 01/01/2018	Worksheet D-1	
	To 12/31/2018		
	Title XIX Hospital	5/29/2019 11: 5 Cost	os am_
	Cost Center Description Total Total Average Per Program Days	Program Cost (col. 3 x col.	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2)	4)	
42.00	1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 313,614 731 429.02 7	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	3, 003	42.00
43. 00 44. 00	INTENSIVE CARE UNIT 2,552,288 496 5,145.74 0	0	43. 00 44. 00
45.00			44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT		46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		47. 00
40.00	Desgram inputions and llarge consists and (West D.2 and 2 Line 200)	1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	44, 950 125, 488	48. 00 49. 00
	PASS THROUGH COST ADJUSTMENTS		F0 00
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50. 00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)	0	52. 00
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and	0	53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		
	Program di scharges	0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)	0. 00 0	55. 00 56. 00
57. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the	0 0. 00	58. 00 59. 00
	market basket		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by	0. 00 0	60. 00 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		
62. 00	Relief payment (see instructions)	0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0	65. 00
	instructions)(title XVIII only)		
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
40.00	(line 13 x line 20)	0	69. 00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	U	69.00
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)		72. 00
73. 00 74. 00	Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00	Program capital related costs (line 9 x line 76)		77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)		78. 00 79. 00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)		83. 00
84. 00 85. 00	Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions)		84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)		86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)	229	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1, 409. 72	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see instructions)	322, 826	89. 00

Health Financial Systems	JOHNSON MEMORI	IAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od: From 01/01/2018	Worksheet D-1	
				To 12/31/2018	Date/Time Pre 5/29/2019 11:	pared: 55 am
		Ti tl	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	1
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST			·		
90.00 Capital -related cost	578, 129	8, 012, 847	0. 07215	0 322, 826	23, 292	90. 00
91.00 Nursing School cost	0	8, 012, 847	0.00000	0 322, 826	0	91.00
92.00 Allied health cost	0	8, 012, 847	0.00000	0 322, 826	0	92. 00
93.00 All other Medical Education	0	8, 012, 847	0.00000	0 322, 826	0	93. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0001	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T001	To 12/31/2018	Date/Time Prepared: 5/29/2019 11:55 am
	Title XIX	Subprovi der -	Cost
		IRF	

		litle XIX	Subprovider -	Cost	
	Cost Center Description		110		
	DATE AND DESIGNATION OF THE CONTRACTOR OF THE CO			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		449	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			449	
3.00	Private room days (excluding swing-bed and observation bed day	0	3. 00		
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		24 -6	449	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	on days) through becembe	er 31 or the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	•			
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December 3	21 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei s	or or the cost	O	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	0	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		room days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, er		days) ares	· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar years)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra	am (excludina swina-bed	davs)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(gg		731	
16. 00	Nursery days (title V or XIX only)			7	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 d	of the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00					
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
20.00	reporting period	s arter becember 31 or t	.ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	s)		560, 801	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	na period (line 6	0	23. 00
23.00	x line 18)	31 of the cost reportin	ig period (Title of	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		560, 801	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•
34. 00	Average per diem private room charge differential (line 32 mir		ctions)	0.00	•
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	560, 801	37.00
200	27 minus line 36)				000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 040 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 249. 00 0	
40. 00	Medically necessary private room cost applicable to the Progra			0	
	Total Program general inpatient routine service cost (line 39			0	

	Financial Systems	JOHNSON MEMORIA		ON 45 0004		eu of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Component	CCN: 15-0001 CCN: 15-T001	Period: From 01/01/2018 To 12/31/2018			
			· ·	e XIX	Subprovi der -	5/29/2019 11: Cost	55 am	
					I RF			
	Cost Center Description	Total Inpatient Costli	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NUDCEDY (+; +l c V & VIV only)	1.00	2. 00	3.00	4.00	5. 00	42.00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42. 00	
43.00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	43. 00 44. 00	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45. 00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00	
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	lino 200)			1.00	48. 00	
49. 00				ns)		0	•	
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	ı Wkst. D, sum	of Parts I and	0	50. 00	
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	0	51.00	
52. 00	Total Program excludable cost (sum of lines!					0		
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	sician anesth	etist, and	0	53. 00	
54.00	Program di scharges					0		
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	ı	
57. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (I	ine 56 minus	line 53)	0	57. 00	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, u	pdated and co	mpounded by the	0.00	58. 00 59. 00	
	market basket	0.00						
61.00	0.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 1.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							
(0.00	amount (line 56), otherwise enter zero (see instructions)							
62. 00 63. 00	0							
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Decem	ber 31 of the	cost reporti	na period (See	0	64. 00	
65. 00	instructions)(title XVIII only)	J		•	3 1 .	0	65. 00	
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin					0	66. 00	
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing		•		•	0		
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	-				0		
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient i			·	3 1	0		
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70. 00	
71. 00	Adjusted general inpatient routine service of						71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 v li	ne 35)			72. 00 73. 00	
74.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)	ŕ			74. 00	
75. 00	Capital-related cost allocated to inpatient (26, line 45)		costs (from W	orksheet B, P	art II, column		75. 00 76. 00	
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line	. *					77. 00	
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovi der record	le)			78. 00 79. 00	
80.00	Total Program routine service costs for compa	arison to the co			us line 79)		80. 00	
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li						81. 00 82. 00	
83. 00	Reasonable inpatient routine service costs (see instructions					83. 00	
84. 00 85. 00	Program inpatient ancillary services (see insultilization review - physician compensation		s)				84. 00 85. 00	
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00	
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00	
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00	
89. UU	Observation bed cost (line 87 x line 88) (see	e instructions)				I O	89. 00	

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Subprovider -	Cost	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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	45, 782	560, 801	0. 08163	7 0	0	90.00
91.00 Nursing School cost	0	560, 801	0.00000	0	0	91.00
92.00 Allied health cost	0	560, 801	0.00000	0	0	92.00
93.00 All other Medical Education	0	560, 801	0. 00000	0 0	0	93. 00

L		eu of Form CMS-2	
r CCN: 15-0001	Peri od:	Worksheet D-3	
	From 01/01/2018 To 12/31/2018		narod:
	10 12/31/2010	5/29/2019 11:	
tle XVIII	Hospi tal	PPS	
Ratio of Cos		Inpatient	
To Charges	Program	Program Costs	
	Charges	(col. 1 x col.	
		2)	
1.00	2. 00	3. 00	
			1
	3, 815, 347		30.00
	478, 358		31.00
	0		41. 00
			43.00
		T	
0. 1990			
0. 0457			
0. 1277			
0. 1934			
0. 3146			
0. 3545			
0. 2603			
0. 50328			
0. 2031			
0. 8388			
0. 4065			
0. 37110			
0. 45073			
1. 03434			
0. 5134	37 0	0	76. 97
0. 27840	4.5	2 747	00.00
			1
0. 2479		_	
1)			201.00
		0. 247971	0. 247971 0 0 0 15, 395, 054 3, 868, 881

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

15, 395, 054

201. 00 202. 00

201.00 202.00

Health Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of Form CMS-2552- INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-0001 From 01/01/2018 Component CCN: 15-T001 To 12/31/2018 Date/Time Prepared
From 01/01/2018
Component con. 13-1001 10 12/31/2010 Date/II mie Frepared
5/29/2019 11:55 am
Title XVIII Subprovider - PPS
IRF
Cost Center Description Ratio of Cost Inpatient Inpatient
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 0 30. 0
31. 00 03100 INTENSI VE CARE UNIT
41. 00 04100 SUBPROVI DER - I RF 158, 549 41. 0
43. 00 04300 NURSERY 43. 0
50. 00 05000 OPERATING ROOM 0. 199041 1, 848 368 50. 0
53. 00 05300 ANESTHESI OLOGY 0. 045750 0 0 53.0
53. 00 05300 ANEST REST OLOGY 0. 043730 0. 0437
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0. 127/12 14, 458 1, 846 54. 0 60. 00 06000 LABORATORY 0. 193475 56, 909 11, 010 60. 0
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 0.406559 1,461 594 71.0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 371160 0 0 72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 450734 11, 052 4, 982 73. 0
76. 00 03020 0NC0L0GY 1. 034347 0 0 76. 0
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 513487 0 0 76. 9
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 0. 278465 0 0 90. 0
91. 00 09100 EMERGENCY 0. 177842 0 0 91. 0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.247971 0 0 92.0
200.00 Total (sum of lines 50 through 94 and 96 through 98) 237,110 67,759 200.0
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.0
202.00 Net charges (line 200 minus line 201) 237,110 202.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	narod:
			10 12/31/2016	5/29/2019 11:	55 am
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	I npati ent	I npati ent	
		To Charges		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			143, 093		30.00
31.00 03100 INTENSIVE CARE UNIT			2, 733		31. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY			0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 19904	1 73, 795	14, 688	50.00
53. 00 05300 ANESTHESI OLOGY		0. 04575	10, 001	458	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12771	2 16, 520	2, 110	54.00
60. 00 06000 LABORATORY		0. 19347	5 36, 767	7, 113	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 31463	7, 015	2, 207	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 35452	0 613	217	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26033	4 509	133	67.00
68.00 06800 SPEECH PATHOLOGY		0. 50328	4 128	64	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 19590	9 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 83881	5 44	37	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 40655	9, 064	3, 685	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 37116	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 45073	4 25, 151	11, 336	73.00
76. 00 03020 ONCOLOGY		0. 86771	o	0	76. 00
76. 97 07697 CARDIAC REHABILITATION		0. 51348	7 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 27846	5 0	0	90. 00
01 00 00100 EMEDGENCY		0 17704	1 1 210	2 002	01 00

0. 278465 0. 177842 0. 247971

16, 319

195, 926

91. 00 92. 00

201. 00 202. 00

2, 902 0

44, 950 200. 00

200.00

201.00 202.00

91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | OBSERVATION | BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu o	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	From 01/01/2018 Pa To 12/31/2018 Da	orksheet E art A ate/Time Prepared: /29/2019 11:55 am

		Title XVIII	Hospi tal	5/29/2019 11:	55 am
		TI LIE AVIII	nospi tai	FF3	
				1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring instructions)	0	1. 01		
1. 02	DRG amounts other than outlier payments for discharges occurring instructions)	ng on or after October	1 (see	5, 383, 023	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI fo 1 (see instructions)	r discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI fo October 1 (see instructions)	r discharges occurring o	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			21, 216 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0	2. 02
3.00	Managed Care Simulated Payments			0	3. 00
4. 00	Bed days available divided by number of days in the cost repor Indirect Medical Education Adjustment			82. 25	4. 00
5. 00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)	recent cost reporting p	period ending on	0. 00	5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet th new programs in accordance with 42 CFR 413.79(e)		·	0. 00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified u ACA § 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopat affiliated programs in accordance with 42 CFR 413.75(b), 413.7 [1989], and 67 FR 5060 (August 1, 2003)			0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slo report straddles July 1, 2011, see instructions.	ts under § 5503 of the /	ACA. If the cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slo lunder § 5506 of ACA. (see instructions)	ts from a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line instructions)	s (8, 8,01 and 8,02) (9	see	0. 00	9. 00
	FTE count for allopathic and osteopathic programs in the curre FTE count for residents in dental and podiatric programs.	nt year from your record	ds		11. 00
12.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00	12. 00 13. 00
14. 00	Total allowable FTE count for the penultimate year if that yea otherwise enter zero.	r ended on or after Sep	tember 30, 1997,	0.00	
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	
17. 00	Adjustment for residents displaced by program or hospital clos	ure			17. 00
18. 00	Adjusted rolling average FTE count			0.00	
20. 00	Current year resident to bed ratio (line 18 divided by line 4) Prior year resident to bed ratio (see instructions)	•		0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
22.0.	Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA			22.0.
23. 00	Number of additional allopathic and osteopathic IME FTE reside $(f)(1)(iv)(C)$.		FR 412. 105	0. 00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the linstructions)	ower of line 23 or line	24 (see	0.00	25. 00
	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
	IME payments adjustment factor. (see instructions)			0. 000000	
	IME add-on adjustment amount (see instructions)			0	28. 00
	IME add-on adjustment amount - Managed Care (see instructions)			0	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29. 00 29. 01
20.00	Disproportionate Share Adjustment	tiont days (!	ti ono)	0.07	20.00
	Percentage of SSI recipient patient days to Medicare Part A pa	trent days (see instruct	11 0115)	2. 27	30. 00 31. 00
	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			23. 15	
	Allowable disproportionate share percentage (see instructions)			8. 32	
	Disproportionate share adjustment (see instructions)			111, 967	
	, , , , , , , , , , , , , , , , , , ,		'	, ,	

	Financial Systems JOHNSON MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	ATION OF REIMBORSEMENT SETTLEMENT	Frovider Con. 15-0001	From 01/01/2018 To 12/31/2018	Part A Date/Time Pre	pared:
		Title XVIII	Hospi tal	PPS	33 alli
			Prior to 10/1		
	Uncompanyated Care Adjustment		1. 00	2. 00	
35. 00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		0	0	35. 00
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	
35. 02	Hospital uncompensated care payment (If line 34 is zero, enter	r zero on this line) (se	e 605, 548	815, 209	35. 02
35. 03	instructions) Pro rata share of the hospital uncompensated care payment amou	unt (coo i netructions)	452 017	205, 478	35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03	,	452, 917 658, 395	203, 476	36. 00
	Additional payment for high percentage of ESRD beneficiary dis				
40. 00	Total Medicare discharges on Worksheet S-3, Part I excluding of	discharges for MS-DRGs	0		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83 684 an 685 (see	0		41. 00
41.00	instructions)	03, 004 dri 003. (3cc			71.00
41. 01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41. 01
42.00	an 685. (see instructions)	fu for adjustment)	0.00		42. 00
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not quality Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682		0.00		43. 00
	instructions)	_,, (
44. 00	Ratio of average length of stay to one week (line 43 divided by	by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instructions))	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41.		0.00		46. 00
47. 00	Subtotal (see instructions)		6, 174, 601		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sr	mall rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions)			6, 174, 601	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt.			440, 075 0	50.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, lin			0	52. 00
53.00	Nursing and Allied Health Managed Care payment	·		0	
54.00	Special add-on payments for new technologies			0	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	
56. 00	Cost of physicians' services in a teaching hospital (see intru	•		0	56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. II		hrough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 11 line 200)		0	58.00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			6, 614, 676 0	
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		6, 614, 676	1
62. 00	Deductibles billed to program beneficiaries			735, 516	
63.00	Coinsurance billed to program beneficiaries				63.00
64. 00 65. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			95, 909 62, 341	1
66. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		95, 909	
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		5, 938, 821	67. 00
68. 00	Credits received from manufacturers for replaced devices for a			0	
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	1
70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	
70. 87	Demonstration payment adjustment amount before sequestration			0	
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see insti	ructions)			70. 89
	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	
				O	1
70. 91 70. 92	Bundled Model 1 discount amount (see instructions)		l	0	70. 92
70. 91 70. 92 70. 93				0 34, 414 -1, 831	70. 93

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-1	0
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Peri od: Worksheet E	_
		From 01/01/2018 Part A	
		To 10/21/2010 Doto/Time December	

				From 01/01/2018 To 12/31/2018	Part A Date/Time Pre 5/29/2019 11:	
		Titl∈	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	2	2018	46, 667	70. 96
70 07	the corresponding federal year for the period prior to 10/1)	1 0		0	0	70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70. 97
70. 98	the corresponding federal year for the period ending on or after Valume Payment 2	ter 10/1)			0	70. 98
70. 96 70. 99	Low Volume Payment-3 HAC adjustment amount (see instructions)				0	70. 98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	50 g 70)			6, 018, 071	1
71.00	Sequestration adjustment (see instructions)	37 & 70)			120, 361	1
71. 01	Demonstration adjustment (see First detrois) Demonstration payment adjustment amount after seguestration				120, 301	1
71.02	Interim payments				5, 751, 245	
73. 00	Tentative settlement (for contractor use only)				0, 731, 243	1
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	72 and			146, 465	1
7 1. 00	73)	_, ,_, and			110, 100	/ 1. 00
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			89, 375	75.00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		•			1
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93.00
94.00	The rate used to calculate the time value of money (see instru	uctions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				0	95.00
96. 00	Time value of money for capital related expenses (see instruct	tions)			0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount					ļ
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions)	-)		0.0000000000	0.0000000000	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	>)		0	U	102. 00
102 00	HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000	0. 0000	102 00
	HRR adjustment amount for HSP bonus payment (see instructions)	١		0.0000		104. 00
104.00	Rural Community Hospital Demonstration Project (§410A Demonstr		Istment	<u> </u>		1104.00
200 00	Is this the first year of the current 5-year demonstration per	riod under t	the 21st			200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.		2.101			200.00
	Cost Reimbursement					i
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				201. 00
202.00	Medicare discharges (see instructions)					202.00
203.00	Case-mix adjustment factor (see instructions)					203.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the curren	t 5-year demonst	ration	
	peri od)					
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204)					205. 00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement					
	Program reimbursement under the §410A Demonstration (see instr	,				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00
	Reserved for future use					210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
010 00	Comparision of PPS versus Cost Reimbursement	244)				1010 00
	Total adjustment to Medicare Part A IPPS payments (from line 2	211)				212. 00
	Low-volume adjustment (see instructions)	ad acat r-!-	aburaaman+\			213. 00
∠18.00	Net Medicare Part A IPPS adjustment (difference between PPS and (line 212 minus line 213) (see instructions)	iu cost rein	ibui Seilient)			218. 00
	(TITHE ZIZ IIII HUS TITHE ZIS) (SEE THStructions)			1 1		I

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2018 Part A Exhi bit 4 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 11:55 am Provider CCN: 15-0001

No. Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Part Par						11	12/31/2010	5/29/2019 11:	
1.00 B66 semants other then outlier 0.0			W/C E B I A						
1.00 1983 amounts other than outlier 1.00 0 0 0 0 0 0 0 0 0									
1.01 1.02 1.02 1.03 1.02				 					
1.01 Sick amounts other than out lier 1.01 0 0 0 0 1.01	1.00	I and the second	1. 00	0	0	0	0	0	1. 00
1.02 DRG amounts other than outlier 1.02 5.383.023 0 5.383.023 5.383.023 1.02 pagments for discharged to courting promote or after October 1.03 0 0 0 0 0 0 1.03 0 1.03 0 0 0 0 0 0 0 0 0	1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	0		0	1. 01
perating payeent for Model 4 BBCL occurring prior to Cotober 1 Cotober 1	1. 02	DRG amounts other than outlier payments for discharges	1. 02	5, 383, 023	0		5, 383, 023	5, 383, 023	1. 02
1.04 DRC for Federal specific operating payment for Model 4 BPCI occurring payment for Model 4 BPCI occurring payment for Potodel 4 BPCI occurring payment for Potodel 4 BPCI occurring on or after Cotober 1 States payments for all scharges (see Instructions)	1.03	operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
discharges (see instructions)	1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	o d		0	0	1. 04
dischargies for Model 4 BPCI 2.01	2. 00		2. 00	21, 216	0	0	21, 216	21, 216	2. 00
Property Property	2. 01		2. 02	0	0	0	0	0	2. 01
Dayments	3. 00		2. 01	0	0	0	0	0	3. 00
5.00 Anount From Worksheet E, Part 21.00 0.0000000 0.0000000 0.00000000	4. 00	payments		0	0	0	0	0	4. 00
A, I Ine 21 (see instructions) 6. 00 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	F 00			0.000000	0.000000	0.000000	0.000000		F 00
6.00 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0	5.00		21.00	0.000000	0.000000	0.000000	0.000000		5.00
ME payment adjustment for 22.01	6. 00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	6. 01	IME payment adjustment for managed care (see	22. 01	0	O	0	0	0	6. 01
1.00 IME payment adjustment factor 27.00 0.0000000 0.0000000 0.0000000 0.00000000			istment for the	Add on for Co.	a+: an 122 of +	ha MMA			
See Instructions See S	7. 00						0. 000000		7. 00
Second IME payment adjustment add on for managed care (see instructions) 10		(see instructions)				0	0	0	
Instructions Total IME payment (sum of 29.00 0 0 0 0 0 0 0 0 0	8. 01	IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
1.00 1.00		instructions)		_		_		_	
Care (Sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Disproportionate Share Adjustment Share Adjustment Disproportionate Share Adjustment Disproportionate Share Adjustment Disproportionate Share Percentage (See Instructions) Disproportionate Share adjustment (See Instructions) Disproportionate Share Share Disproportionate Share Disproportionate Share Share Disproportionate Share Disproportionate Share Share Disproportionate Share Disproportionate Share Share Disproportionate Share Share Disproportionate Share Share Disproportionate Share Disproportionate Share Share Disproportionate Share Dispropor		lines 6 and 8)		0	0	0	0		
10.00 All lowable disproportionate 33.00 0.0832	9.01	care (sum of lines 6.01 and	29.01	0	U	0	0	0	9.01
Share percentage (see instructions) Disproportionate share 34.00 111,967 0 0 111,967 111,967 111,007 111			ent						
11.00 Disproportionate share 34.00 111,967 0 0 111,967 111,967 11.00 adjustment (see instructions) 1.01 1.00	10. 00		33. 00	0. 0832	0. 0832	0. 0832	0. 0832		10. 00
11. 01 Uncompensated care payments 36. 00 658, 395 0 452, 917 205, 478 658, 395 11. 01	11. 00	Di sproporti onate share	34. 00	111, 967	0	0	111, 967	111, 967	11. 00
12.00 Total ESRD additional payment (see instructions) 13.00 Subtotal (see instructions) 14.00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 15.00 Total payment for inpatient operating costs (see instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technol ogies 17.01 Net organ aquisition cost 17.02 Credits received from manufacturers for replaced 18.00 O O O O O O O O O O O O O O O O O O	11. 01	Uncompensated care payments				452, 917	205, 478	658, 395	11. 01
13.00 Subtotal (see instructions) 47.00 6,174,601 0 452,917 5,721,684 6,174,601 13.00 14.0	12. 00	Total ESRD additional payment		o beneficiary o		0	0	0	12. 00
14. 00 Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) 48. 00 0 0 0 0 0 0 0 0 0	13. 00		47. 00	6, 174, 601	0	452, 917	5, 721, 684	6, 174, 601	13. 00
16.00 Operating costs (see instructions) Operatin	14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	0	0	0	0	0	14. 00
capital (from Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 17.01 Net organ aquisition cost 17.02 Credits received from 68.00 0 0 0 0 0 17.02 manufacturers for replaced		operating costs (see instructions)				452, 917			
new technologies 17. 01 Net organ aquisition cost 17. 02 Credits received from 68. 00 0 0 0 0 17. 02 manufacturers for replaced		capital (from Wkst. L, Pt. I, if applicable)		440, 075	0	0	440, 075	440, 075	
17. 02 Credits received from 68.00 0 0 0 17.02 manufacturers for replaced		new technologies	54. 00	0	0	0	0	0	
		Credits received from manufacturers for replaced		O	0	0	0	0	

LOW VO	ILUME CALCULATION EXHIBIT 4			Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/29/2019 11:	pared:
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Peri od Pri or		Total (Col 2	
		line 0	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
10.00	C14-1	•	1.00	2.00	3. 00	4.00	5. 00	10.00
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	O	0		0	0	
19. 00	SUBTOTAL			0	452, 91	7 6, 161, 759	6, 614, 676	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	438, 364	0		0 438, 364	438, 364	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	1, 711	0		0 1, 711	1, 711	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	440, 075	0		0 440, 075	440, 075	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
	T	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. 10303 46, 66		46, 667	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Health Financial Systems JOHNSON MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0001 Peri od: Worksheet E From 01/01/2018 Part A Exhibit 5 Date/Time Prepared: 12/31/2018 5/29/2019 11:55 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 after 10/01 A. line and 3) A) 2.00 3. 00 4. 00 0 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 0 0 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 5. 383. 023 5. 383. 023 5, 383, 023 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October 1.04 DRG for Federal specific operating payment 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 21, 216 0 21, 216 21, 216 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 0 0 2.01 Operating outlier reconciliation 3 00 2 01 O 0 0 3 00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCT	ION CALCULATION EXHIBIT 5	Provider CC		Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Exhibi Date/Time Pre 5/29/2019 11:	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				

					To 12/31/2018	3 Date/lime Pre 5/29/2019 11:	
			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	438, 364		0 438, 36	4 438, 364	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2.00	1, 711		0 1, 71	1 1, 711	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0 0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0.000	D	22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 000	0.000	D	24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0		0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	440, 075		0 440, 07	440, 075	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	1 = 7. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	34, 414		0 34, 41	4 34, 414	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-1, 831		0 -1, 83	1 -1, 831	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
						(Amt. to Wkst.	
		0	1. 00	2.00	3.00	E, Pt. A) 4.00	
32. 00	HAC Reduction Program adjustment (see	70. 99	1.00			0 0	32. 00
32.00	instructions)	, , ,]	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-000	1 Peri od: Worksheet E From 01/01/2018 Part B Date/Ti me Prepared: 5/29/2019 11:55 am

PRET MEDICAL AND OTHER HEATH SERVICES 1.00			5/29/2019 11:	55 am_
Next 8 - MeDICAL AND OTHER REALTH SERVICES 1.114 1.00 Next out and off other services (see instructions) 7.870.07 2.00 Next out and off other services (see instructions) 7.870.07 2.00 2		Title XVIII Hospital	PPS	
Next 8 - MeDICAL AND OTHER REALTH SERVICES 1.114 1.00 Next out and off other services (see instructions) 7.870.07 2.00 Next out and off other services (see instructions) 7.870.07 2.00 2			1 00	
		PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
Medical and other services relabursed under OPPS (see Instructions) 7,787,097 2,00	1.00		1, 114	1. 00
20. Duti Fer payment (see instructions) 3,7.79 4.00				2. 00
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.00000000	3.00	OPPS payments	5, 900, 484	3.00
Enter the hospital specific payment to cost ratio (see instructions)	4.00	Outlier payment (see instructions)	37, 739	4. 00
Line 2 times line 5		· · · · · · · · · · · · · · · · · · ·	-	
2.00 Sum of Fines 3, 4, and 4.01, divided by line 6 0.00 7.00 2.00 0.00 2.00 0.				
Transitional corridor payment (see Instructions) 0			-	
0.00 Organ acquisitions 1.00 Total Coat (sum of lines 1 and 10) (see instructions) 1.114 1.00 Total Coat (sum of lines 1 and 10) (see instructions) 1.00 Organ acquisition for LESSER OF COST OR CHARGES 1.00 Organ acquisition for pages 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 12 and 13) 1.00 Organ acquisition for pages (sum of lines 13 and 13) 1.00 Organ acquisition for pages (sum of lines 13 and 13) 1.00 Organ acquisition for pages (sum of lines 13 and 13) 1.00 Organ acquisition for pages (sum of lines 13 and 13) 1.00 Organ acquisition for charges (sum instructions) 1.114 1.00 1.00 Organ acquisition for charges (sum instructions) 1.114 1.00 1.00 Organ acquisition for charges (sum instructions) 1.114 1.00 1.00 Organ acquisition for charges (sum instructions) 1.114 1.00 1.00 Organ acquisition for charges (sum instructions) 1.114 1.00 1.00 Organ acquisition for charges (sum instructions) 1.114 1.00 0.00 Organ acquisition for charges (sum instructions) 1.114 1.00 Organ acquisition for charges (sum			-	
1.00 Total cost (sun of lines 1 and 10) (see instructions) 1.114 11.00 1.114			-	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges 3,988 12.00 Ancil lary service charges (From Wast. D-4, Pt. 111, cal. 4, line 69) 3,988 12.00 13.00 Organ acquisit it in charges (From Wast. D-4, Pt. 111, cal. 4, line 69) 3,988 14.00 15.00			1	
Reasonable charges 1.2.00 Ancil lary service charges 1.2.00 Ancil lary service charges 1.2.00 Ancil lary service charges (from Wisst. D-4, Pt. III, col. 4, line 69) 1.3.00 13.00			.,	
2.00 Ancil lary service charges 3,988 12,00 13,00 13,00 10 10 10 11 12 13,00 13,00 13,00 13,00 13,00 10 10 13,00 13,00 13,00 13,00 13,00 10 10 11 12 13,00 1				
14.00 Total reasonable charges (sum of lines 12 and 13) 3,988 14,00 Coursemy charges 3,988 14,00 Coursemy charges 3,988 14,00 Coursemy charges 3,00 15,00 16,00 Appropriate 3,00 16,00 16,00 Appropriate 3,00 16,00 16,00 Appropriate 3,00 16,00 1	12.00		3, 988	12.00
Customary charges	13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
15.00 Aggregate amount actually collected from patients Iable for payment for services on a charge basis 0 15.00	14. 00		3, 988	14. 00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000			_	
had such payment been made in accordance with 42 CFR §413.13(e)				
17.00	16.00		0	16.00
18. 00 Total customery charges (see instructions) 2.874 9. 00 1 1 1 1 1 1 1 1 1	17 00		0.00000	17 00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 1.874 19. 00 1.874 1.875		· · · · · · · · · · · · · · · · · · ·		
Instructions				
Instructions			, -	
21. 00 Lesser of cost or charges (see instructions) 0. 22. 00 22. 00 Cost of physicians' services in a teaching hospital (see instructions) 0. 23. 00 22. 00 Cost of physicians' services in a teaching hospital (see instructions) 0. 23. 00 23. 00 Cost of physicians' services in a teaching hospital (see instructions) 0. 23. 00 ComPUTATION OF REIMBURSEMENT SETILEMENT 25. 00 Deductible sand coinsurance amounts (for CAH, see instructions) 1, 198, 831 26. 00 27. 00 ComPUTATION OF REIMBURSEMENT SETILEMENT 25. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 1, 198, 831 26. 00 27. 00 Each of the composition	20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
22.00 Interns and residents \(\tilde{\t				
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 5, 30, 20 23. 00 25. 00				
Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) 5, 938, 223 4, 00				
COMPUTATION OF REINBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 0 25 00 00 00 00 00 00			1	
25.00 Deductibles and coin surance amounts (For CAH, see instructions) 0 25.00	24.00		3, 930, 223	24.00
26.00 Deductibles and Coin sourance amounts relating to amount on line 24 (for CAH, see instructions) 1,198,831 26.00 27.00 Instructions 1,198,831 26.00 27.00 Instructions 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 28.00 28.00 29.00 28.00 29.00 2	25. 00		0	25. 00
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 28.00 29.00 ESRD direct medical education payments (from Wkst. E-4, line 50) 0 29.00 29.0				
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29. 00 20. 00 2	27. 00			
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.0		instructions)		
30.00 Subtotal (sum of lines 27 through 29) 4,740,506 30.00 70 70 70 70 70 70 70			1	
31.00 Primary payer payments 277 31.00 32.00 Subtotal (line 30 minus line 31) 4,740,229 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 33.00 34.00 Allowable bad debts (see instructions) 79,626 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 79,626 34.00 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 79,626 36.00 37.00 Subtotal (see instructions) 79,626 36.00 37.00 Subtotal (see instructions) 79,626 36.00 38.00 MSP-LCC reconciliation amount from PS&R 4,791,986 37.00 39.00		· · · · · · · · · · · · · · · · · · ·	-	
32.00 Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESR0 (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 79, 626 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 79, 626 34.00 37.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 79, 626 36.00 37.00 Subtotal (see instructions) 4, 791, 986 37.00 38.00 MSP-LCC reconciliation amount from PS&R 9.00 MSP-LCC reconciliation amount from PS&R 9.00 39.00 MSP-LCC reconciliation amount from PS&R 9.00 39.00 39.90		· · · · · · · · · · · · · · · · · · ·		
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00 Composite rate ESRD (from Wkst. I - 5, line 11)	32.00	ALLOWARIE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	4, 140, 221	32.00
35. 00 Adjusted reimbursable bad debts (see instructions) 51,757 35. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 79,626 36. 00 37. 00 Subtotal (see instructions) 4,791,986 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 90 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 97 Pioneer ACO demonstration payment adjustment (see instructions) 39. 50 39. 98 Demonstration payment adjustment amount before sequestration 0 39. 90 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 95. 838 40. 01 40. 01 Sequestration adjustment (see instructions) 95. 838 40. 01 40. 02 Tentative settlement (for contractors use only) 47. 754,045 41. 00 41. 00 Intertin payments -57,987 43. 00 44. 00 Fortested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5.	33.00		0	33. 00
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 79,626 36.00 37.00 Subtotal (see instructions) 4,791,986 37.00 38.00 MSP-LCC reconciliation amount from PS&R 90 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 40.01 Sequestration adjustment (see instructions) 4,791.896 40.00 40.02 Linterim payments 95.838 40.01 42.00 Educative settlement (for contractors use only) 4,754,045 41.00 43.00 Balance due provider/program (see instructions) -57,987 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515.2 0 40.00 90.00 Des COMPLETED BY CONTRACTOR 0 90.00 90.00 Outlier reconciliation adjustment amount (see instructions) 0 90	34.00	Allowable bad debts (see instructions)	79, 626	34.00
37. 00 Subtotal (see instructions)	35.00	Adjusted reimbursable bad debts (see instructions)	51, 757	
38.00 MSP-LCC reconciliation amount from PS&R 90 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39. 97 Demonstration payment adjustment amount before sequestration 0 39.97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40. 01 Subtotal (see instructions) 4,791,896 40.00 40. 02 Demonstration adjustment (see instructions) 95,838 40.01 40. 02 Demonstration payment adjustment amount after sequestration 95,838 40.01 41. 00 Interim payments 4,754,045 41.00 42. 00 Tentative settlement (for contractors use only) 0 42.00 43. 00 Balance due provider/program (see instructions) -57,987 43.00 44. 00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0				
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Interim payments 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{\f				
39. 50 39. 97 39. 97 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 4, 791, 896 40. 00 Suestration adjustment (see instructions) 4, 791, 896 40. 00 Demonstration payment adjustment amount after sequestration 40. 02 Interim payments 4, 754, 045 41. 00 42. 00 Halance due provider/program (see instructions) 4. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, Si15. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Q1. 00 Q1. 00 Q1. 00 Q1. 00 Q2. 00 Q3. 00 Q4. 00 Q5. 00 Q6. 00 Q7. 0				
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 00 Subtotal (see instructions) 0 39. 99 40. 01 Sequestration adjustment (see instructions) 0 39. 99 40. 02 Demonstration payment adjustment amount after sequestration 0 40. 01 Interim payments 1 4, 791, 896 40. 02 Interim payments 1 5 4, 754, 045 1 1, 00 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98			0	
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 5 5 5 5 5 5 5 5 5				
40.00 Subtotal (see instructions) 4,791,896 40.00 40.01 Sequestration adjustment (see instructions) 95,838 40.01 40.02 40.00 40.02 41.00 41.00 47.54,045 42.00 42.00 43.00 43.00 43.00 44.00 4		·		
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{2}\$ 10 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 95, 838 40.01 96, 00 40.02 47, 754, 045 41.00 97, 987 43.00 97, 987 43.00 97, 987 43.00 98, 10 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			4, 791, 896	
41.00 Interim payments	40. 01		95, 838	40. 01
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 1 The rate used to calculate the Time Value of Money 1 Time Value of Money (see instructions) 0 93.00	40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Over the concept of the concept			4, 754, 045	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f				
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0 93.00				
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00	44.00		0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00				
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90. 00		n	90. NN
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00				
93.00 Time Value of Money (see instructions) 0 93.00		· · · · · · · · · · · · · · · · · · ·		
94.00 Total (sum of lines 91 and 93) 0 94.00	93. 00			
	94. 00	Total (sum of lines 91 and 93)	0	94. 00

Health Financial Systems JOHN
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0001

					5/29/2019 11:	55 am
		Title	: XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		5, 728, 959		4, 644, 245	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) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2018	22, 286	12/31/2018	81, 700	3. 01
3. 02 3. 03 3. 04 3. 05	AUJUSIMENTS TO PROVIDER	12/31/2016	22, 260 0 0 0	04/05/2018	28, 100 0 0	3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3. 50 3. 51 3. 52	ADJUSTMENTS TO PROGRAM		0 0		0 0	3. 50 3. 51 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)		22, 286		109, 800	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5, 751, 245		4, 754, 045	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
- 04	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03			0		0	5. 02 5. 03
5.03	Dravi dan ta Dragnam		U		U	5.03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50 5. 51	ILIVIATI VE TO PROGRAMI		0			5. 50
5. 51			0			5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		146, 465		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		57. 987	6. 02
7. 00	Total Medicare program liability (see instructions)		5, 897, 710		4, 696, 058	7. 00
			3,377,710	Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•			. '	

Component CCN: 15-T001

Title XVIII Subprovi der -PPS

		II ti e	: AVIII	I RF	PP3	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		196, 092	!	0	1. 00
2.00	Interim payments payable on individual bills, either		0)	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	T	T	T		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02 3. 03			0		0	3. 02 3. 03
3. 04						3. 03
3. 05						3. 04
5. 05	Provider to Program			1		3.03
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		0		0	3. 99
4. 00	3.50-3.98)		196, 092		0	4. 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		190, 092		ا	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
г о1	Program to Provider TENTATIVE TO PROVIDER	1		1	1 0	5. 01
5. 01 5. 02	TENTATIVE TO PROVIDER		0			5. 01
5. 02						5. 02
5. 05	Provider to Program			1		3.03
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0)	0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					, 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		o	6. 01
6. 02	SETTLEMENT TO PROGRAM		4, 459	1		6. 02
7. 00	Total Medicare program liability (see instructions)		191, 633			
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	Number 1.00	(Mo/Day/Yr) 2.00	8. 00

Heal th	Financial Systems JOHN:	SON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0001 Period: From 01/01/2018 To 12/31/2018 Date/Time Provider CCN: 15-0001 Period: Part II Date/Time Provider CCN: 15-0001 Period: Part II Date/Time Provider CCN: 15-0001 Period: Part II Date/Time Provider CCN: 15-0001					pared:	
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST					1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND					1
1. 00	Total hospital discharges as defined in AARA §4102			14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of		-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. I	ine 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of	flines 1, 8-	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8	line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-1	10, col. 3 li	ne 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the pulline 168	urchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see inst	tructions)				8. 00
9.00	Sequestration adjustment amount (see instructions))				9. 00
10.00	Calculation of the HIT incentive payment after sec	questration ((see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					1
30.00	Initial/interim HIT payment adjustment (see instru	uctions)				30. 00
	Other Adjustment (specify)	•				31.00
	20 Delance due provider (Line 0 (an line 10) minus line 20 and line 21) (acc instructions)					

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	JOHNSON MEMORIAL H	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0001		Worksheet E-3
			From 01/01/2018	Part III
		Component CCN: 15-T001	To 12/31/2018	Date/Time Prepared:
				5/29/2019 11:55 am
		Title XVIII	Subprovi der -	PPS
			1.05	

	I RF		
		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	187, 896	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	5, 411	3. 00
4.00	Outlier Payments	6, 233	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5.00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7. 00
8. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8. 00
0.00	teaching program" (see instructions)	0.00	0.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10.00	Average Daily Census (see instructions)	1. 230137	10. 00
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12. 00	Teaching Adjustment (see instructions)	0	12. 00
13.00	Total PPS Payment (see instructions)	199, 540	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	199, 540	
18. 00	Primary payer payments	0	18. 00
19. 00	Subtotal (line 17 less line 18).	199, 540	
20.00	Deducti bl es	3, 996	
21. 00	Subtotal (line 19 minus line 20)	195, 544	21. 00
22. 00 23. 00	Coinsurance	105 544	22. 00 23. 00
24. 00	Subtotal (line 21 minus line 22) Allowable bad debts (exclude bad debts for professional services) (see instructions)	195, 544 0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		26. 00
27. 00	Subtotal (sum of lines 23 and 25)	195, 544	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	l ő	29. 00
30. 00	Outlier payments reconciliation	l ol	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	o	31.50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	195, 544	32.00
32. 01	Sequestration adjustment (see instructions)	3, 911	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00	Interim payments	196, 092	
34. 00	Tentative settlement (for contractor use only)	0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-4, 459	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36. 00
	TO BE COMPLETED BY CONTRACTOR		
50 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	6, 233	50. 00
51.00	, ,	0, 233	51. 00
	The rate used to calculate the Time Value of Money		
	Time Value of Money (see instructions)		53.00

Health Financial Systems	JOHNSON MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Peri od: Worksheet E-3 From 01/01/2018 Part VII To 12/31/2018 Date/Time Prepared: 5/29/2019 11:55 am

PART_VII_CALCULATION_OF_REINBURSEMENT_ALL_OTHER_HEALTH_SERVICES_FOR_TITLES_VOR_XIX_SERVICES				10 12/31/2018	5/29/2019 11:	
Inpati ent			Title XIX	Hospi tal		
PART VII - CALCULATION OF MET DESTRUCES					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES 1.0.0						
Inpatient hospital / SNF/NF services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI	X SERVICES		
Medical and other services		COMPUTATION OF NET COST OF COVERED SERVICES				1
Medical and other services	1.00			125, 488		1.00
Organ acquisition (certified transplant centers only) 125, 488 0.4, 0.5 0.5 0.0 1.0 1.0 1.0 1.0 1.0 1.0 0.0	2.00	Medical and other services			0	2.00
Subtotal (sum of lines 1, 2 and 3)	3.00			o		3.00
Inpatient primary payer payments 0 0 0 0 0 0 0 0 0	4.00			125, 488	0	4.00
Outpati ont pri marry payer payments 0 6.00	5.00	1		o		5.00
Subtotal (Line 4 less sum of lines 5 and 6)					0	1
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges Reasonable Charges 145, 826 8.00 Routine service charges 195, 926 0.90 0.00	7.00			125, 488	0	7.00
8.00 Routine service charges 145,826 0,9		COMPUTATION OF LESSER OF COST OR CHARGES				1
9.00 Ancil lary service charges 195,926 0 9.00		Reasonabl e Charges				1
10.00 Organ acquisition charges, net of revenue 0 10.00 11.0	8.00	Routi ne servi ce charges		145, 826		8.00
11.00 Incentive From target amount computation 341,752 0 11.00	9.00	Ancillary service charges		195, 926	0	9.00
12.00 Total reasonable charges (sum of lines 8 through 11) 341,752 0 12.00	10.00	Organ acquisition charges, net of revenue		0		10.00
CUSTOMARY CHARGES 0 0 13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 13.00 Amounts that would have been realized from patients liable for payment for services on 0 0 14.00 14.00 15.00 16.00 1	11. 00			0		11.00
13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 0.000000 0.000000 15.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	12.00	Total reasonable charges (sum of lines 8 through 11)		341, 752	0	12.00
basis		CUSTOMARY CHARGES				
14. 00 Amounts that would have been realized from patients Liable for payment for services on a large basis had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 0.000000 0.000000 0.000000 0.15.00 0.000000 0.15.00 0.0000000 0.00000000	13.00		services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 13 to line 14 (not to exceed 1.000000) 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.0000000 10.0000000 10.0000000 10.0000000 10.00000000						
15.00	14. 00			0	0	14.00
16.00 Total customary charges (see instructions) 341,752 0 16.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 216,264 0 17.00 17.00 17.00 18.00 18.00 19.00			12 CFR §413.13(e)			
17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 11		,				
11			1611 44			
18. 00	17.00		y IT line 16 exceeds	216, 264	0	17.00
16) (see instructions)	10 00		v if line 4 evecede line		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 instructions) 0 2 0 0 0 0 0 2 0 0 0 0 2 0 0 0 0 2 0 0 0 0 2 0 0 0 2 0 0 0 0 2 0 0 0 2 0 0 2 0 0 2 0 0 2 0 0 2 0 0 2 0 0 2 0 0 2 <t< td=""><td>18.00</td><td></td><td>y II Time 4 exceeds Time</td><td>٩</td><td>U</td><td>18.00</td></t<>	18.00		y II Time 4 exceeds Time	٩	U	18.00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 0. 20. 00 21. 00 Cost of covered services (enter the lesser of line 4 or line 16) 125, 488 0. 21. 00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.	10 00				0	10 00
21.00			suctions)	٩	_	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				9	_	
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 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 26. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 125, 488 0 29. 00 29. 00 Tottles V or XIX (sum of lines 21 and 27) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 125, 488 0 31. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 125, 488 0 31. 00 32. 00 Deductibles 0 0 32. 00 0 33. 00 0	21.00				0	21.00
23. 00 Outlier payments	22 00		Compreted for 113 provid		0	22 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 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 0 0 28.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 0 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 125, 488 0 31.00 32.00 Deductibles 0 0 33.00 0 0 33.00 33.00 Cinsurance 0 0 33.00 0 0 34.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 0 34.00 35.00 Utilization review 0 0 35.00 0 0		1 3		_		
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 29. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 29. 00 Deductibles 20. 00 Deductibles 20. 00 Ocinsurance 20. 00 Ocinsurance 20. 01 Ocinsurance 20. 02 Ocinsurance 20. 03 Ocinsurance 20. 04 lowable bad debts (see instructions) 20. 00 Utilization review 20. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 20. 01 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 21. 25, 488 22. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 23. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 24. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 25. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 26. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 27. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 28. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 OTHER ADJUSTMENTS (SEE INS		1 3		_		
26. 00 Routine and Ancillary service other pass through costs 7. 00 Subtotal (sum of lines 22 through 26) 8. 00 Customary charges (title V or XIX PPS covered services only) 9. 00 Titles V or XIX (sum of lines 21 and 27) 125, 488 9. 00 Computation of Reimbursement settlement 10 Computation of Reimbursement settlement 10 Computation of Reimbursement settlement 10 Computation of Reimbursement settlement 11 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 12 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 12 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 13 Coi nsurance 14 Coi nsurance 15 Coi nsurance 16 Coi nsurance 17 Coi nsurance 18 Coi nsurance 19 Coi nsurance 10 Coi nsurance 11 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 10 Coi nsurance 10 Coi nsurance 10 Coi nsurance 11 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 12 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 13 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 14 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 15 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 15 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 15 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 15 Subtotal (sum of lines 31, 34 and 35 m		9 1 3		_		
27. 00 Subtotal (sum of lines 22 through 26) 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REI MBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 125, 488 0 31. 00 32. 00 Deductibles 0 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 125, 488 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 125, 488 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 0 40. 00 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) -63, 556 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00				-	0	
28.00 Customary charges (title V or XIX PPS covered services only) 7				o	0	
29. 00 Titles V or XIX (sum of lines 21 and 27) 125, 488 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 125, 488 0 31. 00 32. 00 Deductibles 0 0 32. 00 0 0 32. 00 33. 00 Coi nsurance 0 0 33. 00 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 125, 488 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 125, 488 0 38. 00 39. 00 Di rect graduate medical education payments (from Wkst. E-4) 0 39. 00 125, 488 0 40. 00 41. 00 Interim payments 189, 044 0 41. 00	28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28.00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	29.00	Titles V or XIX (sum of lines 21 and 27)		125, 488	0	29.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 125, 488 126, 488 127, 488 128, 488 128, 488 129, 488 120, 4		COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
32.00 Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37) Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) O Total amount payable to the provider (sum of lines 38 and 39) Interim payments Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, O 33.00 O 32.00 O 32.00 O 33.00 O 34.00 O 34.00 O 35.00 O 35.00 O 35.00 O 36.00 O 37.00 O 48.00 O 40.00 O 41.00 O 41.00 O 43.00	30.00	Excess of reasonable cost (from line 18)		0	0	30.00
33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 125, 488 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 125, 488 0 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 40.00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 0 40.00 41.00 Interim payments 189,044 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) -63,556 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	125, 488	0	31.00
34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 126, 488 127, 488 128, 488 129, 488 120,	32.00	Deducti bl es		0	0	32.00
35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 0 36.00 37.00 38.00 39.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00	33.00	Coi nsurance		0	0	33.00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 0 36.00 37.00 38.00 39.00 125, 488 0 38.00 39.00 125, 488 0 40.00 10 terim payments 110, 488 0 40.00 10 days of lines 38 and 39) 125, 488 0 40.00 10 days of lines 38 and 39) 125, 488 0 40.00 10 days of lines 38 and 39) 125, 488 0 40.00 10 days of lines 38 and 39) 125, 488 0 40.00 10 days of lines 38 and 39) 125, 488 0 40.00 10 days of lines 38 and 39) 125, 488 0 40.00 125,	34.00	Allowable bad debts (see instructions)		0	0	34.00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 125, 488 126, 488 127, 488 128, 488 129, 4	35.00	Utilization review		0		35. 00
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 125, 488 0 38.00 39.00 40.00 41.00 41.00 42.00 43.00			d 33)	125, 488		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 41.00 Interim payments Balance due provider/program (line 40 minus line 41) 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 40.00 41.00 42.00 43.00				0	0	
40.00 Total amount payable to the provider (sum of lines 38 and 39) 125, 488 189, 044 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				125, 488	0	
41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0		39. 00
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00						
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00						
chapter 1, §115.2	43.00		nce with CMS Pub 15-2,	0	0	43. 00
		cnapter 1, § 15.2		1		I

Health Financial Systems

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

Provi der CCN: 15-0001

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 11:55 am

OH y)					5/29/2019 11:	55 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS	39, 451, 645	il o	0	0	1.00
2.00	Cash on hand in banks Temporary investments	39, 451, 645		_		
3.00	Notes recei vabl e			_	0	3. 00
4. 00	Accounts recei vabl e	12, 948, 915	Ö	Ō	Ō	
5.00	Other recei vabl e	0	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
7.00	Inventory	2, 174, 485		0	0	
8. 00 9. 00	Prepaid expenses Other current assets	2, 153, 107		0	0	
10.00	Due from other funds			_	0	10.00
11. 00	Total current assets (sum of lines 1-10)	56, 728, 152	1	_	•	11.00
00	FIXED ASSETS	00//20//02				1 00
12.00	Land	4, 743, 426	0	0	0	12. 00
13.00	Land improvements	2, 889, 286		0		13. 00
14. 00	Accumulated depreciation	-1, 293, 077	1	_	1	14. 00
15. 00	Bui I di ngs	69, 624, 719	1	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-28, 197, 145		0	0	16. 00 17. 00
18. 00	Accumulated depreciation			_	0	18.00
19. 00	Fi xed equipment	13, 061, 221	1	_	0	19.00
20. 00	Accumul ated depreciation	-11, 144, 034	1	o o	o o	20.00
21.00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	76, 492, 114	1	0	0	23. 00
24. 00	Accumulated depreciation	-35, 274, 274	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation			0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e			_	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	90, 902, 236	Ō	Ō		30.00
	OTHER ASSETS					
31. 00	Investments	0	0	_	-	
32. 00	Deposits on Leases	0	0	_	_	32. 00
33. 00	Due from owners/officers	0	0	_	0	33. 00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	52, 769, 227 52, 769, 227			0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	200, 399, 615	1	_	0	36.00
30. 00	CURRENT LIABILITIES	200, 377, 013	,			30.00
37.00	Accounts payable	6, 020, 473	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	3, 894, 229	0	0		38. 00
39. 00	Payroll taxes payable	894, 185	1	0	0	
40. 00	Notes and Loans payable (short term)	16, 802, 043	0	0	0	1
41.00	Deferred income	0	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0		0	0	42. 00 43. 00
44. 00	Other current liabilities	694, 009		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	28, 304, 939	•	_	l .	1
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	-	
47. 00	Notes payable	171, 042		_	-	
48. 00	Unsecured Loans	0	0	_		1
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	171 042	0	_	· -	49. 00 50. 00
50.00	Total liabilities (sum of lines 45 and 50)	171, 042 28, 475, 981				51.00
31.00	CAPITAL ACCOUNTS	20, 473, 701		0		31.00
52. 00	General fund balance	171, 923, 634	ı			52. 00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	171, 923, 634		_	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	200, 399, 615		0	0	
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared: Provider CCN: 15-0001

					То	12/31/2018	Date/Time Pre 5/29/2019 11:	pared: 55 am_
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	
		1.00	2. 00	3.00		4. 00	5. 00	
1 00	Fund halanasa at haginning of pagind	1.00				4.00		1, 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		167, 262, 942 4, 660, 692			U		2.00
3. 00	Total (sum of line 1 and line 2)		171, 923, 634			0		3.00
4. 00	Additions (credit adjustments) (specify)	0	171, 723, 034		0	U	0	1
5. 00	Additions (credit adjustments) (specify)				0		0	
6. 00					0		Ö	
7. 00		0			0		0	1
8. 00		0			0		Ö	
9. 00		0			0		Ö	
10.00	Total additions (sum of line 4-9)		0			0		10.00
11.00	Subtotal (line 3 plus line 10)		171, 923, 634			0		11. 00
12.00	Deductions (debit adjustments) (specify)	o			0		0	12. 00
13.00		0			0		0	13.00
14.00		0			0		0	14. 00
15. 00		0			0		0	
16. 00		0			0		0	
17. 00		0			0		0	
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		171, 923, 634			0		19. 00
	Sheet (Time II iiii nus II ne 18)	Endowment Fund	PI ant	Fund				
1.00	Te iii	6. 00	7. 00	8. 00				1.00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)				0			3.00
4. 00	Additions (credit adjustments) (specify)		0		U			4. 00
5. 00	and trons (credit adjustments) (specify)		0					5.00
6. 00			0					6.00
7.00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12. 00
13. 00			0					13. 00
14.00			0					14.00
15.00			0					15. 00
16.00		1	0	1				16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		0			17. 00 18. 00
19. 00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)							17.00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0001

			10 12/31/2018	5/29/2019 11:	
	Cost Center Description	Inpati ent	Outpati ent	Total	
	·	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	12, 183, 83	3	12, 183, 833	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	633, 78	2	633, 782	3. 00
4.00	SUBPROVI DER			_	4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF	'		0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8. 00 9. 00	NURSING FACILITY OTHER LONG TERM CARE				8. 00 9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	12, 817, 61		12, 817, 615	10.00
10.00	Intensive Care Type Inpatient Hospital Services	12,017,01	2	12, 017, 013	10.00
11. 00	INTENSIVE CARE UNIT	1, 374, 06	7	1, 374, 067	11. 00
12. 00	CORONARY CARE UNIT	1,0,1,00		1, 0, 1, 00,	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	1, 374, 06	7	1, 374, 067	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	14, 191, 68	2	14, 191, 682	17. 00
18. 00	Ancillary services	32, 798, 48		161, 238, 963	18. 00
19. 00	Outpatient services	3, 609, 43	37, 859, 938	41, 469, 372	19. 00
20. 00	RURAL HEALTH CLINIC		0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		1, 122, 439	1, 122, 439	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE NRCC	200	0 407 27/	0 407 0/7	26. 00 27. 00
27. 00 27. 01	PRO FEES	-30 ^o 840, 70		9, 487, 067 4, 562, 533	27. 00
27. 01	OTHER INCOME	4, 43		4, 562, 533 9, 750	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst			232, 081, 806	28. 00
20.00	G-3, line 1)	. 31, 444, 43	100, 037, 373	232, 001, 000	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		86, 019, 929		29. 00
30.00	ADD (SPECIFY)				30. 00
31.00					31. 00
32.00					32.00
33.00					33.00
34.00					34.00
35.00					35.00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00					39. 00
40. 00					40.00
41.00		'			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)(trans	ter	86, 019, 929		43. 00
	to Wkst. G-3, line 4)	I	1 1		

	Financial Systems	JOHNSON MEMORIAL			u of Form CMS-2	
STATE	MENT OF REVENUES AND EXPENSES		Provider CCN: 15-0001	Peri od: From 01/01/2018	Worksheet G-3	
				To 12/31/2018	Date/Time Pre	pared.
				10 12,01,2010	5/29/2019 11:	
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Par				232, 081, 806	1. 00
2.00	Less contractual allowances and discounts of	on patients' account	ts		158, 823, 524	2. 00
3.00	Net patient revenues (line 1 minus line 2)				73, 258, 282	3. 00
4.00	Less total operating expenses (from Wkst. (43)		86, 019, 929	
5.00	Net income from service to patients (line 3	3 minus line 4)			-12, 761, 647	5. 00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	6. 00
7. 00	Income from investments				0	7. 00
8.00	Revenues from telephone and other miscellar	neous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service				0	
10.00	Purchase di scounts				0	
11. 00	Rebates and refunds of expenses				0	
12.00	Parking Lot receipts				0	12.00
	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gu	uests			0	14.00
15.00	3 1				0	15. 00
16.00	Revenue from sale of medical and surgical s	supplies to other th	nan patients		0	16.00
17.00	Revenue from sale of drugs to other than pa	atients			0	17.00
18.00	Revenue from sale of medical records and al	ostracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,	etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER I NCOME				911, 338	24.00
24. 01	NON-OPERATING INCOME				614, 581	24. 01
24. 02	UPL INCOME				15, 894, 942	24. 02
24. 03	RECONCILING ITEM				1, 478	
25.00	Total other income (sum of lines 6-24)				17, 422, 339	25. 00
26.00	Total (line 5 plus line 25)				4, 660, 692	
	OTHER EXPENSES (SPECIFY)				0	27. 00
	Total other expenses (sum of line 27 and su	ubscripts)			0	

0 28.00 4,660,692 29.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

708, 725

0

0

708, 725

23.50

24.00

Tel emedi ci ne

24.00 Total (sum of lines 1-23)

23. 50

Heal th	Financial Systems		JOHNSON MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST		Provi der C	CN: 15-0001	Period: From 01/01/2018	Worksheet H-1	
				HHA CCN:	15-7510	To 12/31/2018	Date/Time Pre	pared:
						Home Health	5/29/2019 11: PPS	55 am_
			Capital Rela	atod Costs		Agency I		
			Сарітаі кета	ated Costs				
		Net Expenses for Cost	Bl dgs & Fi xtures	Movable	Plant Operation &	Transportation		
		Allocation	FIXTUIES	Equi pment	Mai ntenance		(cols. 0-4)	
		(from Wkst. H, col. 10)						
		0	1.00	2. 00	3.00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	ol				Ι ο	1. 00
1.00	Fixtures		٩				٥	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2. 00
3. 00	Plant Operation & Maintenance	0	O	O		0	О	3. 00
4.00	Transportation Administrative and General	0	0	0	1	0 0		4.00
5. 00	HHA REIMBURSABLE SERVICES	254, 299	0	0	ή	0 0	254, 299	5. 00
6.00	Skilled Nursing Care	213, 705	0	0		0 0		1
7. 00 8. 00	Physical Therapy Occupational Therapy	120, 102 84, 320	0	0		0 0	120, 102 84, 320	1
9.00	Speech Pathology	0	O	O		0 0	0	9. 00
10. 00 11. 00	Medical Social Services Home Health Aide	100 31, 264	0	0		0 0	100 31, 264	•
12. 00	Supplies (see instructions)	4, 935	o	0		0 0	4, 935	•
13. 00 14. 00	Drugs DME	0	0	0	1	0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES	0	<u> </u>		<u>′</u>	0 0		14.00
15.00	Home Dialysis Aide Services	0	0	0	1	0 0	-	
16. 00 17. 00	Respiratory Therapy 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	19. 00 20. 00
21. 00	Home Delivered Meals Program	0	ō	O		0 0	ō	21. 00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22. 00 23. 00
23. 50	Tel emedi ci ne	0	Ö	0	1	0 0	ő	23. 50
24. 00	Total (sum of lines 1-23)	708, 725 Admi ni strati ve	Total (cols	0)	0 0	708, 725	24. 00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5.00	6. 00					
1.00	Capital Related - Bldg. &							1. 00
2. 00	Fixtures Capital Related - Movable							2. 00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	254, 299						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	119, 590	333, 295					6. 00
7.00	Physi cal Therapy	67, 210	187, 312					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	47, 186 0	131, 506 0					8. 00 9. 00
10. 00	Medical Social Services	56	156					10.00
11.00	Home Heal th Ai de	17, 495 2, 762	48, 759					11. 00 12. 00
12. 00 13. 00	Supplies (see instructions) Drugs	2, 762	7, 697					13.00
14. 00	DME	0	O					14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0					15. 00
16. 00	Respiratory Therapy	0	0					16. 00
17. 00 18. 00	Private Duty Nursing Clinic	0	0					17. 00 18. 00
19. 00	Health Promotion Activities	0	О					19. 00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0					20. 00 21. 00
22.00	Homemaker Service	0	0					22. 00
23. 00 23. 50	All Others (specify) Telemedicine	0	0					23. 00 23. 50
	Total (sum of lines 1-23)		708, 725					24. 00

	Financial Systems LLOCATION - HHA STATISTICAL BAS	110	JOHNSON MEMOR	Provider C	N. 15 0001	Period:	eu of Form CMS-2 Worksheet H-1	
CUST	ALLOCATION - HHA STATISTICAL BAS	01.3		Provider Co	JN. 15-0001	From 01/01/2018		
				HHA CCN:	15-7510	To 12/31/2018	Date/Time Prep 5/29/2019 11:	pared:
						Home Health	PPS	<u> </u>
		Capital Rel	atad Casts			Agency I		
		Capitai kei	ateu costs					
		BI dgs &	Movabl e	PI ant	Transportati	onReconciliation	Admi ni strati ve	1
		Fi xtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Maintenance (SQUARE FEET)			(ACCUM. COST)	
		1.00	2.00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS			0,00		57 55	5. 55	
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2. 00	Capital Related - Movable Equipment		0			0		2. 00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see		0	0		0		4.00
	instructions)		_	_				
5.00	Administrative and General	0	0	0		0 -254, 299	454, 426	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0		0 0	213, 705	
7.00	Physical Therapy	0	0	0		0 0	120, 102	
8.00	Occupati onal Therapy	0	0	0		0 0	84, 320	
9.00	Speech Pathology	0	0	0			0	/. 00
10.00	Medical Social Services	0	0	0		0	100	
11.00	Home Heal th Aide	0	0	0		0 0	31, 264	
12.00	Supplies (see instructions)	0	0	0		٥	4, 935	
13. 00 14. 00	Drugs DME	0 0	0	0		0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0		14.00
15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16.00	Respiratory Therapy	0	0	0		0 0	0	16, 00
17. 00	Private Duty Nursing	0	0	0		0 0	0	
18. 00	Clinic	0	0	0		0	0	
19. 00	Health Promotion Activities	0	0	0		0 0	o o	
20.00	Day Care Program	ا م	0	0		0 0	o o	20.00
21. 00	Home Delivered Meals Program	١	0	0		0	o o	
22. 00	Homemaker Service	١	0	0		0	o o	22.00
23. 00	All Others (specify)		0	0		0 0	0	
23. 50	Tel emedi ci ne		0	0		0 0	0	
24. 00	Total (sum of lines 1-23)	1	0			0 -254, 299	"	
25. 00	Cost To Be Allocated (per	0	0			0 -234, 277	254, 299	
20.00	Worksheet H-1, Part I)		0				204, 277	25.00
	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.0000	1	I	26. 00

LEUCATION OF GENERAL SERVICE COSIS TO HHA COST CENTERS

| Provider CCN: 15-0001 | Period: | Worksheet H-2 | From 01/01/2018 | Part | From 01/01/2018 | Date/Time Prepared: | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 11:55 am

Home Health PPS Agency I CAPITAL RELATED COSTS NEW BLDG & MVBLE EQUIP **EMPLOYEE** HHA Trial COMMUNI CATI ONS DATA Cost Center Description Bal ance (1) FIXT **BENEFITS** PROCESSI NG DEPARTMENT 1.00 2.00 4. 01 4. 02 0 4.00 1.00 Administrative and General 1, 413 103 5, 748 54, 862 1.00 207, 232 333, 295 2 00 0 C C 2 00 Skilled Nursing Care 0 3.00 Physical Therapy 187, 312 0 0 0 0 3.00 4.00 Occupational Therapy 131, 506 0 0 0 0 0 0 4.00 Speech Pathology 0 0 5 00 5 00 0 O 0 6.00 Medical Social Services 156 C 6.00 0 7.00 Home Health Aide 48, 759 7.00 8.00 Supplies (see instructions) 7,697 00000000 0 0 0 8.00 0 9.00 Ω Drugs 0 9 00 10.00 DMF 0 10.00 0 0 0 0 11.00 Home Dialysis Aide Services 11.00 Respiratory Therapy 12.00 12.00 0 0 13.00 Private Duty Nursing Ω 13.00 14.00 Clinic 14.00 Health Promotion Activities 15.00 15.00 0 0 Day Care Program 0 0 0 16, 00 16,00 0 17 00 Home Delivered Meals Program C 0 17 00 18.00 Homemaker Service 0 0 0 18.00 19.00 All Others (specify) 0 0 Ω 0 0 19.00 19.50 Tel emedi ci ne 0 19.50 0 0 20.00 Total (sum of lines 1-19) (2) 708, 725 1, 413 103 207.232 5.748 54, 862 20.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description MATERI ALS ADMI TTI NG PATI ENT Subtotal ADMINISTRATIVE OPERATION OF MANAGEMENT ACCOUNTI NG & GENERAL **PLANT** 4.04 4A. 05 4.03 4.05 5.00 7.00 5, 967 1.00 Administrative and General 901 11, 896 288 122 13, 920 17, 761 1 00 2.00 Skilled Nursing Care 0 333, 295 16, 102 2.00 3.00 Physical Therapy 0 0 0 187, 312 9,050 3.00 Occupational Therapy 0 4.00 0 0 0 0 131, 506 6, 353 4.00 0 0 Speech Pathology 5 00 Ω 5 00 C 0 6.00 Medical Social Services C 156 8 6.00 7.00 Home Health Aide 48, 759 2, 356 7.00 8 00 0 00000000 Ω 7, 697 372 8 00 Supplies (see instructions) 9.00 Drugs C 0 0 9.00 10.00 DME 0 0 10.00 0 11.00 Home Dialysis Aide Services 0 0 0 11.00 0 12 00 Respiratory Therapy Ω 12 00 13.00 Private Duty Nursing 13.00 14.00 14.00 Clinic 0 Health Promotion Activities 0 15.00 0 0 15.00 0 0 Ω 16.00 Day Care Program 16.00 0 17.00 Home Delivered Meals Program 0 0 0 0 17.00 Homemaker Service 0 18.00 18.00 All Others (specify) 0 0 0 19.00 0 0 19.00 19.50 Tel emedi ci ne 0 0 0 19.50 Total (sum of lines 1-19) (2) 11, 896 20.00 901 5, 967 996, 847 48, 161 17, 761 20.00 21.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

6 decimal places.

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.

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

Peri od: Worksheet H-2
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 11:55 am Provi der CCN: 15-0001 HHA CCN: 15-7510

							5/29/2019 11:	55 am_
						Home Health Agency I	PPS	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		LINEN SERVICE				ADMI NI STRATI ON		
		0.00	0.00	10.00	11 00	10.00	SUPPLY	
1.00	Administrative and General	8.00	9. 00 7, 380	10.00	11. 00 14, 62	13.00	14.00	1.00
2.00	Skilled Nursing Care	0	7, 380	0	14, 02			1
3.00	Physical Therapy	0	0	0		0 0	Ö	
4. 00	Occupational Therapy	0	o	0		0 0	Ö	
5.00	Speech Pathology	0	0	0		0	0	5. 00
6.00	Medical Social Services	0	0	0		0	0	1
7.00	Home Heal th Ai de	0	0	0		0	0	
8. 00 9. 00	Supplies (see instructions) Drugs	0	0	0	1	0 0	0	
10.00	DME	0	0	0	1		ĺ	10.00
11.00	Home Dialysis Aide Services	0	0	0		0	0	11. 00
12. 00	Respi ratory Therapy	0	0	0		0	0	12. 00
13.00	Private Duty Nursing	0	0	0		0	0	13.00
14. 00 15. 00	Clinic Health Promotion Activities	0	0	0		0 0	0	14. 00 15. 00
16. 00	Day Care Program	0	0	0	1	0 0	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	1	o o	Ĭ	1
18. 00	Homemaker Service	0	0	0		0	0	18. 00
19. 00	All Others (specify)	0	0	0		0	0	
19. 50	Tel emedi ci ne	0	0	0		0	0	19. 50
20. 00 21. 00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0	7, 380	0	14, 62	O O	0	20.00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intern &	Subtotal	Allocated HHA	
	cost center bescription	FIIARWACI	RECORDS &	Subtotal	Residents Cos		A&G (see Part	
			LI BRARY		& Post		11)	
					Stepdown			
		15. 00	16. 00	24. 00	Adjustments 25.00	26. 00	27. 00	
1. 00	Administrative and General	0	5, 656	347, 459		0 347, 459		1. 00
2.00	Skilled Nursing Care	0	0	349, 397	'	0 349, 397	163, 399	2. 00
3. 00	Physi cal Therapy	0	0	196, 362	1	0 196, 362	91, 832	1
4.00	Occupational Therapy	0	0	137, 859	1	0 137, 859 0 0	64, 472	
5. 00 6. 00	Speech Pathology Medical Social Services	0	0	164	1	0 164	77	5. 00 6. 00
7. 00	Home Heal th Aide	0	0	51, 115	1	0 51, 115	23, 905	
8.00	Supplies (see instructions)	0	0	8, 069	1	8, 069		
9.00	Drugs	0	0	0		0	0	
10.00	DME	0	0	0		0	0	
11. 00 12. 00	Home Dialysis Aide Services Respiratory Therapy	0	0	0		0	0	11. 00 12. 00
13. 00	Private Duty Nursing	0	0	0		0 0		
14. 00		0	o	0		o o	1	
15. 00	Health Promotion Activities	0	0	0		0	0	15. 00
16. 00	Day Care Program	0	0	0		0	0	
17. 00	Home Delivered Meals Program	0	0	0		0	0	17. 00
18. 00 19. 00	Homemaker Service All Others (specify)	0	0	0	1	0 0	0	18. 00 19. 00
19. 50	Tel emedi ci ne	0	0	0	1		ĺ	19. 50
20.00	Total (sum of lines 1-19) (2)	0	5, 656	1, 090, 425	5	0 1, 090, 425	347, 459	1
21. 00	Unit Cost Multiplier: column						0. 467665	21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
		,	,					

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

					3/29/2019 11.	oo alli
				Home Health Agency I	PPS	
	Cost Center Description	Total HHA		Agency i		
	cost center bescription	Costs				
		28. 00				
1. 00	Administrative and General					1. 00
2.00	Skilled Nursing Care	512, 796				2.00
3.00	Physical Therapy	288, 194				3. 00
4.00	Occupational Therapy	202, 331				4. 00
5. 00	Speech Pathology	0				5. 00
6.00	Medical Social Services	241				6. 00
7.00	Home Heal th Aide	75, 020				7. 00
8.00	Supplies (see instructions)	11, 843				8. 00
9.00	Drugs	0				9. 00
10.00	DME	0				10. 00
11. 00	Home Dialysis Aide Services	0				11. 00
12.00	Respiratory Therapy	0				12. 00
13.00	Private Duty Nursing	0				13. 00
14.00	Clinic	0				14. 00
15.00	Health Promotion Activities	0				15. 00
16.00	Day Care Program	0				16. 00
17.00	Home Delivered Meals Program	0				17. 00
18. 00	Homemaker Service	0				18. 00
19. 00	All Others (specify)	0				19. 00
19. 50	Tel emedi ci ne	0				19. 50
20.00	Total (sum of lines 1-19) (2)	1, 090, 425				20. 00
21. 00						21. 00
	26, line 1 divided by the sum					
	of column 26, line 20 minus					
	column 26, line 1, rounded to					
	6 decimal places.					

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

							5/29/2019 11: 5	ob am_
						Home Health Agency I	PPS	
		CAPITAL REL	ATED COSTS			Agency 1		
	Cost Center Description	NEW BLDG & FIXT (TOTAL FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI ONS (# NON PT PHONES)	DATA PROCESSI NG (WORK ORDERS)	MATERI ALS MANAGEMENT (SUPPLY USAGE)	
		1.00	2.00	4.00	4. 01	4. 02	4. 03	
2. 00 Sk 3. 00 Ph 4. 00 Oc 5. 00 Sp 6. 00 Me 7. 00 Ho 8. 00 Dr 10. 00 DM 11. 00 Ho 12. 00 Re 13. 00 Pr 14. 00 Cl 15. 00 He 16. 00 Da 17. 00 Ho 18. 00 Ho 19. 00 Al 19. 50 Te 20. 00 To	dministrative and General cilled Nursing Care hysical Therapy occupational Therapy occupational Therapy occupational Therapy occupational Therapy occupational Services of the Health Aide pupplies (see instructions) or the property of the Market Services of the Market Services of the Market Services of the Market Services of the Market Service of the	1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	628, 642 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	49 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 226 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00
		CHARGES)	(GROSS CHARGES)		(ACCUM. COST)	(TOTAL FEET)	(POUNDS OF LAUNDRY)	
		4. 04	4. 05	5A	5. 00	7. 00	8. 00	
2. 00 Sk 3. 00 Ph 4. 00 Oc 5. 00 Sp 6. 00 Me 7. 00 Ho 8. 00 Dr 10. 00 DM 11. 00 Ho 12. 00 Re 13. 00 Pr 14. 00 Cl 15. 00 He 16. 00 Da 17. 00 Ho 18. 00 Ho 19. 00 Al 19. 50 Te 20. 00 To	dministrative and General cilled Nursing Care chysical Therapy coupational Therapy chech Pathology chech Program chech Pathology chech Patholo	1, 122, 439 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 122, 439 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	288, 122 333, 295 187, 312 131, 506 0 156 48, 759 7, 697 0 0 0 0 0	1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	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 20. 00 20. 00 21. 00 21. 00

				HHA CCN:	15-7510 To	o 12/31/2018	Date/Time Pre 5/29/2019 11:	pared: 55 am_
						Home Health Agency I	PPS	
	Cost Center Description	HOUSEKEEPI NG (TOTAL FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS PAI D)	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		9. 00	10. 00	11. 00	13.00	14. 00	15. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 000 14. 00 15. 00 17. 00 18. 00 19. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0	16, 924		0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
20. 00	,	1, 305	0	16, 924		0	0	
21. 00 22. 00		7, 380 5. 655172	0. 000000	14, 620 0. 863862		0, 000000	0. 000000	21. 00 22. 00
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00						
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 50 20. 00 21. 00 22. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	1, 122, 439 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 21. 00 22. 00

Hoal th	Financial Systems		JOHNSON MEMORI	AI HOSDITAI		In lie	eu of Form CMS-2	2552_10
	TIONMENT OF PATIENT SERVICE COST	S	JULINSON WEWORL		CN: 15-0001	Peri od:	Worksheet H-3	
7 0	TOTAL OF THE EAST OF THE OF TH					From 01/01/2018	Part I	
				HHA CCN:	15-7510	To 12/31/2018	Date/Time Pre 5/29/2019 11:	
				Title	e XVIII	Home Health	PPS	<u> </u>
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
	cost center bescription	H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.		Per Visit	
		col. 28, line		Costs (from	+ 2)		(col. 3 ÷ col.	
			,	Part ÌI)	ĺ		4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LIN	MITATION COST, O	R	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	512, 796		512, 79	96 2, 527	202. 93	1.00
2.00	Physi cal Therapy	3.00	288, 194	(288, 19	1, 801	160. 02	2. 00
3.00	Occupational Therapy	4.00	202, 331	(202, 3	1, 169	173. 08	3. 00
4.00	Speech Pathology	5. 00		(0 49		
5.00	Medical Social Services	6. 00			24			
6.00	Home Heal th Ai de	7. 00			75, 0		37, 510. 00	1
7. 00	Total (sum of lines 1-6)		1, 078, 582	(1, 078, 58			7. 00
					Program Visi	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	cost conton boson per on	0000 21 1111 10	050/1 110/ (1)		Deducti bl es			
					Coi nsurance			
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
9 00	Limitation Cost Computation Skilled Nursing Care	T	18020	(J .	27	I	8.00
8. 00 8. 01	Skilled Nursing Care		26900	(1		-	8. 00
9. 00	Physical Therapy		18020			34		9. 00
9. 01	Physical Therapy		26900		•	49		9. 01
10.00	Occupational Therapy		18020	C	1	22		10.00
10. 01	Occupational Therapy		26900	(37		10. 01
11. 00	Speech Pathology		18020	(1		11. 00
11. 01	Speech Pathology		26900	() :	23		11. 01
12. 00	Medical Social Services		18020	(0		12.00
12. 01	Medical Social Services		26900	(0		12. 01
13.00	l .		18020 26900	(0		13. 00 13. 01
13. 01	Home Health Aide Total (sum of lines 8-13)		20900		2, 5:	2		14. 00
14.00		From Wkst H-2	Facility Costs	Shared	Total HHA		Ratio (col. 3	14.00
	cost center beserver on	Part I, col.	(from Wkst.	Ancillary	Costs (col s.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
				Part II)	·			
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
15. 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	ations 8.00	11, 843	(11, 8	43 0	0. 000000	15. 00
16. 00		9.00		(۱۱, 8٬	0 0		1
10.00	COST OF Drugs		Program Visits		Cost of		0.00000	10.00
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles &			Deductibles &		
		4 00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	0F AGGREGATE F	7.00 PROGRAM COST A	8.00 GGREGATE OF TH	9.00 F PROGRAM LIN	10.00	11. 00 R	
	BENEFICIARY COST LIMITATION	OF AGGREGATE F		SURLEMITE OF TE	I ROOKAWI ETI	//// 5/0 5051, '01		
	Cost Per Visit Computation]
1.00	Skilled Nursing Care	0	.,			0 215, 918	3	1. 00
2.00	Physi cal Therapy	0				0 141, 298		2. 00
3.00	Occupational Therapy	0	559			0 96, 752		3. 00
4.00	Speech Pathology	0	24			0)	4. 00
5.00	Medical Social Services	0	0			0 75 000		5.00
6. 00 7. 00	Home Health Aide Total (sum of lines 1-6)	0	2, 532			0 75, 020 0 528, 988		6. 00 7. 00
7.00	Total (sum of filles 1-0)	1	2, 532	l	1	O ₁ 520, 900	1	1 7.00

Heal tr	n Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
	TIONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-0001	Peri od: From 01/01/2018	Worksheet H-3	3
				HHA CCN:	15-7510	To 12/31/2018	Part I Date/Time Pre 5/29/2019 11:	
				Ti tl e	· XVIII	Home Health Agency I	PPS	00 4
	Cost Center Description	(00	7.00	0.00	0.00		11 00	
	Limitation Cost Computation	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 12. 01 13. 00 13. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01
14. 00	Total (sum of lines 8-13)	Prog	ram Covered Cha	erges	Cost of			14. 00
		1109	Par		Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
15. 00	Supplies and Drugs Cost Computation Cost of Medical Supplies	ations 0	3, 369	O	I	0 0	(15.00
	Cost of Drugs		0,307			0	(
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						_
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	?	
1.00	Skilled Nursing Care	215, 918						1.00
2.00	Physical Therapy Occupational Therapy	141, 298 96, 752						2.00
4.00	Speech Pathology	90, 752						4.00
5.00	Medical Social Services	0						5. 00
6.00	Home Heal th Ai de	75, 020						6.00
7.00	Total (sum of lines 1-6) Cost Center Description	528, 988						7. 00
	555 55561 55561 1 511 611	12. 00						
	Limitation Cost Computation	l	T					
8. 00 8. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services							8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 12. 01 13. 00 13. 01

Health Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 15-0001	Peri od:	Worksheet H-3	
			HHA CCN:	15-7510	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 11:	
			Title	XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge		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 SERVIO	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00 Physical Therapy	66. 00	0. 354520	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67. 00	0. 260334	0)	0 col. 2, line 3	. 00	2. 00
3.00 Speech Pathology	68. 00	0. 503284	0		0 col. 2, line 4	. 00	3. 00
4.00 Cost of Medical Supplies	71.00	0. 406559	0		0 col. 2, line 1	5. 00	4. 00
5.00 Cost of Drugs	73. 00	0. 450734	0)	0 col. 2, line 1	6. 00	5. 00

	Financial Systems JOHNSON MEMORIAL				u of Form CMS-2	2552-
CALCUL	ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der CC	CN: 15-0001	Peri od: From 01/01/2018	Worksheet H-4	
		HHA CCN:	15-7510	To 12/31/2018	Part I-II Date/Time Pre 5/29/2019 11:	
		Title	XVIII	Home Health Agency I	PPS	
					t B	
			Part A	Not Subject to Deductibles &		
			1.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGE	1.00 S	2. 00	3. 00	
	Reasonable Cost of Part A & Part B Services	SWART CHARGE	<u> </u>			1
. 00	Reasonable cost of services (see instructions)			0 0	0	1.
. 00	Total charges			0 0	0	2.
00	Customary Charges				0	,
00	Amount actually collected from patients liable for payment for on a charge basis (from your records)	r services		0 0	0	3.
. 00	Amount that would have been realized from patients liable for	pavment		0 0	0	4.
	for services on a charge basis had such payment been made in a					
	with 42 CFR §413.13(b)					
. 00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	_ _		
. 00 . 00	Total customary charges (see instructions) Excess of total customary charges over total reasonable cost	(complete		0 0	0	1
. 00	only if line 6 exceeds line 1)	(comprete			U	′.
. 00	Excess of reasonable cost over customary charges (complete onl	lyifline		0 0	0	8.
	1 exceeds line 6)					
. 00	Primary payer amounts			0 0	0	9.
				Part A Servi ces	Part B Servi ces	
				1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
0.00	Total reasonable cost (see instructions)			0	0	
1.00	Total PPS Reimbursement - Full Episodes without Outliers			0	478, 357	
2. 00 3. 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0	0 2, 033	1
4. 00	Total PPS Reimbursement - PEP Episodes			0	2,033	1
5. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	0	1
5. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	1
7. 00	Total Other Payments			0	0	1
3. 00	DME Payments			0	0	
9. 00). 00	Oxygen Payments Prosthetic and Orthotic Payments			0	0	
1. 00	Part B deductibles billed to Medicare patients (exclude coins	urance)		0	0	
2. 00	Subtotal (sum of lines 10 thru 20 minus line 21)			0	480, 390	1
3. 00	Excess reasonable cost (from line 8)			0	0	1
4. 00	Subtotal (line 22 minus line 23)			0	480, 390	1
5.00	Coinsurance billed to program patients (from your records)				0	
6.00	Net cost (line 24 minus line 25)			0	480, 390	1
7. 00 3. 00	Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see in	nstructions)				27. 28.
9. 00	Total costs - current cost reporting period (line 26 plus line			0	480, 390	
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•		0	0	1
0. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	0	
0. 99	Demonstration payment adjustment amount before sequestration			0	0	
1.00	Subtotal (see instructions)			0	480, 390	
1. 01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	9, 608 0	1
1 02	Interim payments (see instructions)			0	470, 782	
						1
2. 00	Tentative settlement (for contractor use only)			0	0	33.
31. 02 32. 00 33. 00 34. 00 35. 00				0	0 0 0	34.

Heal th Financial Systems JOHNSON MEMORIAL HOSPITAL ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED Provider In Lieu of Form CMS-2552-10

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 11:55 am Provider CCN: 15-0001 TO PROGRAM BENEFICIARIES HHA CCN: 15-7510

				Home Health Agency I	PPS	
		Inpatien	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider			0	470, 782	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	T				
3. 01				0	0	3. 01
3. 02 3. 03				0	0 0	3. 02 3. 03
3. 04				0		3. 03
3. 05				0	o o	3. 05
	Provider to Program			- 1		
3.50				0	0	3. 50
3. 51				0	0	3. 51
3. 52 3. 53				0	0 0	3. 52 3. 53
3. 53				0		3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
0. , ,	3. 50-3. 98)					0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)			0	470, 782	4. 00
	(transfer to Wkst. H-4, Part II, column as appropriate,					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	1				
5. 01				0	0 0	5. 01
5. 02 5. 03				0		5. 02 5. 03
5.05	Provider to Program	L		0		3. 03
5. 50	r row do r rogram			0	0	5. 50
5.51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER			0	o	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	470, 782	7. 00
				Contractor	NPR Date	
		1)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		,	1.00	2.00	8. 00
		1		1	'	

			u of Form CMS-2	<u> 2552-10</u>	
		Peri od: From 01/01/2018	Worksheet L Parts I-III		
			To 12/31/2018		pared:
		5/29/2019 11:55 am			
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
1. 00	Capital DRG other than outlier			438, 364	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1
2.00	Capital DRG outlier payments			1, 711	1
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)			16. 44	3. 00
4.00	0 Number of interns & residents (see instructions)			0.00	4. 00
5.00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0	6. 00
	1.01) (see instructions)				
7. 00				0.00	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instructions)			0.00	8.00
9. 00				0.00	
10. 00				0.00	
11. 00				0.00	
12. 00				440, 075	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1
2.00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	
3. 00 4. 00	Capital cost payment factor (see instructions)			0	
4. 00 5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
5.00	Total impatrent program capital cost (Time 3 x Time 4)			U	3.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (see i			0.00	
7. 00 8. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) Capital minimum payment level (line 5 plus line 7)			0	
9. 00	Current year capital payments (from Part I, line 12, as applicable)			0	
10.00	Current year capital payments (from Part 1, 17he 12, as appr Current year comparison of capital minimum payment level to		less line 0)	0	
11. 00	Carryover of accumulated capital minimum payment level over			0	
11.00	Worksheet L, Part III, line 14)	capital payment (110m pri	or year		11.00
12. 00	Net comparison of capital minimum payment level to capital p	avments (line 10 plus lin	ne 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, ente			0	
14.00	Carryover of accumulated capital minimum payment level over			0	14. 00
	(if line 12 is negative, enter the amount on this line)	· · · ·	÷ .		

15.00 0 16. 00 0 17. 00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)