JOHNSON MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0001 Worksheet S Peri od. From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: То 7/30/2021 11:08 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/30/2021 Time: 11:08 am Manually prepared cost report use only 2. []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [6. Date Received: 7. Contractor No. Contractor 10. NPR Date: 5.]Cost Report Status [

 (1) As Submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit 8.
 [N] Initial Report for this Provider CCN
 11. Contractor's Contractor's Vendor Code:
 4

 (3) Settled with Audit 9.
 [N] Final Report for this Provider CCN
 number of times reopened = 0-9.

 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION 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 01/01/2020 and ending 12/31/2020 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. [X] 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) ADAM PUTVIN

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)

Da	۱t	е
	ιL	C

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	240, 424	-26, 020	0	-417, 201	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	240, 424	-26, 020	0	-417, 201	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.

PI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		MEMORIAL			N: 15-0001	Period:	<u>In Lie</u>	Works	heet S-2	
							From 01/ To 12/		Date/	Time Pre	
	1.00	2.	00		3.00			4.00	//30/.	2021 11:	08 a
	Hospital and Hospital Health Care Co										
	Street: 1125 WEST JEFFERSON STREET City: FRANKLIN	PO Box: State: I	N	Zip Cod	o. 161	31	unty: JOHNSC	M			1.
	orty. HANKEIN	Component Na		CCN	CBS		Y		ent Sys	stem (P,	2.
			1	Number	Numb	ber Type	Certifi		, <u>0</u> , <u>o</u>		4
		1.00		2.00	3.0	00 4.00	5.00	V 6.00	XVII 7.00		+
	Hospital and Hospital-Based Componen		:	2.00	0.0	1.00	0.00	0.00	5 7.00	0.00	
0	Hospi tal	JOHNSON MEMORIAL HOSPITAL		150001	269	00 1	07/01/19	966 N	P	0	3
00 00 00 00 00 00 00 00 00 00	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital -Based SNF Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA Separately Certified ASC Hospital -Based Hospice	JOHNSON MEMORIAL HEALTH	. HOME	157510	269	00	07/01/19	997 N	Ρ	Ν	4 5 6 7 8 9 10 11 12 13 14
00 00 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis Other										15. 16. 17. 18. 19.
								om: 00		Го: . 00	-
00	Cost Reporting Period (mm/dd/yyyy)						01/01	/2020		1/2020	20
00	Type of Control (see instructions)							9			21
						1.00	2.	00	3	. 00	1
	Inpatient PPS Information Does this facility qualify and is it					Y		N			22
01	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft	r yes or "N" for 412.106(c)(2)(Pi r yes or "N" for compensated care mn 1, "Y" for ye riod occurring p " for no for the	no. Is the ckle amend no. payments s or "N" to rior to Od portion d	his dment for th for no ctober of the	is for 1.	Y		Y			22
	Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1.	requires final port settlement? " for no, for the er 1. Enter in co e cost reporting	uncompensa (see ins e portion olumn 2, ' period ou	ated ca tructio of the 'Y" for n or af	ns) yes ter	N		N			22
	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ds for delineatine olumn 1, "Y" for g period prior to no for the portioner er October 1. (so 100 but not more	ng statis [.] yes or "I o October on of the ee instruc than 499	tical a N" for 1. Ent cost ctions) beds (reas no er as	Ν		N		N	22
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admission, 2 of identifying t method used in t	if census he days in he prior o <u>"N" for n</u>	days, n this cost no.	or 3 cost	0.1		N		0+1	23.
			In-State Medicaid paid days 1.00	Medi s elig unp da	cai d i bl e ai d	Out-of State Medicaid paid days 3.00	Out-of State Medicaid eligible unpaid 4.00	Medica HMO da	ays Me	Other edi cai d days 6.00	
00	If this provider is an IPPS hospital	, enter the	31		745				456		24.
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in									

DSPI T	Financial Systems JOHNSON AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	CN: 15-0001	Peri od:	In Lieu	Worksh	eet S-2	
					From 01/0 To 12/3	31/2020 31/2020	Date/T	ime Pre 021 11:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	aid C ays Me	di cai d days	
5.00	If this provider is an IRF, enter the in-state 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.	1.00 0	2.00 0	3.00	4.00 0		0	6.00	25.
						Rural S 00	Date of 2.	- Geogr 00	
o. 00 7. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban c	or rural. vage) status	at the en	d of the co:		1 1			26. 27.
5. 00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	ication in	column 2.			0			35.
					Begi n 1.	ni ng: 00	Endi 2.	ng: 00	-
. 00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for num					36.
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		er of perio	ds MDH stat	us	0			37.
. 01	Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)								37.
. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.
						/N 00		/N 00	-
0. 00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction), (ii), or the mileage ii)? Enter	(iii)? En e requireme in column	ter in colu ents in 2 "Y" for ye	es	N	1	J	39. 40.
. 00	"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for				XVI I I		40.
						1.00	_	3.00	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	ent for disp	proportiona	te share in	accordanc	e N	N	N	45.
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.
. 00 . 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymer Teaching Hospitals					N N	N N	N N	47. 48.
	Is this a hospital involved in training residents ir "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for	impacted by no in colu	CR 11642	(or subseque	ent CR), M				56.
	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	bryes or "N hth of this Y", complet I, if appli	l" for no i cost repor e Workshee cable.	n column 1. ting period t E-4. lf c	lf column ? Enter " olumn 2 is	Y"			57
00	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15–1, chapter 21, §2148? If yes,			ans' servico	es as	N			58.
. 00	Are costs claimed on line 100 of Worksheet A? If ye	es, complete	Wkst. D-2	, Pt. I. NAHE 413.8 Y/N		neet A e #	Cri te	cation erion	59.
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in cc is "Y", are you impacted by CR 11642 (or subsequent	8.85? (see olumn 1. If	column 1	1.00 N	2.	00		de 00	60.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	.ТА	Provider C	F	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/30/2021 11:	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.0
column 1. (see instructions) 1.01 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						61.0
instructions) 1.02 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						61.0
 ACA). (see instructions) 1.03 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 						61.0
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.0
current cost reporting period. (see instructions). 1.05 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. 0
 61.04 minus line 61.03). (see instructions) 1.06 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) 						61.00
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 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. 				0.00		61. 2
					1.00	-
ACA Provisions Affecting the Health Resources and Ser						
 2.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction) 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide 	ctions) a Teach gram. (ing Health Cer see instructic	nter (THC) into			62.0 62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63.0
			Unweighted FTEs Nonprovider Site	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			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			-This base yea	r is your cost	reporti ng	
4.00 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 ir of (column 1 divided by (column 1 + column 2)). (see	ty trai n-prima all no n non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	0.0	0 0.00	0. 000000	64.0

	EX IDENTIFICATION D	ATA Provider C		eriod:	Worksheet S-	-2
			Fr To	rom 01/01/2020 0 12/31/2020		repare
					7/30/2021 1	1:08 a
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 ·	.
			Nonprovi der	Hospi tal	col. 4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0.00	0.00	0. 00000	00 65.
divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 - col. 2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current		n Nonprovider Settin				
beginning on or after July 1, 20 00 Enter in column 1 the number of u		ary care resident	0.00	0.00	0. 00000	20 44
FTEs attributable to rotations of	ccurring in all nonp			0.00		00 00.
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	Unweighted FTEs	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 ·	
Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. ary care resident 3 the ratio of astructions)	Unwei ghted	Unweighted FTEs in	Ratio (col.	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program	unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 - col. 4)) 5.00	+
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. my care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 col. 4)) 5.00	+
Enter in column 2 the number of a FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. my care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 col. 4)) 5.00 0.00000	+ 67.
Enter in col umn 2 the number of u FTEs that trained in your hospita (col umn 1 divided by (col umn 1 + 00 Enter in col umn 1, the program name associated with each of your primary care programs in which you trained residents. Enter in col umn 2, the program code. Enter in col umn 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in col umn 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in col umn 5, the ratio of (col umn 3 divided by (col umn 3 + col umn 4)). (see instructions)	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	Provi der settings. ary care resident 3 the ratio of Istructions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 col. 4)) 5.00 0.00000	+ 67.
Enter in column 2 the number of a FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> PS ychiatric Facility (Provi der settings. ary care resident 3 the ratio of Istructions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 col. 4)) 5.00 0.00000	+
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PI 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.	unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u> <u>1.00</u>	The ratio of the r	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subj ing program in yes or "N" for s in a new teacl yes or "N" for	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see hi ng no.	Ratio (col. 3/ (col. 3 col. 4)) 5.00 0.00000	+ 00 67.
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1 1 1 1 1 1 1 1 1 1 1 1 1	unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00 PS ychiatric Facility (the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y y PPS	CiPF), or does it con an approved GME teach (1PF), or does it con an approved GME teach (1PF) for does it con an approved GME teach (1PF) for does it con an approved for the teach (1PF) for does it con an approved for the teach (1PF) for teach (1PF) for teach (1PF) for teach (1PF) for teach (1PF) for teach (1PF) for teach (1	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF sub ing program in yes or "N" for in s in a new teacl yes or "N" for in s cost reporting	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see hi ng no.	Ratio (col. 3/ (col. 3 col. 4)) 5.00 0.00000	+

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	CCN: 15-0001	Period: From 01/01/ To 12/31/	2020 2020	Workshee Part I Date/Tim	e Prepa
				7/30/202	1 11:08
			1.00	2.00	3.00
6.00 If line 75 is yes: Column 1: Did the facility have an approved GME teach recent cost reporting period ending on or before November 15, 2004? Ente no. Column 2: Did this facility train residents in a new teaching progra CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: I indicate which program year began during this cost reporting period. (see	r "Y" for yes m in accordan f column 2 is	or "N" for ce with 42 Y,	N	N	0 7
				1.00	
Long Term Care Hospital PPS					
D. 00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for 1.00 Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no. TEFRA Providers		ng period? E	nter	N N	8
5.00 Is this a new hospital under 42 CFR Section $413.40(f)(1)(i)$ TEFRA? Ent 5.00 Did this facility establish a new Other subprovider (excluded unit) unde			no.	N	8
<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 s this hospital an extended neoplastic disease care hospital classified</pre>	under sectio			N	8
		V 1.00		XI X 2. 00	
Title V and XIX Services					
D. 00 Does this facility have title V and/or XIX inpatient hospital services? yes or "N" for no in the applicable column.	Enter "Y" for	Y		Y	9
1.00 Is this hospital reimbursed for title V and/or XIX through the cost repo full or in part? Enter "Y" for yes or "N" for no in the applicable colum	n.	N		Y	9
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certifica instructions) Enter "Y" for yes or "N" for no in the applicable column.	tion)? (see			Ν	9
B. 00 Does this facility operate an ICF/IID facility for purposes of title V a "Y" for yes or "N" for no in the applicable column.		N		Ν	9
Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for applicable column.		N		Ν	9
5.00 If line 94 is "Y", enter the reduction percentage in the applicable colu b.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.		0.00 N		0. 00 N	9
7.00 If line 96 is "Y", enter the reduction percentage in the applicable colu B.00 Does title V or XIX follow Medicare (title XVIII) for the interns and re stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N column 1 for title V, and in column 2 for title XIX.	sidents post	0. 00 Y		0. 00 Y	9
B. 01 Does title V or XIX follow Medicare (title XVIII) for the reporting of c C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and i title XIX.				Y	9
B. 02 Does title V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no for title V, and in column 2 for title XIX.		Y		Y	9
8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for for title V, and in column 2 for title XIX.				Ν	9
8. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 1 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 fo in column 2 for title XIX.		d		Ν	9
8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE d Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX.				Y	9
.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed f Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX. Rural Providers		Y		Y	9
5.00Does this hospital qualify as a CAH? 6.00If this facility qualifies as a CAH, has it elected the all-inclusive me	thod of payme	nt N		_	10 10
<pre>for outpatient services? (see instructions) 7.00Column 1: If line 105 is Y, is this facility eligible for cost reimburse training programs? Enter "Y" for yes or "N" for no in column 1. (see in Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train l& approved medical education program in the CAH's excluded IPF and/or IRF Enter "Y" for yes or "N" for no in column 2. (see instructions)</pre>	structions) Rs in an	N			10
08.00 Is this a rural hospital qualifying for an exception to the CRNA fee sch	edule? See 4	2 N			10

	Provider C		eriod: rom 01/01/2020	Worksheet S- Part I	-2
		Т			
-	Physi cal	Occupati onal	Speech	Respi ratory	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3.00 N	4.00 N	109.00
				1.00	-
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes o	r "N" for no. I	f yes,	N	110.00
			1.00	2.00	-
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this construction prong of the FCHIP demo in which this CAH is participate and the	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111.00
		1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	period? s "Y", enter he	N			112.00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes				
16.00 s this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
17.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	rance? Enter	Y			117.00
18.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		2	2		118.00
In the portey is craim-made. Enter 2 in the portey is decar	rence.	Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
18.01 List amounts of malpractice premiums and paid losses:		1.00 153,977			0118.0
		153, 977	(_
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.		153, 977 than the	(2	118.02
 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheck and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendment 	dule listing d Harmless pro n column 1, "" ualifies for	153,977 than the cost centers ovision in ACA Y" for yes or the Outpatient	(2	118.02
 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schect 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 §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implational context and the provision of the cost implicable cost implicabl	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions)	1.00 N	2.00	118.0 119.0 120.0
 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheomand amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for no. 21.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	1.00 N	2.00	118.0 119.0 120.0
 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched 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 §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? 21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for 	dule listing d Harmless pro- n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1.00 N N	2.00	118. 0. 119. 0(120. 0(121. 0(122. 0(
 18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, erter 	dule listing d Harmless pro- n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1.00 N N Y N	2.00	118. 0. 119. 00 120. 00 121. 00 122. 00 125. 00
 18. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 21. 00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, enter and the support of the sis a Medicare certified heart transplant center, enter signal center (mathematica) and termination date, if applicable, in column 2. 	dule listing d Harmless pro- n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date	1.00 N N Y N	2.00	118. 0 119. 0 120. 0 121. 0 122. 0 125. 0 126. 0
 18. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? 21. 00 DId this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 27. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 	dule listing d Harmless pro- n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2. ter the certi	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	1.00 N N Y N	2.00	118. 0 119. 0 120. 0 121. 0 122. 0 125. 0 126. 0 127. 0
 18. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21. 00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 28. 00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 28. 00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29. 00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pro- n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the cert 2. ter the cert 2.	than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	1.00 N N Y N	2.00	118.0 119.0 120.0 121.0 122.0 125.0 126.0 126.0 127.0 128.0
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2. 	dule listing d Harmless pro- n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the cert 2. ter the cert 2. ter the cert 2. ter the cert 2. ter the cert 3. ter the cert 4.	153,977 than the cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date ication date in	1.00 N N Y N	2.00	0 118. 0 0 118. 0 119. 00 120. 00 121. 00 122. 00 125. 00 126. 00 128. 00 128. 00 129. 00 130. 00

Health Financial Systems	JOHNSON MEMORI				u of Form CMS-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provider CC		Period: From 01/01/2020	Worksheet S-2 Part I	2
			-	To 12/31/2020	Date/Time Pre 7/30/2021 11:	epared: 08 am
132.00 If this is a Medicare certified is	slot transplant contor on	tor the cortif	ication data	1.00	2.00	132.00
in column 1 and termination date,						132.00
133.00 Removed and reserved			:			133.00
134.00 If this is an organ procurement o and termination date, if applicab		ne UPU number	In column I			134.00
All Providers						1
140.00 Are there any related organization chapter 10? Enter "Y" for yes or				N		140.00
are claimed, enter in column 2 th						
1.00 If this facility is part of a cha	2.00		ugh 142 tho r	3.00	of the home	_
office and enter the home office			Jugii 143 the i		of the nome	
141.00Name:	Contractor's Name:		Contracto	r's Number:		141.00
142.00Street: 143.00Ci ty:	PO Box: State:		Zip Code:			142.00 143.00
	prator		12.1 p 000001			
144.00 Are provider based physicians' co	sts included in Werksheet	12			1.00 Y	144.00
144. OOAre provider based physicians co.	sts merdded mi worksneet i	<u> </u>			1	144.00
				1.00	2.00	
145.00 If costs for renal services are c inpatient services only? Enter "Y						145.00
no, does the dialysis facility in	clude Medicare utilization					
period? Enter "Y" for yes or "N" 146.00Has the cost allocation methodolog		usly filed cos	t roport?	N		146.00
Enter "Y" for yes or "N" for no i	5 5	5				140.00
yes, enter the approval date (mm/	dd/yyyy) in column 2.					
					1.00	-
147.00 Was there a change in the statist					N	147.00
148.00 Was there a change in the order of 149.00 Was there a change to the simplif				no	N N	148.00 149.00
147. oomas there a change to the shipirri		Part A	Part B	Title V	Title XIX	147.00
Dece this facility contain a prov	iden that qualifies for an	1.00	2.00	3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or						
155.00Hospi tal		N	N	N	N	155.00
156.00Subprovi der – IPF 157.00Subprovi der – IRF		N N	N N	N	N N	156.00 157.00
158. 00 SUBPROVI DER						158.00
159.00SNF 160.00HOME HEALTH AGENCY		N N	N N	N	N N	159.00 160.00
161. 00 CMHC		IN	N N	N N	N	160.00
				- I		_
Multicampus					1.00	
165.00 Is this hospital part of a Multica	ampus hospital that has on	e or more camp	ouses in diffe	rent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State Zip	Code CBSA	FTE/Campus	
	0	1.00		. 00 4. 00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column					0.00	0166.00
0, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in column 5 (see instructions)						
` `				•		_
Health Information Technology (HI	T) incentive in the Americ	an Recovery an	nd Reinvestmer	ot Act	1.00	
167.00 Is this provider a meaningful use	r under §1886(n)? Enter "	Y" for yes or	"N" for no.		Y	167.00
168.00 If this provider is a CAH (line 10			ue 167 is "Y")	, enter the		168.00
reasonable cost incurred for the 168.01 If this provider is a CAH and is			er qualifv for	a hardshi p		168.01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N"	for no. (see	instructions)		_	
169.00 If this provider is a meaningful transition factor. (see instruction		ıs not a CAH	(IINE 105 is	"N"), enter the	9.9	9169.00
	/				1	1

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA		Period:	Worksheet S-	2
			From 01/01/2020 To 12/31/2020	Date/Time Pr	onarad
			10 12/31/2020	7/30/2021 11	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)	ning date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider	have any days for indiv	viduals enrolled in	N		0171.00
section 1876 Medicare cost plans report	ed on Wkst. S-3, Pt. I,	line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1.	lf column 1 is yes, er	nter the number of sectio	n		
1876 Medicare days in column 2. (see in	nstructions)				

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0001		Date/Time P 7/30/2021 1	repared:
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N f	or all NO re	esponses. Ent			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					_
	Provider Organization and Operation Has the provider changed ownership immediately prior to the b	eainnina of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in col					1.00
			Y/N	Date	V/I	
2 00	Use the provider terminated participation in the Medicare Dra	arom2 lf	1.00 N	2.00	3.00	2.00
	Has the provider terminated participation in the Medicare Proyes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	3, "V" for				2.00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home off or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ices, drug or its the board	N			3. 00
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					_
4. 00 5. 00	Column 1: Were the financial statements prepared by a Certif Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avail column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differe	Compiled, able in	Y	A		4.00
5.00	those on the filed financial statements? If yes, submit recon					01.01
	Approved Educational Activition			Y/N 1.00	Legal Oper. 2.00	_
6.00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: I	fves is t	he provider i	s N		6.00
0.00	the legal operator of the program?	. joo, .o				
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see inst Were nursing school and/or allied health programs approved an cost reporting period? If yes, see instructions.		d during the	N N		7.0 8.0
9.00	Are costs claimed for Interns and Residents in an approved gr	aduate medi	cal educatior	n N		9.00
10. 00	program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.	renewed in	the current	Ν		10. 0
11.00	Are GME cost directly assigned to cost centers other than I & Teaching Program on Worksheet A? If yes, see instructions.	R in an Ap	proved	N		11.0
					Y/N 1.00	_
	Bad Debts				1.00	
12.00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection pol period? If yes, submit copy.			cost reporting	Y N	12.00 13.00
	If line 12 is yes, were patient deductibles and/or co-payment Bed Complement				Ν	14.0
15.00	Did total beds available change from the prior cost reporting		<u>yes, see ins</u> t A	structions. Par	N + B	15.0
		Y/N	Date	Y/N	Date	_
		1.00	2.00	3.00	4.00	
	PS&R Data				04 /05 /55	
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 instructions)	Y	01/05/2021	Y	01/05/2021	16.0
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		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	Ν		Ν		18.0
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.	Ν		Ν		19.00

	Financial Systems JOHNSON MEMORI			In Lie		S-2552-10
103PI IA	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (CN: 15-0001	Period: From 01/01/2020 To 12/31/2020		Prepared:
			iption	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3.00 N	20.00
	Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
21 00 1	Nas the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
	records? If yes, see instructions.	IN		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPI TALS)			
	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions				22.00
	Have changes occurred in the Medicare depreciation expense			rina the cost		22.00
	reporting period? If yes, see instructions.			5		
	Nere new leases and/or amendments to existing leases entere	ed into during	, this cost r	eporting period?		24.00
	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	orting period	?lfves see		25.00
	instructions.	the cost rope	in thing point ou	joo, ooo		20100
	Nere assets subject to Sec.2314 of DEFRA acquired during th	ne cost report	ing period?	lfyes, see		26.00
	instructions. Has the provider's capitalization policy changed during the	e cost reporti	na period? l	fves submit		27.00
	copy.		ng period. I	, yos, subin t		27.00
	nterest Expense					
	Nere new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into du	iring the cos	t reporting		28.00
	Did the provider have a funded depreciation account and/or	bond funds ([ebt Service	Reserve Fund)		29.00
1	treated as a funded depreciation account? If yes, see instr	ructions		ŕ		
	Has existing debt been replaced prior to its scheduled matu	urity with new	/debt?lfye	s, see		30.00
	instructions. Has debt been recalled before scheduled maturity without is	suance of new	/debt?lfve	s. see		31.00
i	instructions.			-,		
	Purchased Services					
	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ied through c	ontractual		32.00
	If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to compet	itive bidding? If	,	33.00
	no, see instructions.	-		-		_
	γrovider-Based Physicians Are services furnished at the provider facility under an ar	rangement wit	h provider-h	ased physicians?		34.00
	If yes, see instructions.	Tangement wit				54.00
	If line 34 is yes, were there new agreements or amended exi		ents with the	provi der-based		35.00
F	ohysicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1.00	2.00	
	lome Office Costs					
36.00 V	Nere home office costs claimed on the cost report?	concored by the	home office	2		
36.00 V 37.00 I	If line 36 is yes, has a home office cost statement been pr	repared by the	e home office	?		
36.00 V 37.00 I 38.00 I	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	ice different	from that o			37.00
36.00 V 37.00 I 38.00 I 1	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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	fice different l of the home	from that o office.	f		37.00 38.00
36.00 V 37.00 I 38.00 I 39.00 I	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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 If line 36 is yes, did the provider render services to othe	fice different l of the home	from that o office.	f		37.00 38.00
36.00 V 37.00 I 38.00 I 39.00 I s	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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	Fice different d of the home er chain compo	from that o office. ments? If ye	f s,		37.00 38.00 39.00
36. 00 V 37. 00 I 38. 00 I 39. 00 I 40. 00 I	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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 If line 36 is yes, did the provider render services to othe see instructions.	Fice different d of the home er chain compo	from that o office. ments? If ye	f s,		37.00 38.00 39.00
36. 00 V 37. 00 I 38. 00 I 39. 00 I 40. 00 I	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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 If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	Fice different of the home er chain compo home office?	from that o office. nents? If ye If yes, see	f s,	00	37.00 38.00 39.00
36. 00 V 37. 00 I 38. 00 I 39. 00 I 40. 00 I i	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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 If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	Fice different of the home er chain compo home office?	from that o office. ments? If ye	f s,	00	37.00 38.00 39.00
36. 00 V 37. 00 I 38. 00 I 39. 00 I 40. 00 I 41. 00 E	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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 If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position	Fice different of the home er chain compo home office?	from that o office. nents? If ye If yes, see	f s,	00	37.00 38.00 39.00 40.00
36. 00 V 37. 00 I 38. 00 I 39. 00 I 40. 00 I i 41. 00 E	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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 If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions.	Fice different of the home er chain compo home office?	from that o office. nents? If ye If yes, see	f s, 	00	37.00 38.00 39.00 40.00
36. 00 V 37. 00 I 38. 00 I 39. 00 I 40. 00 I i 41. 00 E F r	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. 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 off line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position neld by the cost report preparer in columns 1, 2, and 3, respectively.	Fice different of the home er chain compo home office?	from that o office. nents? If ye If yes, see	f s, 	00	37.00 38.00 39.00 40.00 41.00
36. 00 V 37. 00 I 38. 00 I 39. 00 I 40. 00 I 41. 00 E 41. 00 E F	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offiche the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	Fice different d of the home er chain compo home office?	from that o office. nents? If ye If yes, see	f s, 2. SEVERS		36.00 37.00 38.00 39.00 40.00 41.00 42.00
36. 00 V 37. 00 I 38. 00 I 39. 00 I 40. 00 I 41. 00 E 42. 00 E 43. 00 E	If line 36 is yes, has a home office cost statement been pr If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offiche the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	Fice different d of the home er chain compo home office?	from that o office. nents? If ye If yes, see	f s, 		37. 00 38. 00 39. 00 40. 00 41. 00

Heal th	Financial Systems JOHNSON MEN	IORI A	L HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-0001	Period:	Worksheet S-2	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
					7/30/2021 11:	08 am
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	MA	ANAGER			41.00
	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
	preparer.					
43.00	Enter the telephone number and email address of the cos	:				43.00
	report preparer in columns 1 and 2, respectively.					

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JOHNSON MEMORI	Provider C	°N· 15_0001	Peri od:	Worksheet S-3	2552-10
1105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC	AL DATA	TTOVIDEI C	CN. 13-0001	From 01/01/2020	Part I	
					To 12/31/2020	Date/Time Pre	
						7/30/2021 11: /P Days /	
						0/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	43	15, 73	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		43	15, 73	0. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	6	2, 19	0. 00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	
14.00	Total (see instructions)		49	17, 93	0.00	0	14.00
15.00	CAH visits					0	
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF	41.00	0		0	0	16.00
17.00	SUBPROVIDER - TRF	41.00	0		0	0	17.00
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	
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)		49				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		0		0		31.00
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		U		32.00
32. UI	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
				1			. 30. 00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JOHNSON MEMORIA AL DATA	Provi der C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	epared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	<u>7/30/2021_11:</u> Equi val ents	<u>08 am</u>
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 644	257	4, 8C	8		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	778 0	1, 176 0				2.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
5.00	Hospital Adults & Peds. Swing Bed NF	1 (1 4	0		0		6.00
7.00 3.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT	1, 644 169	257 0	4, 80			7.00
9.00	CORONARY CARE UNIT	107	0	01	5		9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY		52	61	1		13.0
4.00	Total (see instructions)	1, 813	309	6, 23	4 0.00	568. 18	14.0
15.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF	0	0		0 0.00	0.00	
8.00	SUBPROVIDER						18.0
9.00	SKILLED NURSING FACILITY NURSING FACILITY						19.0
1.00	OTHER LONG TERM CARE						20.0
2.00	HOME HEALTH AGENCY	0	0	3, 58	4 0.00	7.51	
3.00	AMBULATORY SURGICAL CENTER (D. P.)	Ű	0	0,00	0.00	7.01	23.0
4.00	HOSPICE						24.0
4.10	HOSPICE (non-distinct part)			4	8		24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	575.69	
8.00	Observation Bed Days		0	1, 15	7		28.0
9.00	Ambul ance Trips	0			0		29.0
0.00	Employee discount days (see instruction) Employee discount days - IRF				0		30.0
2.00	Labor & delivery days (see instructions)	0	28		0		31.0
32.00 32.01	Total ancillary labor & delivery room outpatient days (see instructions)	0	20		0		32.0
3. 00	LTCH non-covered days	0					33.0
	LTCH site neutral days and discharges	o					33.0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JOHNSON MEMORIAL	Provider C	CN: 15 0001	Period:	u of Form CMS-2 Worksheet S-3	
HUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0001	From 01/01/2020 To 12/31/2020		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
1 00		11.00	12.00	13.00	14.00 27 78	15.00	1 00
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider		0		23 362 0	1, 890	1.00 2.00 3.00
4.00 5.00 6.00 7.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0		4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00	Total (see instructions) CAH visits SUBPROVIDER - IPF	0.00	0	5.	27 78	1, 890	14.00 15.00 16.00
17.00 18.00 19.00 20.00 21.00	SUBPROVI DER – I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY OTHER LONG TERM CARE	0. 00	0		0 0	0	17.00 18.00 19.00 20.00 21.00
22.00 23.00 24.00 24.10 25.00 26.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0.00					22.00 23.00 24.00 24.10 25.00 26.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0.00 0.00					26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

	Financial Systems		JOHNSON MEMORI		N 15 0001 D		u of Form CMS-2	
HUSPI I.	AL WAGE INDEX INFORMATION			Provider CO	IN: 15-0001 Pe Fi Te	eriod: rom 01/01/2020 o 12/31/2020	Date/Time Pre	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	7/30/2021 11: Average Hourly Wage (col. 4 ÷ col. 5)	<u>08 am</u>
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
1.00	Total salaries (see instructions)	200.00	31, 722, 450			964, 811. 00		
2.00	Non-physician anesthetist Part A		0	0	0	0.00		
3.00	Non-physician anesthetist Part B		0	0	0	0.00		
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 2, 158, 885	0 0	0 2, 158, 885	0. 00 20, 843. 32	0. 00 103. 58	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6.00
7.00	services Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7. 01	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7.01
8.00	programs) Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9. 00 10. 00	SNF Excluded area salaries (see	44.00	0 2, 286, 018	0 -24, 651	0 2, 261, 367	0. 00 30, 609. 78	0. 00 73. 88	
	instructions) OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		2, 334, 366	0	2, 334, 366	14, 327. 08	162. 93	11.0
12.00	Contract Labor: Top Level management and other management and administrative		0	0	0	0. 00	0. 00	12.0
13.00	services Contract Labor: Physician-Part		372, 072	0	372, 072	2, 796. 33	133.06	13.0
14. 00	A - Administrative Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.0
	Home office salaries		0	0	0	0.00		14.0
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0 0	0. 00 0. 00		14.0 15.0
16.00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.0
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.0
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.0
	WAGE-RELATED COSTS Wage-related costs (core) (see		8, 023, 976	0	8, 023, 976			17.0
18.00	instructions) Wage-related costs (other)							18.0
19. 00 20. 00	(see instructions) Excluded areas Non-physician anesthetist Part		325, 643 0	0	325, 643 0			19. 0 20. 0
21. 00	A Non-physician anesthetist Part P		0	0	0			21.0
22.00	B Physician Part A - Administrative		0	0	0			22.0
	Physician Part A - Teaching		0	0	0			22.0
23.00 24.00 25.00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		276, 933 0 0	0	276, 933 0 0			23.0 24.0 25.0
25.00 25.50	approved program) Home office wage-related		0	0	0			25.0
25. 50	(core) Rel ated organization		0	0	0			25.5
25. 51	wage-related (core) Home office: Physician Part A		0	0	0			25.5
20. UZ	- Administrative - wage-related (core)		0	0	0			20.0

HOSPITAL WAGE INDEX INFORMATION Provider CON: 15-0001 Period: Tom 01/07/2020 To 12/31/2020 Worksheet S-3 Date/Time Prepared: 01/2020/2111:08 am VINCE Wkst. A Line Number Amount Reported Reclassificat (from Wkst. A-6) Adjusted Salaries in col. 4 Pariation Salaries in col. 4 Pariation Salaries in col. 4 Pariation Salaries in col. 4 Pariation Salaries 25.53 Home office: Physicians Part A - Teaching - wage-related (core) 1.00 2.00 3.00 4.00 5.00 6.00 26.00 Employee Benefits Department contract (see inst.) 5.00 6.00 25.53 1.48, 804.75 21.47 26.00 27.00 Administrative & General contract (see inst.) 6.00 0 0 0 0 0 0 25.53 29.00 Maintenance & Repairs 6.00 0 0 0 0 0 0 0 29.00 20.00 Employee Benefits 5.00 1.963, 422 -3.000 1.960, 422 64,093.23 30.59 28.00 20.00 Administrative & General under contract (see inst.) 0 0 0	Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
Number Reported ion of Salaries (from Wkst. A-6) Salaries (cl. 2 ± col. 3) Related to Salaries in col. 4 Hourly Wage (col. 4 ± col. 5) 25.53 Home office: Physicians Part A - Teaching - wage-related 0 <t< td=""><td></td><td></td><td></td><td></td><td>Provider C</td><td></td><td>Period: From 01/01/2020</td><td>Worksheet S-3 Part II Date/Time Pre</td><td>pared:</td></t<>					Provider C		Period: From 01/01/2020	Worksheet S-3 Part II Date/Time Pre	pared:
Image: constraint of the					i on of Sal ari es	Sal ari es (col . 2 ± col .	Related to Salaries in	Hourly Wage (col. 4 ÷	
25. 53 Home office: Physicians Part A - Teaching - wage-related (core) 0 0 0 0 0 0 0 0 0 0 25. 53			1.00	2.00		1.00	F 00	(00	
- Teaching - wage-rel ated (core) - Teaching - wage-rel ated 0VERHEAD COSTS - DIRECT SALARIES	25 52	Home office, Physicians Part A						6.00	25 52
(core) Covering OVERHEAD OSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 3,196,229 -1,886 3,194,343 148,804.75 21.47 26.00 27.00 Administrative & General 5.00 1,963,422 -3,000 1,960,422 64,093,23 30.59 27.00 28.00 Administrative & General under contract (see inst.) 961,034 0 961,034 9,192.38 104.55 28.00 29.00 Maintenance & Repairs 6.00 0 0 0.00 0.00 29.00 30.00 Operation of Plant 7.00 902,597 0 902,597 38,710.60 23.32 30.00 32.00 Housekeeping 9.00 706,399 0 706,399 51,288.76 13.77 32.00 33.00 Housekeeping under contract (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.03			0	0		0		20.05
OVERHÉAD COSTS - DI RECT SALARI ES 26.00 Employee Benefits Department 4.00 3,196,229 -1,886 3,194,343 148,804.75 21.47 26.00 27.00 Admin istrative & General 5.00 1,963,422 -3,000 1,960,422 64,093.23 30.59 27.00 28.00 Admin istrative & General under contract (see inst.) 961,034 0 961,034 9,192.38 104.55 28.00 29.00 Mai ntenance & Repairs 6.00 0 0 0.00 0.00 29.00 30.00 Operation of Plant 7.00 902,597 0 902,597 38,710.60 23.32 30.00 31.00 Laundry & Linen Service 8.00 104,011 0 104,011 7,026.60 14.80 31.00 32.00 Housekeeping 9.00 706,399 0									
26.00 Employee Benefits Department 4.00 3,196,229 -1,886 3,194,343 148,804.75 21.47 26.00 27.00 Administrative & General 5.00 1,963,422 -3,000 1,960,422 64,093.23 30.59 27.00 28.00 Administrative & General under contract (see inst.) 961,034 0 961,034 9,192.38 104.55 28.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 902,597 0 902,597 38,710.60 23.32 30.00 32.00 Housekeeping 9.00 706,399 0			ES		<u> </u>	1			
27.00 Administrative & General under contract (see inst.) 5.00 1,963,422 -3,000 1,960,422 64,093.23 30.59 27.00 28.00 Administrative & General under contract (see inst.) 961,034 0 961,034 9,192.38 104.55 28.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 902,597 0 902,597 38,710.60 23.32 30.00 31.00 Laundry & Linen Service 8.00 104,011 0 104,011 7,026.60 14.80 31.00 32.00 Housekeeping 9.00 706,399 0 0 0 0.00 0.00 33.00 33.00 Housekeeping under contract (see instructions) 0 0 0 0 0 0 0 0.00 33.00 34.00 Dietary 10.00 687,669 -408,475 279,194 8,844.73 31.57 34.00 35.00 Dietary 11.00 0 408,475 30,683.00 13.31 36.00	26.00			3, 196, 229	-1.886	3, 194, 34	3 148, 804, 75	21.47	26.00
28.00 Administrative & General under contract (see inst.) 961,034 961,034 9,192.38 104.55 28.00 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 902,597 0 902,597 38,710.60 23.32 30.00 31.00 Laundry & Linen Service 8.00 104,011 0 104,011 7,026.60 14.80 31.00 32.00 Housekeeping 9.00 706,399 0 0 0 0 0.00 33.00 34.00 Dietary 10.00 687,669 -408,475 279,194 8,844.73 31.57 34.00 35.00 Dietary 10.00 687,669 -408,475 279,194 8,844.73 31.57 34.00 36.00 Cafteria 11.00 0 408,475 408,475 30,683.00 1.3.31 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 37.00 38.00 Nursing Administration 13.00<									
contract (see inst.) contract (see inst.) contract (see inst.) contract (see inst.) 29.00 Maintenance & Repairs 6.00 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 902,597 0 902,597 38,710.60 23.32 30.00 31.00 Laundry & Linen Service 8.00 104,011 0 104,011 7,026.60 11.80 31.00 32.00 Housekeeping 0.00 706,399 0 706,399 51,288.76 13.77 32.00 33.00 Housekeeping under contract (see instructions) 0 0 0 0 0.00 0.00 33.00 34.00 Dietary under contract (see instructions) 10.00 687,669 -408,475 279,194 8,844.73 31.57 34.00 35.00 Dietary under contract (see instructions) 0 0 0 0.00 0.00 0.00 0.00 0.00 33.00 36.00 Carfeteria 11.00 0 </td <td>28.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	28.00								
29.00 Maintenance & Repairs 6.00 0 0 0 0.00 29.00 30.00 Operation of Plant 7.00 902,597 0 902,597 38,710.60 23.32 30.00 31.00 Laundry & Linen Service 8.00 104,011 0 104,011 7,026.60 14.80 31.00 32.00 Housekeeping 9.00 706,399 0 706,399 51,288.76 13.77 32.00 33.00 Housekeeping under contract 0 0 0 0.00 30.00 34.00 Dietary under contract (see 0 0 0 0.00 30.00 35.00 Dietary under contract (see 0 0 0 0 0.00 30.00 36.00 Cafeteria 11.00 0 408,475 408,475 30,683.00 13.31 36.00 38.00 Nursing Administration 13.00 1,258,231 -8,316 1,249,915 23,054.48 54.22 38.00 39.00 Central Services and Supply 14.00 73,918 73,918 4									
30.00 Operation of Plant 7.00 902, 597 0 902, 597 38, 710.60 23.32 30.00 31.00 Laundry & Linen Service 8.00 104, 011 0 104, 011 7, 026.60 14.80 31.00 32.00 Housekeeping 9.00 706, 399 0 706, 399 51, 288.76 13.77 32.00 33.00 Housekeeping under contract (see instructions) 0 0 0 0 0.00 0.00 0.00 33.00 34.00 Dietary 10.00 687, 669 -408, 475 279, 194 8, 844.73 31.57 34.00 35.00 Dietary under contract (see instructions) 0 0 0 0 0.00 0.00 35.00 36.00 Cafeteria 11.00 0 408, 475 408, 475 30, 683.00 13.31 36.00 38.00 Nursing Administration 13.00 1, 258, 231 -8, 316 1, 249, 915 23, 054.48 54.22 38.00 39.00 Central Services and Supply 14.00 73, 918 0 73, 918 4, 132.83 <td< td=""><td>29.00</td><td></td><td>6.00</td><td>0</td><td>0</td><td></td><td>0 0.00</td><td>0.00</td><td>29.00</td></td<>	29.00		6.00	0	0		0 0.00	0.00	29.00
32.00 Housekeeping 9.00 706,399 0 706,399 51,288.76 13.77 32.00 33.00 Housekeeping under contract (see instructions) 0 0 0 0 0.00 33.00 34.00 Dietary 10.00 687,669 -408,475 279,194 8,844.73 31.57 34.00 35.00 Dietary under contract (see instructions) 0 0 0 0 0.00 0.00 35.00 36.00 Cafeteria 11.00 0 408,475 408,475 30,683.00 13.31 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursi ng Administration 13.00 1,258,231 -8,316 1,249,915 23,054.48 54.22 38.00 39.00 Central Services and Supply 14.00 73,918 0 73,918 4,132.83 17.89 39.00 40.00 Pharmacy 15.00 701,786 0 701,786 16,505.47 42.52 40.00 41.00 Records & Medical Records	30.00	Operation of Plant	7.00	902, 597	0	902, 59	38, 710. 60	23. 32	30.00
33.00 Housekeeping under contract (see instructions) 0	31.00	Laundry & Linen Service	8.00	104, 011	0	104, 01	1 7,026.60	14.80	31.00
(see instructions) 10.00 687,669 -408,475 279,194 8,844.73 31.57 34.00 35.00 Dietary under contract (see instructions) 0 <td>32.00</td> <td>Housekeepi ng</td> <td>9.00</td> <td>706, 399</td> <td>0</td> <td>706, 39</td> <td>9 51, 288. 76</td> <td>13. 77</td> <td>32.00</td>	32.00	Housekeepi ng	9.00	706, 399	0	706, 39	9 51, 288. 76	13. 77	32.00
34.00 Dietary 10.00 687,669 -408,475 279,194 8,844.73 31.57 34.00 35.00 Dietary under contract (see instructions) 0 0 0 0 0.00 35.00 36.00 Cafeteria 11.00 0 408,475 408,475 30,683.00 13.31 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursi ng Administration 13.00 1,258,231 -8,316 1,249,915 23,054.48 54.22 38.00 39.00 Central Services and Supply 14.00 73,918 0 73,918 4,132.83 17.89 39.00 40.00 Pharmacy 15.00 701,786 0 701,786 16,505.47 42.52 40.00 41.00 Medical Records & Medical 16.00 462,639 0 462,639 21,642.44 21.38 41.00 Records Li brary 17.00 0 0 0 0.00 0.00 0.00 0.00 0.00 42.00	33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00
35.00 Dietary under contract (see instructions) 0 0 0 0 0.00 35.00 36.00 Cafeteria 11.00 0 408,475 408,475 30,683.00 13.31 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,258,231 -8,316 1,249,915 23,054.48 54.22 38.00 39.00 Central Services and Supply 14.00 73,918 0 73,918 4,132.83 17.89 39.00 40.00 Pharmacy 15.00 701,786 0 701,786 16,505.47 42.52 40.00 41.00 Records & Medical Records Library 16.00 462,639 0 462,639 21,642.44 21.38 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 0.00 42.00		(see instructions)							
instructions)	34.00		10.00	687, 669	-408, 475	279, 19	4 8, 844. 73	31.57	34.00
36.00 Cafeteria 11.00 0 408,475 408,475 30,683.00 13.31 36.00 37.00 Maintenance of Personnel 12.00 0 0 0 0.00 0.00 37.00 38.00 Nursi ng Administrati on 13.00 1,258,231 -8,316 1,249,915 23,054.48 54.22 38.00 39.00 Central Services and Supply 14.00 73,918 0 73,918 4,132.83 17.89 39.00 40.00 Pharmacy 15.00 701,786 0 701,786 16,505.47 42.52 40.00 41.00 Records Library 16.00 462,639 0 462,639 21,642.44 21.38 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00	35.00	Dietary under contract (see		0	0		0 0.00	0.00	35.00
37.00 Maintenance of Personnel 12.00 0 0 0 0.00 37.00 38.00 Nursing Administration 13.00 1,258,231 -8,316 1,249,915 23,054.48 54.22 38.00 39.00 Central Services and Supply 14.00 73,918 0 73,918 4,132.83 17.89 39.00 40.00 Pharmacy 15.00 701,786 0 701,786 16,505.47 42.52 40.00 41.00 Records Library 16.00 462,639 0 462,639 21,642.44 21.38 41.00 42.00 Social Service 17.00 0 0 0 0.00 0.00 42.00		instructions)							
38.00 Nursi ng Admi ni strati on 13.00 1,258,231 -8,316 1,249,915 23,054.48 54.22 38.00 39.00 Central Services and Supply 14.00 73,918 0 73,918 4,132.83 17.89 39.00 40.00 Pharmacy 15.00 701,786 0 701,786 16,505.47 42.52 40.00 41.00 Medi cal Records & Medi cal Records & Medi cal Li brary 16.00 462,639 0 462,639 21,642.44 21.38 41.00 42.00 Soci al Service 17.00 0 0 0 0.00 0.00 42.00	36.00	Cafeteri a	11.00	0	408, 475	408, 47	5 30, 683. 00	13. 31	36.00
39.00 Central Services and Supply 14.00 73,918 0 73,918 4,132.83 17.89 39.00 40.00 Pharmacy 15.00 701,786 0 701,786 16,505.47 42.52 40.00 41.00 Medical Records & Medical 16.00 462,639 0 462,639 21,642.44 21.38 41.00 42.00 Social Service 17.00 0 0 0 0.00 42.00	37.00	Maintenance of Personnel		0	0		0 0.00	0.00	37.00
40. 00 Pharmacy 15. 00 701, 786 0 701, 786 16, 505. 47 42. 52 40. 00 41. 00 Medi cal Records & Medi cal Records & Medi cal Records Library 16. 00 462, 639 0 462, 639 21, 642. 44 21. 38 41. 00 42. 00 Soci al Service 17. 00 0 0 0 0.00 42. 00	38.00	Nursing Administration	13.00	1, 258, 231	-8, 316	1, 249, 91	5 23, 054. 48	54.22	38.00
41. 00 Medi cal Records & Medi cal 16. 00 462, 639 0 462, 639 21, 642. 44 21. 38 41. 00 Records Library 42. 00 Soci al Service 17. 00 0 0 0. 00 0. 00 42. 00	39.00	Central Services and Supply	14.00	73, 918	0	73, 91	8 4, 132. 83	17.89	39.00
Records Library 17.00 0 0 0 0.00 42.00	40.00		15.00	701, 786	0	701, 78	6 16, 505. 47	42.52	40.00
42.00 Social Service 17.00 0 0 0 0.00 42.00	41.00	Medical Records & Medical	16.00	462, 639	0	462, 63	9 21, 642. 44	21.38	41.00
43.00 Other General Service 18.00 O O O 0.00 43.00				0	0				
	43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems		JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part III Date/Time Pre 7/30/2021 11:	pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		30, 524, 599	-45, 353	30, 479, 24	6 953, 160. 06	31. 98	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 286, 018	-24, 651	2, 261, 36	7 30, 609. 78	73.88	2.00
	instructions)							
3.00	Subtotal salaries (line 1		28, 238, 581	-20, 702	28, 217, 87	9 922, 550. 28	30. 59	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2, 706, 438	0	2, 706, 43	8 17, 123. 41	158.05	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		8, 023, 976	0	8, 023, 97	6 0.00	28.44	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		38, 968, 995	-20, 702	38, 948, 29	3 939, 673. 69	41.45	6.00
7.00	Total overhead cost (see		11,017,935			3 423, 979. 27	25.96	7.00
	instructions)							
	· · · · · ·	·			1			

Heal th	Financial Systems	JOHNSON MEMORIAL	- HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provider CCN: 15-0001	Period: From 01/01/2020	Worksheet S-3	pared:
					Amount Reported	
					1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				233, 454	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contri	buti on			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see in				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)				
5.00	401K/TSA Plan Administration fees	4 <i>i</i>			0	5.00
6.00	Legal /Accounting/Management Fees-Pension PL	an			0	6.00
7.00	Employee Managed Care Program Administratio	n Fees			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Health Insurance (Purchased or Self Funded)				0	8.00
8.01	Health Insurance (Self Funded without a Thi	rd Party Administ	rator)		0	8.01
8.02	Health Insurance (Self Funded with a Third	Party Administrate	or)		4, 910, 421	8.02
8.03	Health Insurance (Purchased)				0	8.03
9.00	Prescription Drug Plan				0	9.00
10.00	Dental, Hearing and Vision Plan				0	10.00
11.00	Life Insurance (If employee is owner or ben	efi ci ary)			54, 083	11.00
12.00	Accident Insurance (If employee is owner or	benefi ci ary)			0	12.00
13.00	Disability Insurance (If employee is owner				101, 173	13.00
14.00	Long-Term Care Insurance (If employee is ow	ner or beneficiar	y)		0	14.00
15.00	'Workers' Compensation Insurance				237, 738	15.00
16.00	Retirement Health Care Cost (Only current y	ear, not the extra	aordinary accrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)					
	TAXES					
	FICA-Employers Portion Only				2, 963, 145	
18.00	Medicare Taxes - Employers Portion Only				0	18.00
19.00	Unemployment Insurance				100, 344	
20.00	State or Federal Unemployment Taxes				0	20.00
	OTHER					
	Executive Deferred Compensation (Other Than instructions))	Retirement Cost I	Reported on lines 1 thro	ugh 4 above. (see	0	21.00
	Day Care Cost and Allowances				0	22.00
23.00	Tuition Reimbursement				26, 194	
24.00	Total Wage Related cost (Sum of lines 1 -23)			8, 626, 552	24.00
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0001	Period: From 01/01/2020	Worksheet S-3 Part V	
				To 12/31/2020	Date/Time Pre 7/30/2021 11:	
	Cost Center Description			Contract Labor	Benefit Cost	
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi	fication:				
1.00	Total facility's contract labor and benefit	cost		2, 334, 366	8, 626, 552	1.00
2.00	Hospi tal			2, 334, 366	8, 626, 552	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA			0	0	
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		Inlie	u of Form CMS-:	2552-10
HOME HEALTH AGENCY STATI STICAL DATA		Provi der C		Period: From 01/01/2020	Worksheet S-4	
		Component		o 12/31/2020	Date/Time Pre 7/30/2021 11:	
				Home Health Agency I	PPS	
		- I	I		00	
0.00 County				1.	00	0.00
	Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5. 00	
HOME HEALTH AGENCY STATISTICAL DATA	1					
 1.00 Home Health Aide Hours 2.00 Unduplicated Census Count (see instructions) 	0.00			-		
		121100		loyees (Full Ti		2100
			C+-66	Contract	Tatal	
	Enter the numb your normal	work week	Staff	Contract	Total	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	()	1.00	2.00	3.00	
3.00 Administrator and Assistant Administrator(s)		40.00	1.21	0.00	1. 21	3.00
4.00 Director(s) and Assistant Director(s) 5.00 Other Administrative Personnel			0.06			
6.00 Direct Nursing Service			2.35			
7.00 Nursing Supervisor			0.00			•
8.00 Physical Therapy Service 9.00 Physical Therapy Supervisor			1.04		1. 04 0. 00	
10.00 Occupational Therapy Service			0.81			
11.00 Occupational Therapy Supervisor 12.00 Speech Pathology Service			0.00			
13.00 Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00 Medical Social Service 15.00 Medical Social Service Supervisor			0.00			
16.00 Home Heal th Ai de			0.81			
17.00 Home Heal th Ai de Supervi sor18.00 Other (speci fy)			0.00			
HOME HEALTH AGENCY CBSA CODES				0.00	0.00	18.00
19.00 Enter in column 1 the number of CBSAs where you provided services during the cost			1			19.00
reporting period.						
20.00 List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20	1		18020			20.00
contains the first code).						
		pisodes With Outliers	LUPA Epi sodes	PEP Only	Total (cols.	
	Outliers			Epi sodes	1-4)	
PPS ACTI VI TY DATA	1.00	2.00	3.00	4.00	5.00	
21.00 Skilled Nursing Visits	763					
22.00 Skilled Nursing Visit Charges 23.00 Physical Therapy Visits	184, 089 449			2,880 0	190, 574 455	
24.00 Physical Therapy Visit Charges	116, 740	0		0	118, 300	24.00
25.00 Occupational Therapy Visits 26.00 Occupational Therapy Visit Charges	240 62, 400				241 62, 660	
27.00 Speech Pathology Visits	0	0	C	0	0	27.00
28.00 Speech Pathology Visit Charges 29.00 Medical Social Service Visits	0	-		-	0	
30.00 Medical Social Service Visit Charges	2, 240	0	31	0	2, 271	30.00
31.00 Home Health Aide Visits 32.00 Home Health Aide Visit Charges	0				0	1
33.00 Total visits (sum of lines 21, 23, 25, 27,	1, 452			-	1, 486	
29, and 31) 34.00 Other Charges	0	l o	, c	0	0	34.00
35.00 Total Charges (sum of lines 22, 24, 26, 28,	365, 469	-	5, 456	-		
30, 32, and 34) 36.00 Total Number of Episodes (standard/non	0		C	0	0	36.00
outlier) 37.00 Total Number of Outlier Episodes		C		0	0	37.00
38.00 Total Non-Routi ne Medical Supply Charges	0					

Heal th	Financial Systems JOHNSON MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
		Provider CC	N: 15-0001	Peri od:	Worksheet S-1	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/30/2021 11:	
					170072021 11	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 colum	n 8)	0. 222636	1.00
	Medicaid (see instructions for each line)				1	
2.00	Net revenue from Medicaid				2, 884, 655	
3.00	Did you receive DSH or supplemental payments from Medicaid?			-: -!?	Y	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplemer If line 4 is no, then enter DSH and/or supplemental payments f				Y O	4.00 5.00
6.00	Medicaid charges		u		36, 244, 794	6.00
7.00	Medicaid cost (line 1 times line 6)				8,069,396	
8.00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of li	nes 2 and 5: if	5, 184, 741	8.00
	< zero then enter zero)				.,	
	Children's Health Insurance Program (CHIP) (see instructions f	or each lin	e)			
9.00	Net revenue from stand-alone CHIP				0	
	Stand-al one CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)	(1)			0	
12.00	Difference between net revenue and costs for stand-alone CHIP	(IINE II MI	nus line 9;	IT < Zero then	0	12.00
	enter zero) Other state or local government indigent care program (see ins	tructions fo	or each line)		
13.00	Net revenue from state or local indigent care program (Not inc				0	13.00
14.00	Charges for patients covered under state or local indigent car				0	•
	10)	1 3 (
	State or local indigent care program cost (line 1 times line 1				0	
16.00	Difference between net revenue and costs for state or local ir	idigent care	program (li	ne 15 minus line	• 0	16.00
	13; if < zero then enter zero)		- /			
	Grants, donations and total unreimbursed cost for Medicaid, CH instructions for each line)	IP and state	e/rocar rndr	gent care progra	ams (see	
17.00	Private grants, donations, or endowment income restricted to f	unding char	ity care		0	17.00
	Government grants, appropriations or transfers for support of				0	
	Total unreimbursed cost for Medicaid , CHIP and state and loca			s (sum of lines	5, 184, 741	
	8, 12 and 16)			-		
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entire fa	cility	5, 759, 33	6 1, 155, 702	6, 915, 038	20 00
20.00	(see instructions)	lorrity	0,107,00	1,100,702	0, 710, 000	20.00
21.00	Cost of patients approved for charity care and uninsured disco	unts (see	1, 282, 23	6 1, 155, 702	2, 437, 938	21.00
	instructions)					
22.00	Payments received from patients for amounts previously writter	off as		0 0	0	22.00
	chari ty care		1 000 00	4 455 300	0 407 000	
23.00	Cost of charity care (line 21 minus line 22)		1, 282, 23	6 1, 155, 702	2, 437, 938	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	nt days bey	ond a Length	of stay limit	N 1.00	24.00
211.00	imposed on patients covered by Medicaid or other indigent care		ond a rongen	or oray rimit		2
25.00	If line 24 is yes, enter the charges for patient days beyond t		care progra	m's length of	0	25.00
	stay limit	-		-		
26.00	Total bad debt expense for the entire hospital complex (see in				8, 084, 664	1
27.00	Medicare reimbursable bad debts for the entire hospital comple	•			52, 914	
27.01	Medicare allowable bad debts for the entire hospital complex (see instruc	tions)		81,406	
28.00 29.00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt ex	nonco (coo	i petructi ope	`	8, 003, 258 1, 810, 305	
29.00 30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	hense (see)	4, 248, 243	
	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			9, 432, 984	
000					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 51.00

Cost					rom 01/01/2020		
Cost (T		Date/Time Pre 7/30/2021 11:	
	Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	VICE COST CENTERS AP REL COSTS-BLDG & FIXT		2, 673, 716	2, 673, 716	ol	2, 673, 716	1.00
	EL COSTS-MUBLE EQUIP		4, 422, 288	4, 422, 288	0	4, 422, 288	2.00
4.00 00400 EMPLOY	YEE BENEFITS DEPARTMENT	326, 950	7, 327, 775	7, 654, 725	65, 166	7, 719, 891	4.00
4.01 00401 COMMUN		89, 875	266, 475	356, 350	-39	356, 311	4.01
4. 02 00402 DATA F 4. 03 00403 MATERI	PROCESSING ALS MANAGEMENT	739, 964	2, 310, 985	3, 050, 949 399, 226	-89	3,050,860	4.02
4. 03 00403 MATERT 4. 04 00404 ADMI TT		364, 737 791, 259	34, 489 8, 327	399, 220 799, 586	-2, 715 -1, 233	396, 511 798, 353	4.03
	NT ACCOUNTING	883, 444	610, 181	1, 493, 625	-149	1, 493, 476	4.05
	STRATIVE & GENERAL	1, 963, 422	1, 909, 035	3, 872, 457	-68, 755	3, 803, 702	5.00
	TION OF PLANT	902, 597	2, 205, 177	3, 107, 774	-306	3, 107, 468	7.00
8.00 00800 LAUNDR 9.00 00900 HOUSER	RY & LINEN SERVICE	104, 011 706, 399	95, 229 109, 814	199, 240 816, 213	-369 -10, 152	198, 871 806, 061	8.00 9.00
10. 00 01000 DI ETAF		687,669	318, 054	1, 005, 723	-597, 767	407, 956	
11.00 01100 CAFETE		0	0	0	597, 399	597, 399	11.00
	NG ADMI NI STRATI ON	1, 258, 231	173, 833	1, 432, 064	-12, 959	1, 419, 105	
	AL SERVICES & SUPPLY	73, 918	129, 425	203, 343	-42, 854	160, 489	14.00
15.00 01500 PHARMA	ACY AL RECORDS & LIBRARY	701, 786 462, 639	5, 100, 579 138, 741	5, 802, 365 601, 380	-4, 194, 755 -83	1, 607, 610 601, 297	
	OUTINE SERVICE COST CENTERS	402,039	130, 741	001, 380	-03	001,297	10.00
	S & PEDIATRICS	5, 616, 790	1, 036, 825	6, 653, 615	-557, 512	6, 096, 103	30.00
	SIVE CARE UNIT	1, 200, 518	126, 758	1, 327, 276	-38, 589	1, 288, 687	31.00
41.00 04100 SUBPRO		0	141	141	0	141	41.00
43.00 04300 NURSER	ERVICE COST CENTERS	0	0	0	409, 134	409, 134	43.00
50. 00 05000 OPERAT		1, 804, 908	597, 748	2, 402, 656	-262, 103	2, 140, 553	50.00
53.00 05300 ANESTH		0	23, 521	23, 521	38, 648	62, 169	
	_OGY-DI AGNOSTI C	1, 972, 415	940, 811	2, 913, 226	-90, 856	2, 822, 370	
60.00 06000 LABORA	ATORY RATORY THERAPY	2, 109, 124	3, 102, 246	5, 211, 370	-177, 690	5,033,680	60.00 65.00
66. 00 06600 PHYSI (1, 070, 661 773, 562	240, 982 25, 384	1, 311, 643 798, 946	-47, 885 -17, 044	1, 263, 758 781, 902	66.00
	ATIONAL THERAPY	273, 289	451	273, 740	0	273, 740	
68.00 06800 SPEECH	H PATHOLOGY	134, 167	18, 173	152, 340	0	152, 340	68.00
69.00 06900 ELECTR		275, 640	110, 175	385, 815	-7, 317	378, 498	69.00
	ROENCEPHALOGRAPHY AL SUPPLIES CHARGED TO PATIENTS	0	55, 021 3, 318, 412	55, 021 3, 318, 412	466– 1, 144, 078–	54, 555 2, 174, 334	
	DEV. CHARGED TO PATIENTS	0	3, 310, 412	3, 310, 412	2, 528, 540	2, 174, 334 2, 528, 540	
73.00 07300 DRUGS	CHARGED TO PATIENTS	0	0	0	4, 247, 053	4, 247, 053	
76.00 03020 ONCOLO	DGY	327, 877	212, 521	540, 398	-8, 434	531, 964	
		134, 820	125, 768	260, 588	-7, 144	253, 444	76.97
90.00 09000 CLINI	SERVICE COST CENTERS	736, 351	1, 714, 143	2, 450, 494	-417, 512	2, 032, 982	90 00
91.00 09100 EMERGE		2,949,409	1, 911, 712		-124, 068	4, 737, 053	
	ATION BEDS (NON-DISTINCT PART)						92.00
	URSABLE COST CENTERS	574.004	100 101	(70.470	0.007	((0.454	101 00
101.00 10100 HOME H	POSE COST CENTERS	574, 994	103, 184	678, 178	-9, 027	669, 151	101.00
113. 00 11300 I NTERE			0	0	0	0	113.00
	TALS (SUM OF LINES 1 through 117)	30, 011, 426	41, 498, 099	71, 509, 525	43, 990	71, 553, 515	
	ABLE COST CENTERS						1
	FLOWER, COFFEE SHOP & CANTEEN	40, 809	18, 186	58, 995	-173	58, 822	
192. 00 19200 PHYSIC 192. 01 19201 SOUTH	CLANS' PRIVATE OFFICES	1, 550, 468 0	498, 860 0	2, 049, 328 0	-38, 812 0	2, 010, 516	192.00 192.01
192. 02 19202 WEST (0	0	0	0		192.01
192. 03 19203 DI ABET		70, 564	6, 547	77, 111	-5, 004	72, 107	
193.00 19300 NONPAI		0	0	0	0	0	193.00
193.01 19301 ADULT/		0	0	0	0		193.01
	CLAN OFFICE BUILDING	0	0	0	0		193. 02 193. 03
193. 03 19303 OPTI FA 194. 00 07950 PARTNE		1, 183	0 19, 070	0 20, 253	_1	20, 252	
194. 01 07951 TRAFAL		0	0	20, 200	0		194.00
194. 02 07952 EDI NBL		0	0	0	Ō	0	194.02
194. 03 07953 JAI L		48, 000	0	48,000	0	48,000	
194. 04 07954 ATHLET		21 722 450	12 040 742	0	0		194.04
200. 00 TOTAL	(SUM OF LINES 118 through 199)	31, 722, 450	42, 040, 762	73, 763, 212	U	73, 763, 212	∠UU. UU

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JOHNSON MEMORI	AL HUSPITAL Provider CC	N: 15-0001	Period:	of Form CMS Worksheet A	-2552-10
					From 01/01/2020	Date/Time Pr	repared:
	Cost Center Description	Adjustments	Net Expenses			7/30/2021 11	1:08 am
	Cost center bescription	(See A-8)	For				
		· · ·	Allocation				
		6.00	7.00				_
	GENERAL SERVICE COST CENTERS	75 400	2 740 215				1 1 00
	00100 NEW CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP	75, 499 0	2, 749, 215 4, 422, 288				1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	-7, 716	7, 712, 175				4.00
	00401 COMMUNI CATI ONS	-36, 222	320, 089				4.01
	00402 DATA PROCESSI NG	0	3, 050, 860				4.02
. 03	00403 MATERIALS MANAGEMENT	-5,744	390, 767				4.03
	00404 ADMI TTI NG	0	798, 353				4.04
	00405 PATIENT ACCOUNTING	0	1, 493, 476				4.0
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-5, 092, 627	-1, 288, 925				5.00
	00800 LAUNDRY & LINEN SERVICE	-53, 578 0	3, 053, 890 198, 871				8.00
	00900 HOUSEKEEPI NG	0	806, 061				9.00
	01000 DI ETARY	0	407, 956				10.00
1.00	01100 CAFETERI A	-231, 605	365, 794				11.00
	01300 NURSI NG ADMI NI STRATI ON	5, 068	1, 424, 173				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	160, 489				14.00
	01500 PHARMACY	-377	1, 607, 233				15.00
	01600 MEDICAL RECORDS & LIBRARY	-52, 412	548, 885				16.00
	03000 ADULTS & PEDIATRICS	-1, 753, 223	4, 342, 880				30.00
	03100 I NTENSI VE CARE UNI T	-45, 454	1, 243, 233				31.00
	04100 SUBPROVI DER – I RF	0	141				41.00
3.00	04300 NURSERY	0	409, 134				43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	-46,000					50.00
	05300 ANESTHESI OLOGY	-9, 847	52, 322				53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0 -817	2, 822, 370 5, 032, 863				54.00 60.00
	06500 RESPI RATORY THERAPY	-38, 625	1, 225, 133				65.00
	06600 PHYSI CAL THERAPY	00,020	781, 902				66.00
7.00	06700 OCCUPATI ONAL THERAPY	0	273, 740				67.00
	06800 SPEECH PATHOLOGY	-17, 763	134, 577				68.00
	06900 ELECTROCARDI OLOGY	-67, 772	310, 726				69.00
	07000 ELECTROENCEPHALOGRAPHY	-50, 624	3, 931				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 174, 334 2, 528, 540				71.00
	07300 DRUGS CHARGED TO PATIENTS	0	4, 247, 053				73.00
	03020 ONCOLOGY	-97, 304	434, 660				76.00
6.97	07697 CARDI AC REHABI LI TATI ON	-85, 950	167, 494				76.9
	DUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	-482, 249					90.00
	09100 EMERGENCY	-2, 666, 958	2, 070, 095				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	10100 HOME HEALTH AGENCY	0	669, 151				101.00
	SPECIAL PURPOSE COST CENTERS	-					
13.00	11300 INTEREST EXPENSE	0	0				113.00
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	-10, 762, 300	60, 791, 215				118.00
	NONREI MBURSABLE COST CENTERS		50,000				-
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	58, 822				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 SOUTH CLINI C	0	2, 010, 516 0				192.00 192.01
	19202 WEST CLINIC	0	0				192.02
	19203 DI ABETES CENTER	0	72, 107				192.02
	19300 NONPAI D WORKERS	0	0				193.00
	19301 ADULT/CHILD CARE	0	0				193.0
	19302 PHYSICIAN OFFICE BUILDING	0	0				193.0
	19303 OPTI FAST/FOUNDATI ON	0	0				193.0
	07950 PARTNERSHI P HFC	0	20, 252				194.00
	07951 TRAFALGAR CLINIC	0	0				194.0
	07952 EDI NBURGH 07953 JAI L	0	0 48, 000				194.02 194.03
	07953 JATE 07954 ATHLETI C TRAI NERS	0	48,000				194.03
	TOTAL (SUM OF LINES 118 through 199)	-10, 762, 300					200.00

	Financial Systems SIFICATIONS		JOHNSON MEMORIA	AL HOSPITAL Provider CCN: 15-0001		
					From 01/01/2020 To 12/31/2020 Date/Time Pr	repared:
		Increases			7/30/2021 11	1:08 am
	Cost Center	Line #	Salary	Other		
	2.00 A - NURSERY RECLASS	3.00	4.00	5.00		
1.00	NURSERY	43.00	375, 831	33, 303		1.00
	TOTALS		375, 831	33, 303		
	B - IMPLANTABLE DEVICE RECLASS	5		-		
1.00	IMPL. DEV. CHARGED TO	72.00	0	2, 528, 540		1.00
	PATIENT	+				
	TOTALS C - CAFETERIA RECLASS		0	2, 528, 540		-
1.00	CAFETERIA	11.00	408, 475	188, 924		1.00
1.00	TOTALS		408, 475	188, 924		1.00
	D - SHORT TERM DI SABILITY RECI	ASS		÷.		
1.00	DATA PROCESSING	4. 02	0	1, 886		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	3,000		2.00
3.00	NURSING ADMINISTRATION	13.00	0	8, 316		3.00
4.00 5.00	PHYSICIANS' PRIVATE OFFICES	50.00 192.00	0	7, 500 24, 651		4.00
5.00	TOTALS		— — — o	45, 353		5.00
	E - EMPLOYEE WELLNESS RECLASS	I		10,000		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	65, 215		1.00
	TOTALS		0	65, 215		
1 00	F - PART A RECLASS	22.25		5.000		
1.00	ADULTS & PEDIATRICS	30.00	0	5,000		1.00
2.00	ANESTHESI OLOGY	<u>53.00</u>	<u>o</u>	38,812 43,812		2.00
	G - MEDICAL SUPPLIES RECLASS			+3, 012		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 384, 462		1.00
	PATIENTS					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00 6.00		0.00 0.00	0	0		5.00
7.00		0.00	0	0		7.00
8.00		0.00	Ő	Ö		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00 15.00		0. 00 0. 00	0	0		14.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00 23.00		0. 00 0. 00	0	0		22.00 23.00
23.00		0.00	0	0		23.00
25.00		0.00	0	Ö		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00 33.00		0. 00 0. 00	0	0		32.00 33.00
55.00	TOTALS		0	1, 384, 462		33.00
	H - DRUGS CHARGEABLE RECLASS			, ,		
1.00	LABORATORY	60.00	0	38, 514		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	4, 247, 053		2.00
3.00		0.00	0	O		3.00
4.00 5.00		0. 00 0. 00	0	0		4.00
5.00 6.00		0.00	0	0		5.00
8.00 7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	Ő	0		10.00
11.00		0.00	О	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00

Health Financial Systems		JOHNSON MEMOR	I AL_HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLASSI FI CATI ONS			Provider (CCN: 15-0001	Period: From 01/01/2020	Worksheet A-	6
						Date/Time Pr 7/30/2021 11	epared: :08 am
	Increases						
Cost Center	Line #	Sal ary	0ther				
2.00	3.00	4.00	5.00				
TOTALS		0	4, 285, 567				
500.00 Grand Total: Increases		784, 306	8, 575, 176				500.00

	Financial Systems		JOHNSON MEMORI		CCN: 15-0001	In Lie Period:	eu of Form CMS-2552-10 Worksheet A-6
RECENS						From 01/01/2020 To 12/31/2020	Date/Time Prepared:
		Decreases					7/30/2021 11:08 am
	Cost Center	Li ne # 7.00	Salary	Other	Wkst. A-7 Ref	· 	
	6.00 A - NURSERY RECLASS	7.00	8.00	9.00	10.00		
1.00	ADULTS & PEDIATRICS	30.00	375, 831	33, 303	3	0	1.00
	TOTALS		375, 831	33, 303	6		
1.00	B - IMPLANTABLE DEVICE RECLAS MEDICAL SUPPLIES CHARGED TO	SS 71.00	0	2, 528, 540		0	1.00
1.00	PATIENTS	71.00	0	2, 528, 540	1	0	1.00
	TOTALS		— — —	2, 528, 540)		
	C - CAFETERIA RECLASS				1	-	
1.00	DI ETARY	<u> </u>	408, 475	<u>188, 9</u> 24 		<u>o</u>	1.00
	D - SHORT TERM DI SABI LI TY REC	CLASS	408, 475	100, 924	*		
1.00	DATA PROCESSI NG	4. 02	1, 886	0)	0	1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	3, 000	0		0	2.00
3.00	NURSING ADMINISTRATION	13.00	8, 316	0		0	3.00
4.00 5.00	OPERATING ROOM PHYSICIANS' PRIVATE OFFICES	50.00 192.00	7, 500 24, 651	0		0	4.00 5.00
0.00	TOTALS		45, 353				0.00
	E - EMPLOYEE WELLNESS RECLASS	S					
1.00	ADMI NI STRATI VE & GENERAL		º_	6 <u>5, 2</u> 15		Q	1.00
	TOTALS F - PART A RECLASS	<u> </u>	0	65, 215			
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	38, 812	2	0	1.00
2.00	DI ABETES CENTER	192. 03	<u>0</u>	5,000		0	2.00
	TOTALS		0	43, 812			
1 00	G - MEDICAL SUPPLIES RECLASS	4.00	0	40		0	1.00
1.00 2.00	EMPLOYEE BENEFITS DEPARTMENT COMMUNICATIONS	4.00 4.01	0	49 39		0	1.00
3.00	DATA PROCESSI NG	4. 02	0	89		0	3.00
4.00	MATERIALS MANAGEMENT	4.03	О	2, 715		0	4.00
5.00		4.04	0	1, 233		0	5.00
6.00 7.00	PATI ENT ACCOUNTI NG ADMI NI STRATI VE & GENERAL	4.05 5.00	0	149 520		0	6.00 7.00
8.00	OPERATION OF PLANT	7.00	0	306		0	8.00
9.00	LAUNDRY & LINEN SERVICE	8.00	0	369		0	9.00
10.00	HOUSEKEEPING	9.00	0	10, 152		0	10.00
11.00 12.00	DI ETARY NURSI NG ADMI NI STRATI ON	10.00 13.00	0	368 12, 959		0	11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00	0	42, 854		0	13.00
14.00	PHARMACY	15.00	Ö	11,080		0	14.00
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	83		0	15.00
16.00	ADULTS & PEDIATRICS	30.00	0	152, 402		0	16.00
17.00 18.00	INTENSIVE CARE UNIT OPERATING ROOM	31.00 50.00	0	38, 467 261, 970		0	17.00 18.00
	ANESTHESI OLOGY	53.00	0	144		0	19.00
20.00	RADI OLOGY-DI AGNOSTI C	54.00	О	82, 477	7	0	20.00
21.00	LABORATORY	60.00	0	216, 204		0	21.00
22.00 23.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	43, 604 17, 042		0	22.00 23.00
24.00	ELECTROCARDI OLOGY	69.00	0	7, 317		0	23.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	133		0	25.00
26.00	ONCOLOGY	76.00	0	6, 155		0	26.00
27.00	CARDI AC REHABI LI TATI ON	76.97	0	7,144		0	27.00
28.00 29.00	CLINIC EMERGENCY	90.00 91.00	0	335, 582 123, 651		0	28.00 29.00
30.00	HOME HEALTH AGENCY	101.00	Ö	9, 027		0	30.00
31.00	GIFT, FLOWER, COFFEE SHOP &	190.00	О	173	6	0	31.00
22.00	CANTEEN	102.02					22.00
32.00 33.00	DI ABETES CENTER PARTNERSHI P HFC	192.03 194.00	0	4		0	32.00 33.00
55.00	TOTALS		— — — o	1, 384, 462	2	Ť	33.00
	H - DRUGS CHARGEABLE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3, 020		0	1.00
2.00 3.00	PHARMACY ADULTS & PEDI ATRI CS	15.00 30.00	0	4, 183, 675 976		0	2.00 3.00
4.00	INTENSIVE CARE UNIT	31.00	0	122		ő	4.00
5.00	OPERATI NG ROOM	50.00	0	133		0	5.00
6.00	ANESTHESI OLOGY	53.00	0	20		0	6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	8, 379		0	7.00
8.00 9.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	4, 281 2		0	8.00 9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	333		ŏ	10.00
11.00	ONCOLOGY	76.00	0	2, 279		0	11.00
12.00		90.00	0	81, 930		0	12.00
13.00	EMERGENCY	91.00	0	417	1	0	13.00

Health Financial Systems		JOHNSON MEMORIA	_ HOSPI TAL		In Lieu	u of Form CMS-	2552-10
RECLASSI FI CATI ONS			Provider (CCN: 15-0001	Period:	Worksheet A-	6
					From 01/01/2020 To 12/31/2020		enared
					10 12/31/2020	Date/Time Pro 7/30/2021 11	:08 am
	Decreases						
Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	,		
6.00	7.00	8.00	9.00	10.00			
TOTALS		0	4, 285, 567	r			
500.00 Grand Total: Decreases		829, 659	8, 529, 823	6			500.00
6.00 TOTALS	Line #	8.00 0	9.00 4,285,567	10.00	-		500. (

	Financial Systems	JOHNSON MEMORI	Provi der CC	N. 15-0001	Peri od:	eu of Form CMS-2 Worksheet A-7	
	TERMININ OF CALLINE COSTS CENTERS			N. 13 0001	From 01/01/2020		
					To 12/31/2020) Date/Time Pre	
						7/30/2021 11:0	<u>08 am</u>
				Acqui si ti ons		4 /	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Balances				Retirements	(
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						1
. 00	Land	4, 743, 426			0 0	0	
. 00	Land Improvements	2, 880, 819	5, 924		0 5, 924		
8.00	Buildings and Fixtures	0			0 0	0	1 0.0.
4.00	Building Improvements	68, 523, 048			0 768, 557		1
5.00	Fixed Equipment	13, 108, 408			0 1, 559		0.00
5.00	Movable Equipment	53, 822, 598	491, 282		0 491, 282	1	0.00
7.00	HIT designated Assets	0	0		0 0	0	1 1.0
8.00	Subtotal (sum of lines 1-7)	143, 078, 299	1, 267, 322		0 1, 267, 322		0.0.
9.00	Reconciling Items	0	0		0 0	0	
10.00	Total (line 8 minus line 9)	143,078,299			0 1, 267, 322	2 0	10.0
		Endi ng	Fully				
		Bal ance	Depreci ated				
		(00	Assets				1
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	6.00	7.00				<u> </u>
1.00	Land	4, 743, 426	0				1.0
2.00	Land Improvements	2, 886, 743				ļ	2.00
2.00	Buildings and Fixtures	2,000,743					3.0
4.00	Building Improvements	69, 291, 605					4.0
4.00 5.00	Fixed Equipment	13, 109, 967					5.0
5.00 6.00	Movable Equipment	54, 313, 880					6.0
	HIT designated Assets	04, 313, 000					7.0
	Subtotal (sum of lines 1-7)	144, 345, 621					8.0
	Reconciling Items	144, 343, 021					9.0
	Total (line 8 minus line 9)	144, 345, 621	0				10.0

Health Financial Systems	JOHNSON MEMOR	I AL_HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0001	Peri od:	Worksheet A-7	
				From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	pared:
					7/30/2021 11:	08 am
		SL	JMMARY OF CAP	I TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
				instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM			and 2	i		
1.00 NEW CAP REL COSTS-BLDG & FIXT	2, 673, 716			0 0	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	4, 422, 288			0 0	0	2.00
3.00 Total (sum of lines 1-2)	7, 096, 004	0		0 0	0	3.00
	SUMMARY O	F CAPI TAL				
			-			
Cost Center Description	Other	Total (1)				
		(sum of cols.				
		9 through 14)				
	instructions)		-			
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM	WORKSHEET A, COLUI		1			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	2, 673, 716				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	4, 422, 288				2.00
3.00 Total (sum of lines 1-2)	0	7, 096, 004				3.00

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: Trom 01/01/2020 To 12/31/2020	Worksheet A-7 Part III Date/Time Prep 7/30/2021 11:0	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col. 2)			
	1.00	2.00	3,00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT	144, 345, 621	0	144, 345, 621	1.000000	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	C	0. 000000	0	2.00
3.00 Total (sum of lines 1-2)	144, 345, 621		144, 345, 621		0	3.00
	ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capital-Relat				
	(ed Costs	through 7)	0.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	6.00	7.00	8.00	9.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT		0		2, 757, 102	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0			4, 422, 288	-	2.00
3.00 Total (sum of lines 1-2)	0	0		7, 179, 390		3.00
		SL	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT	-7, 887	0	(0	2, 749, 215	1.00
2.00 CAP REL COSTS-BEDG & TTXT	-7,007			0	4, 422, 288	2.00
3.00 Total (sum of lines 1-2)	-7,887	0		0	7, 171, 503	3.00
	,			-		

	Financial Systems MENTS TO EXPENSES		JOHNSON MEMOR	I AL HOSPI TAL Provi der CCN: 15-0001	In Lie Period:	u of Form CMS-2 Worksheet A-8	
ADJ031	MENTS TO EXPENSES				From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/30/2021 11:	pared: 08 am
				Expense Classification o			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		<u>(2)</u> 1. 00	2.00	3.00	4.00	<u>Ref.</u> 5.00	
1.00	Investment income - NEW CAP	1.00		NEW CAP REL COSTS-BLDG &	1.00	0.00	1.00
	REL COSTS-BLDG & FIXT (chapter			FLXT			
2.00	2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)		-			-	
3.00	Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
	discounts (chapter 8)						
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)					-	
7.00	Telephone services (pay stations excluded) (chapter		0	1	0.00	0	7.00
	21)						
8.00	Tel evision and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)				0.00	0	9.00
9.00 10.00	Provider-based physician	A-8-2	-5, 361, 509		0.00	0	
	adjustment						
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	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		0		0.00	0	
	and others		_			_	
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
	patients						
17.00	Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
	abstracts				0.00	0	
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20.00	Vendi ng machi nes		0		0.00	0	20.00
21.00	Income from imposition of		0		0.00	0	21.00
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to						
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
20.00	therapy costs in excess of	N 0 0			00.00		20.00
	limitation (chapter 14)						
24.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
07.00	COSTS-BLDG & FIXT		-	FIXT		-	07 0-
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians'assistant		0		0.00	0	
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
	instructions)			l			1

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0001 Period: Period: Con 01/01/2020 To 0	Prepared: 11: 08 am 31: 00 31: 00 0 32: 00 0 33: 00 0 33: 01 0 33: 02 0 33: 03
Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 Adjustment for speech pathol ogy costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68.00 23.00 AHIT Adjustment for Depreciation and Interest 0 0 0.00 5.00 33.01 CAFETERIA CANTEEN VENDING REVENUE B -222,605 CAFETERIA ACANTEEN VENDING REVENUE 0 0.00 33.02 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA CANTEEN VENDING REVENUE 4.05 33.03 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 5.00 5.00 33.03 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 11.00 33.03 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 5.00 33.03 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 5.00 33.03 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 5.00 33.04 MISC OTH	11: 08 am 31: 00 0 32: 00 0 33: 00 0 33: 01 0 33: 02 0 33: 03
Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 O SPEECH PATHOLOGY 68.00 32.00 CAH HIT Adjustment for Depreciation and Interest Revenue 0 0 0.00 0.00 33.00 CAFETTERIA CANTEEN VENDING REVENUE B -222,605 CAFETERIA 11.00 33.02 CAFETTERIA CANTEEN VENDING REVENUE B -9,000 CAFETTERIA 11.00 33.02 CAFETTERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 11.00 33.02 CAFETTERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 11.00 33.03 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 11.00 33.04 MISC OTHER REVENUE B -9,000 CAFETERIA 5.00 33.04 MISC OTHER REVENUE B -1498,834 MINI NI STRATI VE & GENERAL 5.00 33.05 MISC OTHER REVENUE B -7371 PHARMACY 15.00 3.00 33.06 MISC OTHER REVENUE <td>31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03</td>	31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 31. 00 Adj ustment for speech pathol ogy costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68.00 32. 00 CAH HIT Adj ustment for pepciation and Interest 33. 00 A-8-3 0 SPEECH PATHOLOGY 68.00 33. 01 CAFETERIA CANTEEN VENDING REVENUE B -222, 605 CAFETERIA 11.00 33. 01 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 11.00 33. 02 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 11.00 33. 02 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 11.00 33. 03 CAFETERIA CANTEEN VENDING REVENUE B -9,000 CAFETERIA 11.00 33. 04 MISC OTHER REVENUE B -498,834ADMINISTRATIVE & GENERAL 5.00 33. 05 MISC OTHER REVENUE B -252,412/MEDICAL RECORDS & LI BRARY 16.00 33. 07 MISC OTHER REVENUE B -781LABORATORY 60.00 33. 09 MISC OTHER REVENUE B -722,900COLOGY 76.00 33. 09 MISC OTHER REVENUE B -722,000COLOGY 76.00 <	31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
(2)Ref.31. 00Adj ustment for speech pathol ogy costs in excess of 1 imitation (chapter 14)A-8-30SPEECH PATHOLOGY68. 0032. 00CAH HIT Adj ustment for Depreciation and Interest000.000.0033. 00CAFETERIA CANTEEN VENDING REVENUEB-222, 605CAFETERIA11. 0033. 01CAFETERIA CANTEEN VENDING REVENUEB0PATI ENT ACCOUNTING4. 0533. 02CAFETERIA CANTEEN VENDING REVENUEB-9, 000CAFETERIA11. 0033. 03CAFETERIA CANTEEN VENDING REVENUEB-9, 000CAFETERIA11. 0033. 04MI SC OTHER REVENUEB-498, 834 ADMI NI STRATI VE & GENERAL5. 0033. 05MI SC OTHER REVENUEB-52, 412MEDI CAL RECORDS & LI BRARY16. 0033. 06MI SC OTHER REVENUEB-722CAL RECORDS & LI BRARY16. 0033. 09MI SC OTHER REVENUEB-722CLI NI C90. 00	31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
(2)Ref.31. 00Adj ustment for speech pathol ogy costs in excess of 1 imitation (chapter 14)A-8-30SPEECH PATHOLOGY68. 0032. 00CAH HIT Adj ustment for Depreciation and Interest000.000.0033. 00CAFETERIA CANTEEN VENDING REVENUEB-222, 605CAFETERIA11. 0033. 01CAFETERIA CANTEEN VENDING REVENUEB0PATI ENT ACCOUNTING4. 0533. 02CAFETERIA CANTEEN VENDING REVENUEB-9, 000CAFETERIA11. 0033. 03CAFETERIA CANTEEN VENDING REVENUEB-9, 000CAFETERIA11. 0033. 04MI SC OTHER REVENUEB-498, 834 ADMI NI STRATI VE & GENERAL5. 0033. 05MI SC OTHER REVENUEB-52, 412MEDI CAL RECORDS & LI BRARY16. 0033. 06MI SC OTHER REVENUEB-722CAL RECORDS & LI BRARY16. 0033. 09MI SC OTHER REVENUEB-722CLI NI C90. 00	31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
(2)Ref.31. 00Adj ustment for speech pathol ogy costs in excess of 1 imitation (chapter 14)A-8-30SPEECH PATHOLOGY68. 0032. 00CAH HIT Adj ustment for Depreciation and Interest000.000.0033. 00CAFETERIA CANTEEN VENDING REVENUEB-222, 605CAFETERIA11. 0033. 01CAFETERIA CANTEEN VENDING REVENUEB0PATI ENT ACCOUNTING4. 0533. 02CAFETERIA CANTEEN VENDING REVENUEB-9, 000CAFETERIA11. 0033. 03CAFETERIA CANTEEN VENDING REVENUEB-9, 000CAFETERIA11. 0033. 04MI SC OTHER REVENUEB-498, 834 ADMI NI STRATI VE & GENERAL5. 0033. 05MI SC OTHER REVENUEB-52, 412MEDI CAL RECORDS & LI BRARY16. 0033. 06MI SC OTHER REVENUEB-722CAL RECORDS & LI BRARY16. 0033. 09MI SC OTHER REVENUEB-722CLI NI C90. 00	31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
(2)Ref.31. 00Adj ustment for speech pathol ogy costs in excess of limitation (chapter 14)A-8-30SPEECH PATHOLOGY68. 0032. 00CAH HIT Adj ustment for Depreciation and Interest000.000.0033. 00CAFETERIA CANTEEN VENDINGB-222, 605CAFETERIA11. 00REVENUE33. 01CAFETERIA CANTEEN VENDINGB0PATI ENT ACCOUNTING4. 0533. 02CAFETERIA CANTEEN VENDINGB-9, 000CAFETERIA11. 00REVENUEB-9, 000CAFETERIA11. 0033. 02CAFETERIA CANTEEN VENDINGB00REVENUEB-9, 000CAFETERIA11. 00REVENUEB-9, 000CAFETERIA11. 0033. 04MI SC OTHER REVENUEB-498, 834ADMI NI STRATI VE & GENERAL5. 0033. 05MI SC OTHER REVENUEB-52, 412MEDI CAL RECORDS & LI BRARY16. 0033. 06MI SC OTHER REVENUEB-781LABORATORY60. 0033. 09MI SC OTHER REVENUEB-781LABORATORY60. 00 </td <td>31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03</td>	31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
(2)Ref.31. 00Adj ustment for speech pathol ogy costs in excess of limitation (chapter 14)A-8-30SPEECH PATHOLOGY68. 0032. 00CAH HIT Adj ustment for Depreciation and Interest000.000.0033. 00CAFETERIA CANTEEN VENDINGB-222, 605CAFETERIA11. 00REVENUE33. 01CAFETERIA CANTEEN VENDINGB0PATI ENT ACCOUNTING4. 0533. 02CAFETERIA CANTEEN VENDINGB-9, 000CAFETERIA11. 00REVENUEB-9, 000CAFETERIA11. 0033. 02CAFETERIA CANTEEN VENDINGB00REVENUEB-9, 000CAFETERIA11. 00REVENUEB-9, 000CAFETERIA11. 0033. 04MI SC OTHER REVENUEB-498, 834ADMI NI STRATI VE & GENERAL5. 0033. 05MI SC OTHER REVENUEB-52, 412MEDI CAL RECORDS & LI BRARY16. 0033. 06MI SC OTHER REVENUEB-781LABORATORY60. 0033. 09MI SC OTHER REVENUEB-781LABORATORY60. 00 </td <td>31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03</td>	31.00 0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
Image: Note of the sector of the se	0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
31. 00Adj ustment for speech pathol ogy costs in excess of limitation (chapter 14)A-8-3O SPEECH PATHOLOGY68. 0032. 00CAH HI T Adj ustment for Depreciation and Interest000. 0033. 00CAFETERI A CANTEEN VENDING REVENUEB-222, 605CAFETERI A11. 0033. 01CAFETERI A CANTEEN VENDING REVENUEB000. 0033. 02CAFETERI A CANTEEN VENDING REVENUEB00033. 02CAFETERI A CANTEEN VENDING REVENUEB-9, 000CAFETERI A11. 0033. 02CAFETERI A CANTEEN VENDING REVENUEB-9, 000CAFETERI A11. 0033. 03CAFETERI A CANTEEN VENDING REVENUEB-9, 000CAFETERI A11. 0033. 04MI SC OTHER REVENUEB-498, 834ADMI NI STRATI VE & GENERAL S. 005. 0033. 05MI SC OTHER REVENUEB-498, 834ADMI NI STRATI VE & GENERAL S. 005. 0033. 06MI SC OTHER REVENUEB-52, 412 MEDI CAL RECORDS & LI BRARY G. 0016. 0033. 07MI SC OTHER REVENUEB-781 LABORATORY60. 0033. 09MI SC OTHER REVENUEB-929 (ONCOLOGY76. 0033. 09MI SC OTHER REVENUEB120 CLI NI C90. 00	0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
pathol ogy costs in excess of limitation (chapter 14)032. 00CAH HI T Adjustment for Depreciation and Interest033. 00CAFETERIA CANTEEN VENDINGB-222, 605CAFETERIA33. 01CAFETERIA CANTEEN VENDINGB-222, 605CAFETERIA33. 01CAFETERIA CANTEEN VENDINGB-222, 605CAFETERIA33. 01CAFETERIA CANTEEN VENDINGB-222, 605CAFETERIA33. 02CAFETERIA CANTEEN VENDINGB-9, 000CAFETERIA-11. 00REVENUE33. 02CAFETERIA CANTEEN VENDINGB-9, 000CAFETERIA-11. 00REVENUE-33. 03CAFETERIA CANTEEN VENDINGB-9, 000CAFETERIA-11. 00REVENUE-33. 04MISC OTHER REVENUEB-498, 834ADMINISTRATIVE & GENERAL-33. 05MISC OTHER REVENUEB-33. 06MISC OTHER REVENUEB-33. 07MISC OTHER REVENUEB-781LABORATORY60. 00-33. 09MISC OTHER REVENUEB-929ONCOLOGY76. 00-33. 09MISC OTHER REVENUEB-120CLINIC90. 00	0 32.00 0 33.00 0 33.01 0 33.02 0 33.03
32.00CAH HIT Adjustment for Depreciation and Interest00.0033.00CAFETERIA CANTEEN VENDINGB-222,605CAFETERIA11.00REVENUEREVENUEB0PATIENT ACCOUNTING4.0533.01CAFETERIA CANTEEN VENDINGB0PATIENT ACCOUNTING4.0533.02CAFETERIA CANTEEN VENDINGB-9,000CAFETERIA11.00REVENUEB-9,000CAFETERIA11.0033.03CAFETERIA CANTEEN VENDINGB00REVENUEB-9,000CAFETERIA10.0033.04MISC OTHER REVENUEB-498,834ADMINISTRATIVE & GENERAL5.0033.05MISC OTHER REVENUEB-52,412MEDICAL RECORDS & LI BRARY16.0033.08MISC OTHER REVENUEB-781LABORATORY60.0033.09MISC OTHER REVENUEB120CLI NI C90.00	 0 33.00 0 33.01 0 33.02 0 33.03
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33. 10 MI SC OTHER REVENUE B -5, 744 MATERIALS MANAGEMENT 4. 03	0 33.10
33.11 MISC OTHER REVENUE B 5,068 NURSING ADMINISTRATION 13.00 33.12 CABLE SERVICES A -30,171 OPERATION OF PLANT 7.00	0 33.11 0 33.12
33. 12 CABLE SERVICES A -1, 177 NEW CAP REL COSTS-BLDG & 1. 00	9 33.12
FIXT	
33. 14 TELEPHONE_SERVICES A -17, 460 COMMUNICATIONS 4. 01	0 33.14
33. 15 COMMUNI CATI ONS A -18, 762 COMMUNI CATI ONS 4. 01	0 33.15
33. 16 ADVERTISING EXP A&G A -330, 986 ADMINISTRATIVE & GENERAL 5. 00 33. 17 ADVERTISING EXP -NURSING ADMIN A ONURSING ADMINISTRATION 13. 00	0 33.16 0 33.17
33. 18 ADVERTISING EXP - LABORATORY A -36LABORATORY 60.00	0 33.18
33. 19 ADVERTISING EXP - CLINIC A -1, 026 CLINIC 90. 00	0 33.19
33. 20 ADVERTISING EXP - EMERGENCY A 1, 575 EMERGENCY 91. 00	0 33.20
ROOM 33.21 DAYCARE B OEMPLOYEE BENEFITS DEPARTMENT 4.00	0 33.21
33. 22 LOBBYING EXPENSE - AHA A OADMINISTRATIVE & GENERAL 5. 00	0 33.21
33. 23 LOBBYING EXPENSE - I HHA A -2, 058 ADMINI STRATIVE & GENERAL 5. 00	0 33.23
33. 24 PROF - BUILDING A -23, 407 OPERATION OF PLANT 7. 00	0 33.24
33. 25 PROF - BUILDING A -7, 716 EMPLOYEE BENEFITS DEPARTMENT 4. 00	0 33.25
33. 26 1993 AHA LIFE A 84, 563NEW CAP REL COSTS-BLDG & 1. 00 FLXT	9 33.26
33. 27 HAF EXPENSE A -4, 255, 208 ADMI NI STRATI VE & GENERAL 5. 00	0 33.27
33. 28 INTEREST EXPENSE A -7, 887 NEW CAP REL COSTS-BLDG & 1.00	11 33.28
	0 00 00
33. 29 LOBBYING EXPENSE AHA A -5, 541 ADMINISTRATIVE & GENERAL 5. 00 50. 00 TOTAL (sum of lines 1 thru 49) -10, 762, 300 -10, 762, 3	0 33.29 50.00
(Transfer to Worksheet A,	30.00
Column 6, line 200.) Line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1	1

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

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

PROVIDER BASED PHYSICI AN ADJUSTMENT Provider CCB: 15-0001 Period: Error 01/01/200 To 12/31/200 Worksheet A-5 Image: Comparison of the second se	Heal th	Financial Syste	ems	JOHNSON MEMOR	REAL HOSPETAL		In Lie	eu of Form CMS-	2552-10
To 12/31/2020 Date/Time Provider To 12/31/2020 Date/Time Provider Rec Anount Provider 1.00 2.00 3.00 4.00 5.00 6.00 7.00 0<					Provi der				3-2
Identifier Remuneration Component Component Component Hours 1.00 2.00 3.00 4.00 5.00 6.00 7.00 2.00 31.00LNTS & PEDLATRICS 1.753.223 0 0 0 0 2.00 31.00LNTS & PEDLATRICS 1.753.223 0 0 0 0 3.00 0.00LNTS & PEDLATRICS 1.753.223 0 0 0 0 4.00 53.00AALSTHESILOCY 9.847 9.847 0.847 0 0 0 6.00 65.00RESPINATORY 136.625 38.925 0							From 01/01/2020 To 12/31/2020) Date/Time Pre	epared: 08 am
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2.00 31.00 INTENSI VE CARE UNIT 0<				8.00	9.00				
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6.00 65.00 RESPIRATORY THERAPY 0 </td <td>4.00</td> <td></td> <td></td> <td>0</td> <td>C</td> <td>) (</td> <td>0 0</td> <td>0</td> <td>4.00</td>	4.00			0	C) (0 0	0	4.00
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Image: Note of col. Share of col. 14 Image: Note of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRI CS 0 0 1,753,223 2.00 31.00 INTENSI VE CARE UNI T 0 0 45,454 3.00 50.00 OPERATI NG ROM 0 0 46,000 4.00 53.00 ANESTHESI OLOGY 0 0 9,847 5.00 60.00 LABORATORY 0 0 0 38,625 7.00 68.00 SPEECH PATHOLOGY 0 0 0 17,763 8.00 69.00 ELECTROCARDI OLOGY 0 0 0 67,772 9.00 70.00 ELECTROCARDI OLOGY 0 0 0 50,624 10.00 76.00 ONCOLOGY 0 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 481,343		Wkst. A Line #				RCE	Adjustment		
Image: Note of the image is a serie of the image is a s			I denti fi er		Limit	Di sal I owance			
1.00 2.00 15.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRICS 0 0 0 1,753,223 2.00 31.00 INTENSI VE CARE UNIT 0 0 0 45,454 3.00 50.00 OPERATI NG ROOM 0 0 0 46,000 4.00 53.00 ANESTHESI OLOGY 0 0 9,847 5.00 60.00 LABORATORY 0 0 0 9,847 6.00 65.00 RESPI RATORY THERAPY 0 0 0 38,625 7.00 68.00 SPEECH PATHOLOGY 0 0 0 17,763 8.00 69.00 ELECTROCARDI OLOGY 0 0 60,400 67,772 9.00 70.00 ELECTROCARDI OLOGY 0 0 50,624 50,624 10.00 76.00 ONCOLOGY 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 85,950 12.00 90.00 CLI NI C 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>									
1.00 30.00 ADULTS & PEDI ATRICS 0 0 1,753,223 2.00 31.00 INTENSIVE CARE UNIT 0 0 45,454 3.00 50.00 OPERATING ROOM 0 0 46,000 4.00 53.00 ANESTHESI OLOGY 0 0 9,847 5.00 60.00 LABORATORY 0 0 0 38,625 7.00 65.00 RESPI RATORY THERAPY 0 0 0 17,763 8.00 69.00 ELECTROCARDI OLOGY 0 0 67,772 9.00 70.00 RESPI RATORY THERAPY 0 0 67,772 9.00 70.00 ELECTROCARDI OLOGY 0 0 67,772 9.00 70.00 RESPI RATORY THERAPY 0 0 50,624 10.00 76.00 ONCOLOGY 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 85,950 12.00 90.00 CLI NI C 0 0 0 481,343		4.00	0.00		44.00	47.00	10.00		
2.00 31.00 INTENSIVE CARE UNIT 0 0 45,454 3.00 50.00 OPERATING ROOM 0 0 46,000 4.00 53.00 ANESTHESI OLOGY 0 0 9,847 5.00 60.00 LABORATORY 0 214,754 0 0 6.00 65.00 RESPI RATORY THERAPY 0 0 38,625 7.00 68.00 SPEECH PATHOLOGY 0 0 17,763 8.00 69.00 ELECTROCARDI OLOGY 0 0 67,772 9.00 70.00 ELECTROENCEPHALOGRAPHY 0 0 50,624 10.00 76.00 ONCOLOGY 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 85,950 12.00 90.00 CLI NI C 0 0 481,343	1.00			15.00					1 00
3.00 50.00 OPERATING ROOM 0 0 46,000 4.00 53.00 ANESTHESI OLOGY 0 0 9,847 5.00 60.00 LABORATORY 0 214,754 0 0 6.00 65.00 RESPI RATORY THERAPY 0 0 0 38,625 7.00 68.00 SPEECH PATHOLOGY 0 0 17,763 8.00 69.00 ELECTROCARDI OLOGY 0 0 67,772 9.00 70.00 ELECTROCARDI OLOGY 0 0 50,624 10.00 76.00 0NCOLOGY 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 85,950 12.00 90.00 CLI NI C 0 0 481,343				0		· · · · · · · · · · · · · · · · · · ·			1.00
4.00 53.00 ANESTHESI OLOGY 0 0 9,847 5.00 60.00 LABORATORY 0 214,754 0 0 6.00 65.00 RESPI RATORY THERAPY 0 0 38,625 7.00 68.00 SPEECH PATHOLOGY 0 0 17,763 8.00 69.00 ELECTROCARDI OLOGY 0 0 67,772 9.00 70.00 ELECTROCARDI OLOGY 0 0 50,624 10.00 76.00 ONCOLOGY 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 85,950 85,950 12.00 90.00 CLI NI C 0 0 0 481,343				0		0			2.00
5.00 60.00 LABORATORY 0 214,754 0 0 6.00 65.00 RESPIRATORY THERAPY 0 0 0 38,625 7.00 68.00 SPEECH PATHOLOGY 0 0 0 17,763 8.00 69.00 ELECTROCARDI OLOGY 0 0 67,772 9.00 70.00 ELECTROCARDHALOGRAPHY 0 0 50,624 10.00 76.00 0NCOLOGY 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0 85,950 12.00 90.00 CLI NI C 0 0 481,343				0	C	0			3.00
6. 00 65. 00 RESPIRATORY THERAPY 0 0 0 38, 625 7. 00 68. 00 SPEECH PATHOLOGY 0 0 0 17, 763 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 67, 772 9. 00 70. 00 ELECTROCARDI OLOGY 0 0 50, 624 10. 00 76. 00 ONCOLOGY 0 60, 400 96, 375 96, 375 11. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0 85, 950 12. 00 90. 00 CLI NI C 0 0 481, 343				0					4.00
7. 00 68. 00 SPEECH PATHOLOGY 0 0 17, 763 8. 00 69. 00 ELECTROCARDI OLOGY 0 0 67, 772 9. 00 70. 00 ELECTROENCEPHALOGRAPHY 0 0 0 50, 624 10. 00 76. 00 ONCOLOGY 0 60, 400 96, 375 96, 375 11. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0 0 85, 950 12. 00 90. 00 CLI NI C 0 0 0 481, 343						(5.00
8.00 69.00 ELECTROCARDI OLOGY 0 0 67,772 9.00 70.00 ELECTROENCEPHALOGRAPHY 0 0 50,624 10.00 76.00 0NCOLOGY 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 85,950 12.00 90.00 CLI NI C 0 0 0 481,343						0			6.00
9.00 70.00 ELECTROENCEPHALOGRAPHY 0 0 50,624 10.00 76.00 0NCOLOGY 0 60,400 96,375 96,375 11.00 76.97 CARDI AC REHABI LI TATI ON 0 0 85,950 12.00 90.00 CLI NI C 0 0 481,343									7.00
10. 00 76. 00 0NC0L0GY 0 60, 400 96, 375 96, 375 11. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0 0 85, 950 12. 00 90. 00 CLI NI C 0 0 0 481, 343						0			8.00
11.00 76.97 CARDIAC REHABILITATION 0 0 0 85,950 12.00 90.00 CLINIC 0 0 0 481,343					-	(9.00
12. 00 90. 00 CLINIC 0 0 481, 343						96, 375			10.00
						(11.00
					-				12.00
	13.00		EMERGENCY	0			2, 668, 533		13.00
200.00 0 275, 154 96, 375 5, 361, 509	200.00			0	275, 154	96, 375	5, 361, 509 bj		200.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	JOHNSON MEMORI	AL HOSPITAL Provider CO	CN: 15 0001 P	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		FIOVIDEI C	F	rom 01/01/2020 o 12/31/2020	Part I Date/Time Pre	pared:
		CAPI TAL REL	ATED COSTS		7/30/2021 11:	08 am
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ON S	
	0	1.00	2.00	4.00	4. 01	
GENERAL SERVICE COST CENTERS	0.740.045	0.740.045			[1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNI CATIONS 4.02 00402 DATA PROCESSI NG	2, 749, 215 4, 422, 288 7, 712, 175 320, 089 3, 050, 860	2, 749, 215 29, 962 3, 946 62, 857	4, 422, 288 1, 970 0	7, 744, 107 22, 201	346, 236 34, 445	1.00 2.00 4.00 4.01 4.02
4. 03 00403 MATERIALS MANAGEMENT 4. 04 00404 ADMITTING 4. 05 00405 PATIENT ACCOUNTING	3, 030, 880 390, 767 798, 353 1, 493, 476	38, 417 22, 482 66, 773		90, 097 195, 457	7, 399 8, 675 22, 453	4.03
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE	-1, 288, 925 3, 053, 890 198, 871	95, 651 290, 236 24, 139	43, 513 66, 742	484, 263 222, 960	19, 646 12, 502 1, 276	5.00 7.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA	806, 061 407, 956 365, 794	24, 134 18, 747 39, 331 41, 881	6, 613 30, 779 0	174, 495 68, 967	3, 572 6, 634	9.00
13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	1, 424, 173 160, 489 1, 607, 233	99, 075 17, 060 20, 544	48, 515 48, 934	308, 754 18, 259	0 11, 737 0 5, 868	13.00 14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	548, 885	38, 949			9, 440	1
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	4, 342, 880	276, 902	222, 293	1, 294, 615	26, 791	30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	1, 243, 233 141 409, 134	79, 184 0 6, 276	52, 785 0 0	0	7, 144 4, 593 0	41.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM	2,094,553	459, 488	660, 977	443, 996	22, 453	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	52, 322 2, 822, 370	3, 956 165, 998	21, 046 509, 344	0 487, 226	0 13, 268	53.00 54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	5, 032, 863 1, 225, 133 781, 902	80, 820 3, 755 63, 640		264, 475	17, 350 4, 593 6, 379	65.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	273, 740 134, 577	13, 405 833	3, 539	67, 508	1, 531 1, 531	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	310, 726 3, 931	10, 844 1, 827	50, 333 2, 742		10, 971 510	69.00 70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 174, 334 2, 528, 540	0 0	20, 806 0		0	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 ONCOLOGY	4, 247, 053 434, 660	0 70, 277	0 3, 208		0 9, 440	73.00 76.00
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	167, 494	25, 213				
90. 00 09000 CLINIC	1, 550, 733	115, 633	24, 494	181, 893	5, 358	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	2, 070, 095	99, 748	46, 113	728, 563	15, 054	91.00 92.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	669, 151	13, 104	96	142, 035	5, 868	101.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	60, 791, 215	2, 400, 953	4, 256, 005	7, 327, 539	296, 481	113.00 118.00
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLINI C	58, 822 2, 010, 516 0	13, 023 260, 314 0		376, 907	41, 846	190.00 192.00 192.01
192. 02 19202 WEST CLINIC 192. 03 19203 DIABETES CENTER 193. 00 19300 NONPAID WORKERS	0 72, 107 0	0 4, 036 0	0 805 0		765	192. 02 192. 03 193. 00
193. 01 19301 ADULT/CHI LD CARE 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	000000000000000000000000000000000000000	48, 518 0 0	0	0 0 0	1, 276 0	193. 01 193. 02 193. 03
194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C 194. 02 07952 EDI NBURGH	20, 252 0 0	22, 371 0 0		292 0 0	2, 041 0	194. 00 194. 01 194. 02
194. 03 07953 JAIL 194. 04 07954 ATHLETIC TRAINERS 200. 00 Cross Foot Adjustments	48, 000 0	0	0	11, 857 0	0	194. 03 194. 04 200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	63, 000, 912	0 2, 749, 215	0 4, 422, 288	0 7, 744, 107		201. 00 202. 00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		eriod: rom 01/01/2020	Worksheet B Part I	
			Te		Date/Time Pre	
Cost Center Description	DATA	MATERI ALS	ADMI TTI NG	PATI ENT	7/30/2021 11: Subtotal	
	PROCESSI NG	MANAGEMENT		ACCOUNTI NG	44.95	
GENERAL SERVICE COST CENTERS	4. 02	4.03	4.04	4.05	4A. 05	
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. 01 00401 COMMUNI CATI ONS						4.00
4. 02 00402 DATA PROCESSI NG	5, 403, 695					4.01 4.02
4. 03 00403 MATERIALS MANAGEMENT	117,004	653, 506				4.03
4. 04 00404 ADMI TTI NG	189, 627	0				4.04
4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL	455, 912 648, 228	0	0	2, 274, 178 0	2, 376	4.05 5.00
7.00 00700 OPERATION OF PLANT	90, 106	0		0	2, 376 3, 736, 436	
8.00 00800 LAUNDRY & LINEN SERVICE	33, 622	0	0	0	290, 950	•
9. 00 00900 HOUSEKEEPI NG	0	0		0	1, 009, 488	•
10. 00 01000 DI ETARY	73, 968	0	0	0	627, 635	•
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINI STRATION	0 99, 521	0	0	0	508, 576 1, 991, 775	•
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	3, 482	-	0	248, 224	•
15. 00 01500 PHARMACY	91, 451	251, 873		0	2, 158, 595	
16.00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	195, 006	153	0	0	918, 665	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	298, 562	12, 593	61,002	114, 235	6, 649, 873	30.00
31. 00 03100 I NTENSI VE CARE UNI T	185, 592	3, 678		16, 773	1, 893, 898	•
41.00 04100 SUBPROVIDER - IRF	0	0		0	4,734	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	8, 835	16, 544	533, 627	43.00
50. 00 05000 OPERATI NG ROOM	485, 499	19, 075	159, 726	299, 106	4, 644, 873	50.00
53. 00 05300 ANESTHESI OLOGY	0	11	24, 161	45, 245	146, 741	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	203, 076	9, 930		494, 344	4, 969, 699	1
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	242, 077 150, 626	98, 541 9, 160	196, 199 28, 010	367, 406 52, 452	6, 765, 665 1, 761, 165	•
66. 00 06600 PHYSI CAL THERAPY	56, 485	1, 182		31, 583	1, 164, 098	•
67.00 06700 OCCUPATI ONAL THERAPY	24, 208	0		10, 383	399, 859	•
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	13, 449	6	1, 618	3, 031 33, 728	188, 742	•
70. 00 07000 ELECTROCARDI OLOGY	173, 488 0	530 27	18, 011 354	33, 728	676, 720 10, 054	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	197, 942		102, 007	2, 549, 562	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		66, 465	2, 630, 498	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 ONCOLOGY	0 64, 554	0 984	115, 323 4, 688	215, 957 8, 778	4, 578, 333 677, 581	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	04, 554	639		4, 672	249, 132	
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	197, 696 213, 835	28, 597 14, 115	56, 288 148, 424	105, 406 277, 942	2, 266, 098 3, 613, 889	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	213, 035	14, 115	140, 424	211, 742		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	56, 485	634	3, 983	7, 458	898, 814	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 360, 077	653, 152	1, 214, 594	2, 274, 178	58, 766, 375	
NONREI MBURSABLE COST CENTERS	(4 554	011		0	157 004	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	64, 554 950, 821	311 2	0	0	157, 236 3, 799, 266	
192. 01 19201 SOUTH CLINIC	0	0		Ő		192.01
192. 02 19202 WEST CLINIC	0	0	0	0		192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	4, 035 0	29 0		0		192.03 193.00
193. 01 19300 NONPATD WORKERS 193. 01 19301 ADULT/CHI LD CARE	0	0		0		193.00
193.02 19302 PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193.03
194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C	24, 208	12 0	0	0		194.00 194.01
194. 02 07952 EDI NBURGH	0	0	0	0		194.01
194. 03 07953 JAI L	0	0	0	0	59, 857	194.03
194. 04 07954 ATHLETIC TRAINERS	0	0	0	0		194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers		0	0	0		200.00 201.00
202.00 TOTAL (sum Lines 118 through 201)	5, 403, 695	653, 506	1, 214, 594	2, 274, 178	63, 000, 912	

Health Financial Systems	JOHNSON MEMORIA			Inlie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	JUINSON MEMORIA	Provider C		eriod:	Worksheet B	2552-10
			Fi To	rom 01/01/2020 0 12/31/2020	Part I	narod
					Date/Time Pre 7/30/2021 11:	08 am
Cost Center Description		PERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	E & GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	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. 02 00402 DATA PROCESSI NG						4.01 4.02
4. 03 00402 DATA PROCESSING 4. 03 00403 MATERIALS MANAGEMENT						4.02
4. 04 00404 ADMI TTI NG						4.04
4. 05 00405 PATIENT ACCOUNTING						4.05
5.00 00500 ADMI NI STRATI VE & GENERAL	2, 376	0 70/ 570				5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	142	3, 736, 578 42, 169				7.00 8.00
9. 00 00900 HOUSEKEEPI NG	38	32, 750		1, 104, 357		9.00
10. 00 01000 DI ETARY	24	68, 710		20, 723	724, 453	
11. 00 01100 CAFETERI A	19	73, 165		22, 067	0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	76	173, 081		52, 201	0	
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	9	29, 803 35, 890		8, 989 10, 824	0	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	35	68, 043		20, 522	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	253	483, 739		145, 896	663, 250	
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	72	138, 331 0	23, 912 0	41, 721 0	61, 203 0	
41.00 04100 SUBPROVIDER - TRP 43.00 04300 NURSERY	20	10, 963		3, 307	0	•
ANCI LLARY SERVICE COST CENTERS	20	10, 700		0,007		10.00
50. 00 05000 OPERATI NG ROOM	177	802, 711		242, 096	0	50.00
53. 00 05300 ANESTHESI OLOGY	6	6, 911		2, 084	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	189	289, 994		87,462	0	54.00
65. 00 06500 RESPIRATORY THERAPY	240 67	141, 191 6, 560		42, 583 1, 979	0	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	44	111, 177	-	33, 531	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	15	23, 418		7, 063	0	67.00
68.00 06800 SPEECH PATHOLOGY	7	1, 456		439	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	26	18, 945 3, 193		5, 714 963	0	69.00 70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	97	3, 173		903 0	0	70.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	100	0	-	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	174	0	-	0	0	73.00
76.00 03020 ONCOLOGY	26	122, 772	-	37, 028	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	9	44, 046	0	13, 284	0	76.97
90. 00 09000 CLINIC	86	202, 007	1, 365	60, 925	0	90.00
91.00 09100 EMERGENCY	137	174, 256		52, 556	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	24	22,002		6 004	0	101 00
SPECIAL PURPOSE COST CENTERS	34	22, 892	0	6, 904	0	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 215	3, 128, 173	328, 350	920, 861	724, 453	118.00
NONREI MBURSABLE COST CENTERS	1		-			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	6	22, 751		6, 862		190.00
192. 0019200 PHYSICIANS PRIVATE OFFICES 192. 0119201 SOUTH CLINIC	144	454, 760 0	4, 780	137, 156 0		192.00 192.01
192. 02 19202 WEST CLINIC	0	0	0	0		192.02
192. 03 19203 DI ABETES CENTER	4	7, 052	0	2, 127		192.03
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
193. 01 19301 ADULT/CHI LD CARE	2	84, 760		25, 564		193.01
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON		0	0	0		193.02 193.03
194. 00 07950 PARTNERSHI P HFC	3	39, 082	0	11, 787		194.00
194. 01 07951 TRAFALGAR CLINIC	0	0	0	0	0	194.01
194. 02 07952 EDI NBURGH	0	0	0	0		194.02
194. 03 07953 JALL	2	0	0	0		194.03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	0	0	0	0	194.04 200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 376	3, 736, 578	333, 130	1, 104, 357	724, 453	202.00

Heal th	Financial Systems	JOHNSON MEMOR	I AL HOSPITAL		Inlie	u of Form CMS-	2552-10
	ILLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	2002 10
					From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	epared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	7/30/2021 11: MEDI CAL	08 am
	bost benter beschiption	OAI ETERTA	ADMI NI STRATI O	SERVICES &		RECORDS &	
		11.00	N 13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
_	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	18.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00	00400 EMPEOTEE BENEFITIS DEPARTMENT						4.00
4.02	00402 DATA PROCESSI NG						4.02
4.03	00403 MATERIALS MANAGEMENT						4.03
4.04 4.05	00404 ADMI TTI NG 00405 PATI ENT ACCOUNTI NG						4.04 4.05
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	603, 827					11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	19, 283 2, 881			6		13.00 14.00
15.00	01500 PHARMACY	11, 897			0 2, 217, 288		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	15, 257	0		0 0	1, 022, 522	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	65, 749	782, 419	1	0 0	51, 355	30.00
30.00	03100 I NTENSI VE CARE UNI T	24, 099			0 0	7, 540	
41.00	04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
43.00	04300 NURSERY	8, 594	109, 720		0 0	7, 437	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	39, 772	477, 270		0 0	134, 465	50.00
53.00	05300 ANESTHESI OLOGY	0			0 0	20, 340	
54.00	05400 RADI OLOGY-DI AGNOSTI C	40, 989			0 0	222, 390	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	56, 728 20, 908			0 0 0 0	165, 169 23, 580	1
66.00	06600 PHYSI CAL THERAPY	15, 379			0 0	14, 198	
67.00	06700 OCCUPATI ONAL THERAPY	4, 766			0 0	4, 668	1
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2, 292 7, 250			0 0 0 0	1, 362 15, 163	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	298	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0				45, 858	1
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS				0 0 0 2, 217, 288	29, 880 97, 084	
76.00	03020 ONCOLOGY	6, 866	-		0 2,217,200	3, 946	
76.97	07697 CARDI AC REHABI LI TATI ON	2, 780	0		0 0	2, 100	76.97
00 00	OUTPATIENT SERVICE COST CENTERS	20, 043	0	1	0 0	47, 386	90.00
	09100 EMERGENCY	45, 270			0 0	124, 950	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	10, 973	0	1	0 0	2 252	101.00
101.00	SPECIAL PURPOSE COST CENTERS	10, 973	0		<u> </u>	3, 303	
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	421, 776	2, 236, 416	324, 47	6 2, 217, 288	1, 022, 522	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 272	0		0 0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	175, 541	0		0 0	0	192.00
	19201 SOUTH CLINIC	0			0 0		192.01
	19202 WEST CLINIC 19203 DIABETES CENTER	0 1, 292	-		0 0 0 0		192.02 192.03
	19300 NONPAI D WORKERS	0			0 0	0	193.00
	19301 ADULT/CHI LD CARE	0	0		0 0		193.01
	19302 PHYSI CLAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION		0		0 0 0 0		193. 02 193. 03
194.00	07950 PARTNERSHI P HFC	1, 473	0		0 0		194.00
194.01	07951 TRAFALGAR CLINIC	0	0		0 0	0	194.01
	07952 EDI NBURGH 07953 JAI L	0	0		0 0		194.02
	07953 JALL 07954 ATHLETI C TRAI NERS	1, 473	0 0				194.03 194.04
200.00	Cross Foot Adjustments	.,					200.00
201.00		0	-		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	603, 827	2, 236, 416	324, 47	6 2, 217, 288	1, 022, 522	1202.00

CDST: ALLCATION - GREERAL SERVICE COSTS Provider CDR: 15:000	Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lieu of Form CMS	5-2552-10
Cost Center Description Subtorial Intern A set identity Cost Center Description Intern A Set identity Description Total Set identity Description Intern A Set identity Description Intern A	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC			
Dist Center Peach pline Subiolation Tation & Britismus US Stephone Tation & Britismus US Stephone 1.00 Consequence 24.00 25.00 26.00 1.00 1.00 Consequence 24.00 25.00 26.00 1.00 1.00 Consequence 1.00 1.00 1.00 1.00 1.00 2.00 Consequence 1.00 <				T	o 12/31/2020 Date/Time Pi 7/30/2021 1	repared: 1:08 am
ZALOD 25.00 26.00 26.00 CENERAL SERVICE COST CENTERS 1.00 0.000 [kg: CAP IRE, COST SELICA AT TAT 1.00 1.00 DOTOD [kg: CAP IRE, COST SELICA AT TAT 1.00 1.00 1.00 DOTOD [kg: CAP IRE, COST SELICA AT TAT 1.00 1.00 1.00 DOTOD [kg: CAP IRE, COST SELICA AT TAT 1.00 1.00 1.00 DOTOD [kg: CAP IRE, COST SELICA AT TAT 1.00 1.00 1.00 DOTOD [kg: CAP IRE, COST SELICA AT TAT 1.00 1.00 1.00 DOTOD [kg: CAP IRE, COST SELICA AT TAT 1.00 1.00 1.00 DOSO ATTEN TAT TAT IVE & CENERAL 1.00 1.00 1.00 DOSO ATTEN TAT TAT IVE & CENERAL 1.00 1.00 1.00 DOSO ATTEN TAT TAT IVE & CENERAL 1.00 1.00 1.00 DISOD TATES AT TAT IVE & CENERAL 1.00 1.00 1.00 DISOD TATES AT TAT IVE & CENERAL 1.00 1.00 1.00 DISOD TATES AT TAT IVE & CENERAL 1.00 1.00 1.00 DISOD TAT FATTATATAT IVE & CENERAL 1.00	Cost Center Description	Subtotal	Residents Cost & Post	Total		
ENDERAL SERVICE COST CONTENTES 1.00 100 OCTOM NUM CAT PEL COSTS-MULE EDUP 2.00 200 OCTOM COSTS-MULE EDUP 4.01 400 OCTOM NUM CAT PEL COSTS ANREE 4.01 400 OCTOM OFFRANT NO OF PLANT 4.02 400 OCTOM NUM CAT PEL COST CONTRES 9.033 400 OCTOM NUM CAT PEL COST CONTRES 9.033 4100 OCTOM NUM CAT PEL COST CONTRES 9.033 4100 OCTOM NUM CAT PEL COST CONTRES 9.033 4100 OCTOM NUM CAT PEL COST CONTRES 9.04 4100 OCTOM NUM CAT PEL COST CONTRES		24.00		26.00		
2.00 0200 CAP REL COSTS-MARLE EQUIP 4 4.00 0200 CAP REL COSTS-MARLE EQUIP 4 4.00 0200 CAP REL DOSTS-MARLE EQUIP 4 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4.00 0 4.00 0200 CAP REL AS ANALONEST 4 4	GENERAL SERVICE COST CENTERS	24.00	25.00	20.00		-
4.00 00-000 (PMIO) CPE INTER ITS DEPARTMENT 4.00 4.01 00-001 (DMMI) CRATORS 4.01 4.01 00-001 (DMMI) CRATORS 4.01 4.02 00-002 (DATA PROCESSING) 4.01 4.01 00-001 (DATA PROCESSING) 4.01 4.01 00-002 (DATA PROCESSING) 6.00 00-002 (DATA PROCESSING) 0.000 0.000 (DATA PROCESSING) 0.000 00-002 (DATA PROCESSING) 0.000 0.000 (DATA PROCESSING) 0.000 00-002 (DATA PROCESSING) 0.0000 (DATA PROCESSING) 0.0000 0.0000 (DATA PROCESSING) 0.0000 00-003 (DATA PROCESSING) 0.0000 (DATA PROCESSING)						
4. 01 00401_COMMUNICATIONS 4. 01 4. 02 00402_CATA PROCESSING 4. 02 4. 03 00403_CATA PROCESSING 4. 02 4. 04 00403_CATA PROCESSING 4. 02 4. 05 00403_CATA PROCESSING 4. 02 4. 05 00403_CATA PROCESSING 4. 02 4. 05 00500_ADMINISTRATIVE & CHEREALL 5. 00 0. 00500_CANDERSECTING 7. 00 0. 00500_CANDERSECTING 8. 00 0. 00500_CANDERSECTING 10. 00 0. 00500_CANDERSECTING 10. 00 0. 00500_CANDERSECTING 11. 00 0. 00500_CANDERSECTING 11. 00 0. 1000_CANDERSECTING 11. 00 0. 1000_CANDERSECTING 11. 00 0. 1000_CANDERSECTING 2. 479, 968 2. 479, 968 0. 1000_CANDERSECTING 6. 73, 668 73, 668 0. 1000_CANDERSECTING 6. 73, 668 73, 668 0. 1000_CANDERSECTING 6. 73, 668 73, 668 0. 1000_CANDERSECTING 6. 73, 664 74, 734 41, 000 10. 0000_CONDERSECTING 5. 756, 664 75, 662 73, 668 70, 00 <						
1 03 0.003 MATERI ALS MARGEMENT 4.03 44 0.004 MATERI ACCOUNT INC 4.04 45 0.0405 MATERI ACCOUNT INC 4.04 46 0.0405 MATERI ACCOUNT INC 4.04 47 0.0405 MATERI ACCOUNT INC 4.04 48 0.0405 MATERI ACCOUNT INC 4.04 40 0.000 DEPARTIN ON CP PLANT 9.00 50 0.0000 DEFARTIN ON CP PLANT 10.00 10.00 0.000 DEFARTIN ON CP SERVICE ALTIRRAY 10.00 11.00 0.000 AULTS & LINRAY 11.00 11.00 11.00 11.00 11.00 11.00 11.00 0.000 AULTS & LINRAY 11.00 11.00 11.00 0.000 AULTS & MATERI ALINRAY 11.00 11.00 11.00 0.000 AULTS & MATERI ALINRAY 4.73 30.00 11.00 0.000 AULTS & MATERI ALINRAY 4.73 30.00 11.00 0.000 AULTS & MATERI ALINRAY 4.74 4.74 4.74 10.00 0.000	4. 01 00401 COMMUNI CATI ONS					
4. 04 00403 AMDITINE 4.0.6 05 00500 AMDINISTRATIVE & CERERAL 5.00 0.00 00500 AMDINISTRATIVE & CERERAL 5.00 0.00 00500 CAMPINISTRATIVE & CERERAL 5.00 0.00 01500 CARETERIA 11.00 11.00 0100 CARETERIA 11.00 11.00 01000 CARETERIA 11.00 0.00 01000 CARETERIA & ENVICE COST CENTRES						
5. 00 00500 ADM MISTERT VE & GENERAL. 5. 00 7. 00 00500 OPERATION OF HANT 8. 00 00. 00500 OPERATION OF HANT 8. 00 00. 00500 OPERATION OF HANT 8. 00 00. 00500 OPERATION OF HANT 10. 00 10. 00 00500 OPERATION OF HANT 10. 00 10. 00 00500 OPERATION OF HANT 10. 00 10. 00 00500 ADMUESI KERANDIN STRATION 11. 00 11. 00 01400 CENTRAL RECORDS & LIBRARY 15. 00 INMARTER NOUTINE SERVICE COST CENTERES 8. 933, 101 0 8. 933, 101 30. 00 10. 00 3000 ADMUESI & AURIN STRATION 12. 479, 968 0 6. 73, 648 41. 00 41. 00 INTESINE CARL OCT CENTERES 5. 00 0. 73, 648 40. 00 40. 00 0. 00 05000 OPERATION THAR NOT THAR SERVICE COST CENTERES 0 0. 00, 65000 MESENERADIN THAR SERVICE COST CENTERES 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50. 00 50.						
1.00 00/000 (0FERATION OF PLANT 7.00 8.00 008000 (UNDEXEEP) N6 9.00 10.00 000000 (UNDEXEEP) N6 9.00 11.00 011000 CATETER A 11.00 11.00 011000 CATETER A 11.00 11.00 011000 FLARY 11.00 11.00 011000 CATETER A 11.00 11.00 011000 FLARY 11.00 11.00 011000 FLARY 11.00 11.00 011000 FHARMACY 11.00 11.00 01100 FHARMACY 11.00 11.00 01100 FHARMACY 11.00 11.00 01100 FHARMACY 24.079 986 2.479 986 00 03000 INTES INFERATION COST CENTERS 673.668 6.73.668 43.00 01.00 04300 ANDESTAFE COST CENTERS 673.668 0 6.74.662 50.00 01.000 CHARDARTINE COST CENTERS 673.668 0 5.4.664 50.00 50.00 01.000 CHARDARTINE COST CENTERS 7.171.75.76 0 7.171.75.76 60.00 60.00 60.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
8. 00 00000 LAUMORY & LINEN SERVICE 8. 00 9. 00 9000						
10.00 010000 DI CARY 10.00 11.00 01000 CAFFTERIA 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 PHARANCY 14.00 15.00 01500 PHARANCY 14.00 16.00 DI COLOR PHARANCY 16.00 10.00 SUBPROVIDER - LIPER 2.477, 966 0 10.00 SUBPROVIDER - LIPER 4.734 0 4.734 10.00 SUBPROVIDER - LIPER 5.00 55.00 55.00 10.00 SUBPROVIDER - LIPER 5.634, 654 55.00 55.00 10.00 SUBPROVIDER - LIPER 17.00 7.71, 57.6 66.00 0.00 SUBPROVIDER - LIPER PHARY 1.814, 259 1.814, 259 64.00 0.00 SUBODOR - LIPERNER PHARY 1.814, 259						
11.00 01100 CAFETERIA 11.00 13.00 01300 CHARNIN ISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 15.00 DISOD PARAMACY 15.00 16.00 DISOD PARAMACY 15.00 16.00 DISOD APEDIATRICS 8.933.101 0 8.933.101 30.00 10.00 CARDICAL RECORDS & LIBRARY 16.00 0.00 16.00 16.00 16.00 16.00 16.00 10.00 CARDICAL RECORDS & LIBRARY 16.00 8.933.101 0 8.933.101 30.00 16.00 41.00						
13. 00 01300 NURSING ADMINISTRATION 13. 00 14. 00 01400 CHTRAL SERVICE SS & SUPPLY 14. 00 15. 00 01500 PHARMACY 15. 00 10. 00 1000 DUIS AL PECKODS & LIBRARY 15. 00 10. 00 1000 DUIS AL PECKODS & LIBRARY 16. 00 10. 00 01300 DUIS A PECKODS & LIBRARY 30. 00 10. 00 01300 DUIS AL PECKODS & LIBRARY 33. 00 13. 00 03100 INTENT VE CARE UNIT 2. 479, 968 0 2. 479, 966 33. 00 10. 00 04200 NUNSCENT 15. 00 53. 00 65. 00 673, 660 43. 00 60. 00 60. 00 673, 660 43. 00 60						
15.00 01500 PHARMACY 15.00 10.00 1000 BED CAL RECORDS & LIBRARY 16.00 1000 03000 NUTRAT LENT ROUTINE SERVICE COST CENTERS 16.00 1100 01000 SUBTOS IN LESSENUCE COST CENTERS 31.00 0.8,993.101 30.00 31.00 03100 INTERS INCE COST CENTERS 6.933.101 0.4,73.40 4.73.4 04.10.00 ALLARY SERVICE COST CENTERS 6.386.964 0.6,386.964 50.00						
16. 00 01400 JUEDI CAL, RECORDS & LIBRARY 16. 00 10 0.00 03000 ADULTS & PEDI ATRICS 68. 933. 101 0 8. 933. 101 0 8. 933. 101 30. 00 10. 00 3100 DITENSIVE CARE UNIT 2. 479. 968 0. 2. 479. 968 47. 334 41. 00 10. 00 3100 DITENSIVE CARE UNIT 2. 479. 968 0. 47. 334 41. 00 10. 00 3000 DEVENTING R IRF 4. 734 0 47. 334 41. 00 10. 00 5UBPROVIDER - IRF 67. 36.68 0 67. 36.68 53. 00 10. 00 DEPEATING KOMM 6. 386. 964 0. 67. 36.694 56. 00 56. 00 10. 00 DEPEATING KOMM 7. 176. 082 0 7. 176. 082 53. 00 54. 00 0. 00 DE000 DEPEATING KOMM 7. 177. 576 0 7. 171. 576 0 7. 171. 576 0 7. 171. 576 0 7. 171. 576 0 7. 171. 576 0 7. 171. 576 0 7. 171. 576 0 7. 171. 576 0 7. 197. 565 563. 654 0 563. 654 0 565. 00 560. 00 560. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
INPATIENT ROUTINE SERVICE COST CENTERS						
31.00 03100 INTENSIVE CARE UNIT 2.479,968 0 4.749,968 31.00 41.00 04000 SUBPROV DER - INF 6.73,668 0 6.73,668 41.00 40.00 05000 OPERATING ROOM 6.386,964 0 6.73,668 50.00 50.00 05000 OPERATING ROOM 6.386,964 0 6.73,668 53.00 50.00 05000 OPERATING ROOM 7.76,082 53.00 53.00 53.00 55.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 70.00 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.01 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 <t< td=""><td>INPATIENT ROUTINE SERVICE COST CENTERS</td><td></td><td>1</td><td></td><td></td><td></td></t<>	INPATIENT ROUTINE SERVICE COST CENTERS		1			
11. 00 04100 SUBPROVI DER 1. RF 4, 734 0 4, 734 4, 619, 858 5, 74, 74						
ANCILLARY SERVICE COST CENTERS - <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td></th<>						
50.0 0 05000 0F5000 5360 5460 5460 5460 5460 5460 5600 66000 67000 67000 67000 67000 67000 67000 67000 67000 67000 67000 67000 67000 67000 67000 67000 67000 67000 <td< td=""><td></td><td>673, 668</td><td>0</td><td>673, 668</td><td></td><td>43.00</td></td<>		673, 668	0	673, 668		43.00
53.00 05300 05400 53.00 776.082 53.00 54.00 05400 FADOLOSYD LAGNOSTIC 5.634.654 54.00 60.00 06000 RESPI RATORY THERAPY 1.814.259 65.00 60.00 060.00 06000 RESPI RATORY THERAPY 1.344.039 66.00 60.00 060.00 RESPI RATORY THERAPY 1.344.039 67.00 61.00 060.00 RESPI RATORY THERAPY 1.344.039 67.00 62.00 06000 RESPI RATORY THERAPY 1.434.039 1.434.039 68.00 63.00 06000 RESPI RATORY THERAPY 1.4508 726.184 69.00 70.00 RELECTROCARDED OLGY 72.6.184 726.184 72.00 71.00 MELECTROCARDED PATIENTS 6.992.879 6.892.879 73.00 71.00 OTADICAL SUPPLIES CHARGED TO PATIENTS 6.992.879 74.60.478 72.00 72.00 07000 FLECTROCARDE CONT CENTERS 76.00 70.00 76.00 70.00 07000 RELECTROCARDE CONT CENTERS 90.00 90.00 90.00 90.00 0		6, 386, 964	0	6, 386, 964		50.00
60.00 060000 LBORATORY 7, 171, 576 0 7, 171, 576 60.00 65.00 065000 PESPLEATORY THERAPY 1, 344, 039 0 1, 344, 039 65.00 67.00 06700 OCCUPATIONAL THERAPY 1, 344, 039 0 1, 344, 039 67.00 67.00 06800 SPEECH PATHOLOGY 194, 298 0 143, 789 67.00 69.00 069000 ELECTRCARDIOLOGY 726, 184 0 726, 184 69.00 71.00 070.00 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 660, 478 0 2, 660, 478 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 2, 660, 478 0 2, 660, 478 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 892, 879 0 6, 892, 879 76.00 0 76.00 0 76.00 0 76.07 76.00 0 76.00 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	53. 00 05300 ANESTHESI OLOGY	176, 082	-	176, 082		
65.00 06500 06500 77.00 1.814.259 0 1.814.259 65.00 66.00 06000 PHYSICAL THERAPY 1.344.039 0 1.344.039 67.00 68.00 06000 SPECH PATHOLOGY 194.298 0 194.298 68.00 69.00 06900 ELECTROCARDIOLOGY 726.184 0 726.184 69.00 70.00 070.00 MOD MEDICAL SUPPLIES CHARGED TO PATIENTS 2.919.993 0 2.919.993 71.00 71.00 070.00 DRUGA REGED TO PATIENT 2.660,478 0 2.660,478 72.00 73.00 0730.00 03020 DRUGLOGY 2.597,910 0 2.597,910 90.00 90.00 90.00 90.00 0.00 03000 OLLGY CENTERS						
67.00 06700 0CCUPATIONAL THERAPY 139, 789 0 139, 789 67.00 68.00 06900 SPECEH PATHOLOGY 194, 298 0 194, 298 67.00 70.00 07000 ELECTROCARDIOLOGY 194, 508 726, 184 69.00 70.00 07000 ELECTROECPHALOGRAPHY 14, 508 72, 014 69.00 71.00 07000 MELCTROECPHALOGRAPHY 14, 508 72, 014 72, 00 70.00 07000 MELCTROECPHALOGRAPHY 14, 508 72, 00 73, 00 70.00 07000 MELCTROECPHALOGRAPHY 14, 508 72, 00 73, 00 70.00 07200 MELDEX CARAGED TO PATIENTS 6, 892, 879 6, 892, 879 73, 00 70.00 03200 PROCOLOGY 848, 219 0 311, 351 76.90 90.00 09000 CLINC 2, 597, 910 0 2, 597, 910 91.00 92, 900 92, 900 92, 900 92, 900 92, 900 92, 900 92, 900 92, 900 92, 900 92, 900 92, 910 92, 910 92, 910 92, 910						
68.00 06800 SPEECH PATHOLOGY 194, 298 0 194, 298 68.00 07.00 0600 ELCTROCARDIOLOGY 726, 184 0 726, 184 69, 00 70.00 OTOOD MELCTROCARDIOLOGY 726, 184 0 726, 184 072, 00 73.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.02 0.00 73.00 73.00 73.00 73.02 73.00 73.02 73.00 73.00 73.00 73.00 73.00 73.00 73.01 73.00 73.00 73.01 73.00 73.02 76.97 76.97 76.97 76.97 76.97 76.97 76.97 70.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00						
69.00 06900 ELECTROCARDIOLOGY 726, 184 0 726, 184 69, 00 00 07000 ELECTROCARDIOLOGY 726, 184 0 726, 184 726, 00 01 00 07000 ELECTROCARDIOLOGRAPHY 14, 508 0 14, 508 70, 00 71.00 07100 NEDTORCEPHALOGRAPHY 2, 919, 993 0 2, 919, 993 71, 00 72.00 07000 NURL, DEV. CHARGED TO PATIENTS 6, 892, 879 0 6, 892, 879 73, 00 70.00 03200 ONCOLOGY PTENTS 6, 992, 879 0 348, 219 76, 00 00 09000 CLINIC 2, 597, 910 0 311, 351 0 131, 00 1300 1300 1300 14, 619, 858 0 4, 619, 858 9 90, 00 90, 00 90, 00 90, 00 90, 00 90, 00 90, 00 90, 00 90, 00 90, 00 91, 00 92, 00 92, 970 0 942, 970 90, 00 90, 00 90, 00			-			
71.00 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 2, 919, 993 0 2, 919, 993 71.00 72.00 07200 INPL. DEV. CHARGED TO PATIENT 2, 660, 478 0 2, 660, 478 72.00 73.00 07300 DRUSS CHARGED TO PATIENTS 6, 892, 879 0 6, 892, 879 73.00 76.00 03020 ONCOLOCY 848, 219 0 848, 219 76.00 0.00 90000 CLINIC 2, 597, 910 0 2, 557, 910 76.00 0.00 90000 CLINIC 2, 597, 910 0 2, 597, 910 90.00 92.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 91.00 92.00 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 942, 970 942, 970 942, 970 101.00 Inticole HAUROSE COST CENTERS 101.00 10100/HOME HEALTH ACENCY 942, 970 942, 970 101.00 113.00 SUBETOTALS (SUM OF LINES 1 through 117) 57.787, 787, 482 113.00 11300 1100.01 1000 1001.000 1002.01900, 01454.01 SOUTO COST CENTERS 113.00	69. 00 06900 ELECTROCARDI OLOGY		-			
72.00 07200 IMPL DEV. CHARGED TO PATIENT 2, 660, 478 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 892, 879 0 6, 892, 879 73.00 76.00 03020 ONCOLOGY 848, 219 0 311, 351 76.00 70.00 70.67/ CARDI AC REHABLLITATION 311, 351 0 311, 351 76.97 70.00 70.00 00000 CLINIC 2, 597, 910 0 2, 597, 910 90.00 90.00 09000 CLINIC 2, 597, 910 0 2, 597, 910 91.00 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.01 92.01 92.01 92.01			-			
76.00 03020 ONCOLOGY 848,219 0 848,219 76.00 76.97 CARDI AC REHABILITATION 311,351 0 311,351 76.97 90.00 09000 CLINIC 2,597,910 0 2,597,910 90.00 91.00 09000 ENERGENCY 4,619,858 0 4,619,858 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.02 92.01 92.01 92.02 92.01 92.02 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
76.97 07697 CARDIA C REHABILITATION 311,351 0 311,351 76.97 00TPATIENT SERVICE COST CENTERS 0 2,597,910 0 2,597,910 90.00 90.00 09000 CLINIC 2,597,910 0 2,597,910 90.00 91.00 09100 EMERGENCY 4,619,858 0 4,619,858 91.00 92.00 0952RVATION BEDS (NON-DISTINCT PART) 0 942,970 0 942,970 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 942,970 0 942,970 10.00 113.00 11300 INTEREST EXPENSE 0 57,787,482 0 57,787,482 113.00 113.00 11300 INTERST EXPENSE 4,571,647 0 4,571,647 192.00 192.01 19200 PHYSI CLANS (SUM OF FLICES 4,571,647 0 192.01 192.01 192.01 19201 SUHT CLINIC 0 0 0 192.02 192.02 19202 WEST CLINIC 0 0 192.03 193.02 192.03 19203			-			
OUTPATIENT SERVICE COST CENTERS 90.00 Outpatient 90.00 Optool CLINIC 2,597,910 90.00 2,597,910 90.00 90.00 90.00 Descent 90.00 91.00 90.00 91.00 90.00 91.00 91.00 91.00 91.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 92.00 91.00 91.00 92.00 91.00 92.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91.00 91						
91.00 09100 EMERGENCY 4, 619, 858 0 4, 619, 858 91.00 0200 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 01.00 HER REIMBURSABLE COST CENTERS 942, 970 0 942, 970 101.00 SPECIAL PURPOSE COST CENTERS 942, 970 0 942, 970 101.00 113.00 INTERST EXPENSE 113.00 INTERST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 787, 482 57, 787, 482 118.00 190.00 19200 PHY CLINIC 0 189, 127 190.00 192.01 192.01 192.01 SUBTOTALS (SUM OF LINES 1 through 117) 57, 787, 482 190.00 192.02 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.02 192.02 192.02 192.02 192.02 193.01 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.02 193.02 193.02 193.02 193.02 193.03 <td></td> <td>011,001</td> <td></td> <td>011,001</td> <td></td> <td></td>		011,001		011,001		
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0THER REIMBURSABLE COST CENTERS			1			
OTHER REIMBURSABLE COST CENTERS 101.00 HURPOSE COST CENTERS 101.00 SPECIAL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 787, 482 0 NORE: IMBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 787, 482 0 57, 787, 482 100.00 190.00 190.00 190.00 189, 127 0 189, 127 190.00 190.00 <		4, 019, 030		4,019,030		
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 787, 482 0 NONREI MBURSABLE COST CENTERS 113.00 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 189, 127 0 189, 127 190.01 19200 PHYSICIANS' PRIVATE OFFICES 4, 571, 647 0 4, 571, 647 192.01 19201 SOUTH CLINIC 0 0 0 192.02 192.03 19203 DI ABETES CENTER 109, 683 0 109, 683 192.03 193.01 19301 ADULT/CHI LD CARE 160, 120 0 193.00 19302 193.01 193.03 193.03 193.03 193.03 194.00 0 0 0 193.03 193.03 194.00	OTHER REIMBURSABLE COST CENTERS	0.40, 070		0.40, 0.70		
113.00 11300 INTEREST EXPENSE 113.00 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 787, 482 0 57, 787, 482 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 (IFT, FLOWR, COFFEE SHOP & CANTEEN 189, 127 0 189, 127 190.00 192.01 19201 SOUTH CLINIC 0 0 0 192.01 192.02 19203 SUBTOTALS (SUM OF LINES 4, 571, 647 0 4, 571, 647 192.00 192.02 19203 SOUTH CLINIC 0 0 0 192.02 192.03 19203 DI ABETES CENTER 109, 683 0 192.03 193.00 193.00 19300 NONRAI D WORKERS 0 0 0 193.00 193.02 19302 PHYSI CLAN OFFICE BUILDING 0 0 0 193.02 193.03 19303 OFTI FAST/FOUNDATION 0 0 0 193.02 194.00 07950 PARTNERSHI P HFC 121, 521 121, 521 194.00 194.00 194.02 07952		942, 970	0	942, 970		101.00
NONRE I MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 189, 127 0 189, 127 192.00 PHYSI CI ANS' PRI VATE OFFI CES 4, 571, 647 0 4, 571, 647 192.01 19200 SOUTH CLI NI C 0 0 192.00 192.02 J9202 WEST CLI NI C 0 0 192.02 192.03 DI ABETES CENTER 109, 683 0 109, 683 192.03 193.00 I9300 NONPAI D WORKERS 0 0 193.00 193.00 193.01 J9301 ADULT/CHI LD CARE 160, 120 160, 120 193.01 193.02 19302 PHYSI CI AN OFFI CE BUI LDI NG 0 0 193.02 193.03 19303 OPTI FAST/FOUNDATI ON 0 0 193.03 193.03 194.00 07950 PARTNERSHI P HFC 121, 521 121, 521 194.00 194.01 07951 TRAFALGAR CLI NI C 0 0 194.02 194.02 07952 EDI NBURGH	113.00 11300 INTEREST EXPENSE					
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 189, 127 0 189, 127 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 4, 571, 647 0 4, 571, 647 192.00 192.01 19201 SOUTH CLINIC 0 0 0 192.01 192.02 WEST CLINIC 0 0 0 192.02 192.03 19203 DI ABETES CENTER 109, 683 0 109, 683 192.03 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 ADULT/CHI LD CARE 160, 120 160, 120 193.01 193.02 19303 OPTI FAST/FOUNDATI ON 0 0 0 193.03 194.00 07950 PARTINERSHI P HFC 121, 521 0 121, 521 194.00 194.01 07951 TRAFALGAR CLINIC 0 0 0 194.02 194.02 07952 EDI NBURGH 59, 859 59, 859 194.03 194.04 07954 ATHLETI C TRAI NERS 1, 473 1, 473 194.04 <td></td> <td>57, 787, 482</td> <td>0</td> <td>57, 787, 482</td> <td></td> <td>118.00</td>		57, 787, 482	0	57, 787, 482		118.00
192.01 19201 SOUTH CLINIC 0 0 192.01 192.02 WEST CLINIC 0 0 0 192.02 192.03 19203 DI ABETES CENTER 109, 683 0 192.03 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 1901/CHI LD CARE 160, 120 0 193.02 193.02 193.03 OPTI FAST/FOUNDATI ON 0 0 193.02 193.03 19303 OPTI FAST/FOUNDATI ON 0 0 0 193.03 194.00 07950 PARTNERSHI P HFC 121, 521 0 121, 521 194.00 194.01 07951 TRAFALGAR CLINIC 0 0 0 194.01 194.02 07952 EDI NBURGH 0 0 0 194.02 194.03 07953 JAI L 59, 859 59, 859 194.03 194.03 194.04 07954 ATHLETIC TRAINERS 1, 473 144.03 194.04 194.03 194.04 00 0 0 0 200	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	189, 127	0	189, 127		
192.02 WEST CLINIC 0 0 192.02 192.03 19203 DI ABETES CENTER 109,683 109,683 192.03 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 ADULT/CHI LD CARE 160,120 160,120 193.02 193.03 0PTI FAST/FOUNDATI ON 193.02 193.03 0PTI FAST/FOUNDATI ON 0 0 193.03 193.03 0715 TRAFALGAR CLINIC 0 193.03 193.03 0750 PARTNERSHI P HFC 121,521 0 121,521 194.00 194.01 194.00 07950 PARTNERSHI P HFC 121,521 0 121,521 194.00 194.01 194.02 07952 EDI NBURGH 0 0 0 0 194.02 194.03 07953 JAI L 59,859 0 59,859 194.03 194.03 194.04 07954 ATHLETI C TRAINERS 1,473 0 1,473 194.03 194.04 07954 ATHLETI C TRAINERS 0 0 0 0 00.00 <td< td=""><td></td><td>4, 571, 647</td><td>0</td><td></td><td></td><td></td></td<>		4, 571, 647	0			
193.00 19300 NONPAI D WORKERS 0 0 193.00 193.01 19301 ADULT/CHI LD CARE 160,120 160,120 193.01 193.02 19302 PHYSI CI AN OFFICE BUI LDI NG 0 0 0 193.02 193.03 OPTI FAST/FOUNDATI ON 0 0 0 193.03 194.00 193.03 194.00 193.03 194.00 193.03 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.01 194.01 194.01 194.01 194.01 194.01 194.01 194.01 194.01 194.01 194.01 194.02 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.03 194.04 194.		0	0	-		
193.01 19301 ADULT/CHI LD CARE 160, 120 193.01 193.02 19302 PHYSI CI AN OFFICE BUI LDI NG 0 0 193.02 193.03 19303 OPTI FAST/FOUNDATI ON 0 0 0 193.03 194.00 07950 PARTNERSHI P. HFC 121, 521 0 121, 521 194.00 194.01 07951 TRAFALGAR CLI NI C 0 0 0 194.01 194.02 07952 EDI NBURGH 0 0 0 194.02 194.03 07953 JAI L 59, 859 0 59, 859 194.02 194.04 07954 ATHLETI C TRAI NERS 1, 473 194.04 194.04 200.00 Cross Foot Adj ustments 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 201.00		109, 683	0	109, 683		
193.02 19302 PHYSI CI AN OFFICE BUI LDI NG 0 0 193.02 193.03 19303 OPTI FAST/FOUNDATI ON 0 0 193.03 194.00 07950 PARTNERSHI P. HFC 121,521 121,521 194.00 194.01 07951 TRAFALGAR CLINIC 0 0 0 194.01 194.02 07952 EDI NBURGH 0 0 194.02 194.02 194.03 07953 JAI L 59,859 0 59,859 194.03 194.03 194.04 07954 ATHLETI C TRAINERS 1,473 0 1,473 194.04 200.00 Cross Foot Adj ustments 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 201.00		0 160_120	0	0 160 120		
194.00 07950 PARTNERSHI P HFC 121, 521 0 121, 521 194.00 194.01 07951 TRAFALGAR CLINIC 0 0 0 194.01 194.02 07952 EDI NBURGH 0 0 0 194.02 194.03 07953 JAI L 59,859 0 59,859 194.03 194.04 07954 ATHLETI C TRAINERS 1,473 0 1,473 194.03 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00	193.02 19302 PHYSICIAN OFFICE BUILDING	0	0			193.02
194.01 07951 TRAFALGAR CLINIC 0 0 194.01 194.02 07952 EDI NBURGH 0 0 194.02 194.03 07953 JAI L 59,859 0 59,859 194.03 194.04 07954 ATHLETI C TRAINERS 1,473 0 1,473 194.04 200.00 Cross Foot Adjustments 0 0 0 200.00 200.00 201.00 Negative Cost Centers 0 0 0 201.00		0	0	0		
194. 02 07952 EDI NBURGH 0 0 194. 02 194. 03 07953 JAI L 59, 859 0 59, 859 194. 03 194. 04 07954 ATHLETI C TRAI NERS 1, 473 0 1, 473 194. 04 200. 00 Cross Foot Adjustments 0 0 0 200. 00 200. 00 201. 00 Negative Cost Centers 0 0 0 201. 00		121, 521	0			
194.04 07954 ATHLETI C TRAI NERS 1,473 0 1,473 194.04 200.00 Cross Foot Adjustments 0 0 0 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00	194. 02 07952 EDI NBURGH	0	Ō	0		194.02
200.00 Cross Foot Adjustments 0 0 200.00 201.00 Negative Cost Centers 0 0 0 201.00			0			
201.00 Negative Cost Centers 0 0 0 201.00			0			
202.00 101AL (SUM LINES 118 THROUGH 201) 63,000,912 0 63,000,912 202.00	201.00 Negative Cost Centers	0		0		
	202.00 IUTAL (Sum LINES ITS THROUGH 201)	03, 000, 912	0J	63, 000, 912		J2U2. UU

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	JOHNSON MEMORI	AL HOSPITAL Provider CC	F	In Lieu eriod: rom 01/01/2020 o 12/31/2020	u of Form CMS-: Worksheet B Part II Date/Time Pre 7/30/2021 11:	pared:
		CAPI TAL REL	ATED COSTS		773072021 11.	
Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						1
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	О	29, 962	1, 970	31, 932	31, 932	4.00
4. 01 00401 COMMUNI CATI ONS	0	3, 946			92	4.01
4. 02 00402 DATA PROCESSI NG	0	62,857	2,073,213		752	4.02
4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG	0	38, 417 22, 482	9, 822 0		372 806	4.03 4.04
4. 05 00405 PATI ENT ACCOUNTI NG	0	66, 773	17, 336		900	4.05
5.00 00500 ADMINI STRATI VE & GENERAL	0	95, 651	43, 513		1, 998	5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	0	290, 236 24, 139			920 106	7.00 8.00
9. 00 00900 HOUSEKEEPI NG	0	18, 747	6, 613		720	9.00
10. 00 01000 DI ETARY	0	39, 331	30, 779	70, 110	284	10.00
11. 00 01100 CAFETERIA	0	41,881	0		416	11.00
13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY	0	99, 075 17, 060	48, 515 48, 934		1, 274 75	13.00 14.00
15. 00 01500 PHARMACY	0	20, 544	8, 271		715	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	38, 949	11, 951	50, 900	471	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	276, 902	222, 293	499, 195	5, 328	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	79, 184	52, 785		1, 223	31.00
41. 00 04100 SUBPROVIDER - IRF	0	0	C	0	0	41.00
43. 00 04300 NURSERY	0	6, 276	0	6, 276	383	43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	459, 488	660, 977	1, 120, 465	1, 832	50.00
53. 00 05300 ANESTHESI OLOGY	0	3, 956	21, 046		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	165, 998			2, 010	
	0	80, 820	209, 413		2, 149	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	3, 755 63, 640	22, 961 14, 976		1, 091 788	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	13, 405	3, 539		278	67.00
68.00 06800 SPEECH PATHOLOGY	0	833	555		137	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	10, 844 1, 827	50, 333 2, 742		281 0	69.00 70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 027	20, 806		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 ONCOLOGY	0	0	2 209	0	0	73.00
76. 97 07697 CARDIAC REHABILITATION	0	70, 277 25, 213	3, 208 15, 316			76.00 76.97
OUTPATIENT SERVICE COST CENTERS		· · · · ·	· · · ·	· · · · ·		
90. 00 09000 CLINIC	0	115, 633			750	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	99, 748	46, 113	145, 861 0	3, 005	91.00 92.00
OTHER REI MBURSABLE COST CENTERS	I I			-		12100
101.00 10100 HOME HEALTH AGENCY	0	13, 104	96	13, 200	586	101.00
SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 400, 953	4, 256, 005	6, 656, 958	30, 213	118.00
NONREI MBURSABLE COST CENTERS	L					
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	13, 023 260, 314				190.00 192.00
192. 01 19200 PHTSICIANS PRIVATE OFFICES	0	200, 314	156, 600			192.00
192. 02 19202 WEST CLINIC	0	0	C			192.02
192. 03 19203 DI ABETES CENTER	0	4, 036	805		72	192.03
193. 00 19300 NONPAI D WORKERS 193. 01 19301 ADULT/CHI LD CARE	0	0 48, 518				193. 00 193. 01
193. 02 19302 PHYSI CI AN OFFICE BUILDING	0	48, 518				193.01
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	C	-	0	193.03
194. 00 07950 PARTNERSHI P HFC	0	22, 371	0	,		194.00
194. 01 07951 TRAFALGAR CLI NI C 194. 02 07952 EDI NBURGH	0	0		0		194.01 194.02
194. 03 07953 JAI L	0	0	0	0		194.02
194. 04 07954 ATHLETI C TRAI NERS	0	0	C	0		194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers		~		0	0	200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	0	0 2, 749, 215	4, 422, 288	0 7, 171, 503		201.00
	1					•

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		eri od:	Worksheet B	
				rom 01/01/2020 b 12/31/2020	Part II Date/Time Pre	pared:
Cost Conton Deconintian	COMMUNI CATI ON	DATA	MATERI ALS	ADMI TTI NG	7/30/2021 11: PATI ENT	08 am
Cost Center Description	S	PROCESSING	MANAGEMENT	ADMITTING	ACCOUNTING	
	4. 01	4.02	4.03	4.04	4.05	
GENERAL SERVICE COST CENTERS						1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01 00401 COMMUNI CATI ONS	4, 038					4.01
4. 02 00402 DATA PROCESSI NG	402	2, 137, 224				4.02
4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG	86 101	46, 276 75, 000		98, 389		4.03 4.04
4. 05 00405 PATIENT ACCOUNTING	262	180, 318		0, 507	265, 589	4.05
5. 00 00500 ADMINI STRATI VE & GENERAL	229	256, 382		0	0	5.00
7.00 00700 OPERATION OF PLANT	146	35, 638		0	0	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	15 42	13, 298 0	0	0	0	8.00 9.00
10. 00 01000 DI ETARY	77	29, 255		0	0	10.00
11. 00 01100 CAFETERI A	0	0	0	0	0	11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	137	39, 362	0	0	0	13.00
14. 00 01400 CENTRAL_SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0 68	0 36, 170	506 36, 603	0	0	14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	110	77, 127		0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					-	
30. 00 03000 ADULTS & PEDI ATRI CS	312	118, 085		4, 941	13, 337	30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	83 54	73, 404 0	535 0	726 0	1, 958 0	31.00 41.00
41.00 04100 SUBPROVIDER - TRP 43.00 04300 NURSERY	0	0		716	1, 932	41.00
ANCI LLARY SERVICE COST CENTERS	<u> </u>			, 10	1,702	10100
50.00 05000 OPERATING ROOM	262	192, 020		12, 938	34, 922	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		1, 957	5, 283	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	155 202	80, 319 95, 744	1, 443 14, 321	21, 402 15, 892	57, 786 42, 896	54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	54	59, 574		2, 269	6, 124	65.00
66. 00 06600 PHYSI CAL THERAPY	74	22, 340		1, 366	3, 687	66.00
67.00 06700 OCCUPATI ONAL THERAPY	18	9, 574	0	449	1, 212	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	18 128	5, 319 68, 617	1	131 1, 459	354 3, 938	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	6	00,017	4	29	5, 750	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	28, 768	4, 412	11, 910	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	2,875	7,760	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03020 ONCOLOGY	0 110	0 25, 532	0	9, 341 380	25, 214 1, 025	73.00 76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	25, 552		202	545	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · · ·					
90. 00 09000 CLINIC	62	78, 191	4, 156	4, 559	12, 307	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	176	84, 574	2, 051	12, 022	32, 451	91.00 92.00
OTHER REI MBURSABLE COST CENTERS	<u> </u>			1		72.00
101.0010100 HOME HEALTH AGENCY	68	22, 340	92	323	871	101.00
SPECIAL PURPOSE COST CENTERS	1					112 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 457	1, 724, 459	94, 922	98, 389	265, 589	113.00 118.00
NONREI MBURSABLE COST CENTERS	3,437	1,724,437	74,722	70, 307	200, 007	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	45	25, 532		0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	488	376, 063		0		192.00
192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC	0	0	0	0		192.01 192.02
192. 03 19203 DI ABETES CENTER	9	1, 596	4	0		192.02
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
193. 01 19301 ADULT/CHI LD CARE	15	0	0	0		193.01
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193. 02 193. 03
194. 00 07950 PARTNERSHI P HFC	24	9, 574	2	0		193.03
194. 01 07951 TRAFALGAR CLI NI C	0	0	0	Ō	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	0	0	0	0	0	194. 04 200. 00
201.00 Negative Cost Centers	0	0	0	О		201.00
202.00 TOTAL (sum lines 118 through 201)	4, 038	2, 137, 224	94, 973	98, 389	265, 589	202.00

Health F	inancial Systems	JOHNSON MEMORI	AL HOSPLTAL		Inlie	u of Form CMS-	2552-10
	I ON OF CAPITAL RELATED COSTS		Provi der C		eriod:	Worksheet B	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	epared:
						7/30/2021 11:	08 am
	Cost Center Description	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5.00	7.00	8.00	9.00	10.00	
G	ENERAL SERVICE COST CENTERS						
	0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT 0401 COMMUNI CATI ONS						4.00 4.01
	0402 DATA PROCESSING						4.02
4.03 0	0403 MATERIALS MANAGEMENT						4.03
	0404 ADMITTING						4.04
	0405 PATI ENT ACCOUNTI NG 0500 ADMI NI STRATI VE & GENERAL	732					4.05 5.00
	0700 OPERATION OF PLANT	45	393, 727				7.00
	0800 LAUNDRY & LINEN SERVICE	3	4, 443				8.00
	10900 HOUSEKEEPI NG	12	3, 451		38, 782		9.00
	1000 DI ETARY	8	7,240		728	108, 793	
	1100 CAFETERI A 1300 NURSI NG ADMI NI STRATI ON	6 24	7, 709 18, 238		775 1, 833	0	
	1400 CENTRAL SERVICES & SUPPLY	3	3, 140		316	0	
	1500 PHARMACY	26	3, 782		380	0	
	1600 MEDICAL RECORDS & LIBRARY	11	7, 170	0	721	0	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS		F0.032	10.412	E 400	00 (00	20.00
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	80 23	50, 972 14, 576		5, 123 1, 465	99, 602 9, 191	30.00
	4100 SUBPROVIDER – I RF	23	14, 576		1,405	9, 191	
	4300 NURSERY	6	1, 155		116	0	
	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	56	84, 584		8, 501	0	
	15300 ANESTHESI OLOGY 15400 RADI OLOGY-DI AGNOSTI C	2 60	728 30, 557		73 3, 071	0	
	6000 LABORATORY	55	14, 877		1, 495	0	
	6500 RESPI RATORY THERAPY	21	691		69	0	
	6600 PHYSI CAL THERAPY	14	11, 715		1, 178	0	
	6700 OCCUPATI ONAL THERAPY	5	2,468		248	0	
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	2	153 1, 996		15 201	0	
	7000 ELECTROENCEPHALOGRAPHY	0	336		34	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31	0		0	0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENT	32	0		0	0	
	7300 DRUGS CHARGED TO PATIENTS	55	0		0	0	
	13020 ONCOLOGY 17697 CARDI AC REHABI LI TATI ON	8	12, 937 4, 641	0	1, 300 467	0	
	UTPATIENT SERVICE COST CENTERS	5	-, 0+1	0	407	0	,0. ,,
90.00 0	9000 CLI NI C	27	21, 286	202	2, 140	0	90.00
	9100 EMERGENCY	43	18, 362	9, 712	1, 846	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) THER REIMBURSABLE COST CENTERS						92.00
	0100 HOME HEALTH AGENCY	11	2, 412	0	242	0	101.00
	PECIAL PURPOSE COST CENTERS		2,2				
	1300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	680	329, 619	48, 645	32, 337	108, 793	118.00
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2	2, 397	0	241	0	190.00
	9200 PHYSICIANS' PRIVATE OFFICES	46	47, 919		4, 817		192.00
	9201 SOUTH CLINIC	0	0	0	0		192.01
	9202 WEST CLINIC	0	0		0		192.02
	9203 DI ABETES CENTER	1	743		75		192.03
	9300 NONPAI D WORKERS 9301 ADULT/CHI LD CARE	0	0 8, 931	0	0 898		193.00 193.01
	9301 ADDET7CHTED CARE 9302 PHYSICIAN OFFICE BUILDING	0	8, 931		898 0		193.01
193.031	9303 OPTI FAST/FOUNDATI ON	0	0		0		193.03
194.000	7950 PARTNERSHI P HFC	1	4, 118		414	0	194.00
	17951 TRAFALGAR CLINIC	0	0	0	0		194.01
	17952 EDI NBURGH 17953 JAI L	0	0	0	0		194.02 194.03
	17953 JATE 17954 ATHLETI C TRAI NERS	0	0		0		194.03
200.00	Cross Foot Adjustments		0		Ŭ		200.00
201.00	Negative Cost Centers	397, 041	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	397, 773	393, 727	49, 353	38, 782	108, 793	202.00

Health Financial Systems	JOHNSON MEMOR	LAL HOSPITAL		In Lieu	ı of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2020	Worksheet B Part II	
				To 12/31/2020	Date/Time Pre	pared:
Cost Center Description	CAFETERIA	NURSI NG	CENTRAL	PHARMACY	7/30/2021 11: MEDI CAL	08 am
		ADMI NI STRATI O	SERVICES &		RECORDS &	
	11.00	N 13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS						1
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 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 PROCESSI NG 4. 03 00403 MATERI ALS MANAGEMENT						4.02 4.03
4. 04 00404 ADMI TTI NG						4.04
4. 05 00405 PATIENT ACCOUNTING						4.05
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	50, 787					10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 622					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	242		73, 52			14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	1,001			0 107, 560 0 0	127 015	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	1,203	0		0 0	137, 815	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	5, 530			0 0	6, 923	30.00
31. 00 03100 INTENSIVE CARE UNIT	2,027			0 0 0 0	1,017	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0 723			0 0 0 0	0 1, 003	
ANCILLARY SERVICE COST CENTERS				- L		
50. 00 05000 OPERATING ROOM	3, 345			0 0	18, 127	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 3, 448			0 0 0 0	2, 742 29, 950	•
60. 00 06000 LABORATORY	4, 771			0 0	22, 266	
65. 00 06500 RESPI RATORY THERAPY	1, 758			0 0	3, 179	•
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	1, 294 401			0 0	1, 914 629	•
68. 00 06800 SPEECH PATHOLOGY	193			0 0	184	68.00
69. 00 06900 ELECTROCARDI OLOGY	610			0 0	2,044	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		73, 52	0 0 3 0	40 6, 182	70.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	-		0 0	4, 028	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 107, 560	13,088	
76. 00 03020 0NC0L0GY 76. 97 07697 CARDI AC REHABI LI TATI ON	578 234			0 0 0 0	532 283	
OUTPATIENT SERVICE COST CENTERS	234	0		0 0	203	/0. 7/
90. 00 09000 CLINIC	1, 686			0 0	6, 388	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 808	51, 030		0 0	16, 844	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	923	0		0 0	452	101.00
SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	35, 477	210, 080	73, 52	3 107, 560	137, 815	
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	191 14, 762			0 0 0 0		190.00 192.00
192. 01 19201 SOUTH CLINIC	0			0 0		192.00
192. 02 19202 WEST CLINIC	0	-		0 0		192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	109			0 0		192.03 193.00
193. 01 19301 ADULT/CHI LD CARE	0	0		0 0		193.00
193. 02 19302 PHYSICIAN OFFICE BUILDING	0	0		0 0		193.02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	0	-		0 0		193.03 194.00
194. 00 07950 PARTNERSHIP HFC 194. 01 07951 TRAFALGAR_CLINIC	124			0 0		194.00 194.01
194. 02 07952 EDI NBURGH	0	0		0 0	0	194.02
194. 03 07953 JALL	0	0				194.03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	124	0			0	194.04 200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	50, 787	210, 080	73, 52	3 107, 560	137, 815	202.00

	Financial Systems	JOHNSON MEMORI		N 15 0001		of Form CMS-2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CC	JN: 15-0001	From 01/01/2020	Worksheet B Part II
					To 12/31/2020	Date/Time Prepared: 7/30/2021 11:08 am
	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT					4.00
4.01 4.02	00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG					4.01
4.02	00403 MATERIALS MANAGEMENT					4.02
4.04	00404 ADMI TTI NG					4.04
4.05	00405 PATIENT ACCOUNTING					4.05
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
	01300 NURSI NG ADMI NI STRATI ON					13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	898, 174	0	898, 1		30.00
	03100 I NTENSI VE CARE UNI T	268, 905	0	268, 9		31.00
	04100 SUBPROVI DER – I RF 04300 NURSERY	54 22, 617	0	22,6	54	41.00 43.00
101 00	ANCI LLARY SERVI CE COST CENTERS	227017		22,0		
50.00	05000 OPERATI NG ROOM	1, 531, 413	0	1, 531, 4		50.00
53.00	05300 ANESTHESI OLOGY	35, 789	0	35, 7		53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	909, 088 504, 901	0	909, C 504, 9		54.00 60.00
65.00	06500 RESPIRATORY THERAPY	102, 877	0	102, 8		65.00
66.00	06600 PHYSI CAL THERAPY	123, 989	0	123, 9		66.00
67.00	06700 OCCUPATI ONAL THERAPY	32, 226	0	32, 2		67.00
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	7, 895 140, 886	0	7,8		68.00
69.00 70.00	07000 ELECTROENCEPHALOGRAPHY	5, 095	0	140, 8 5, C		69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	145, 632	0	145,6		71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	14, 695	0	14,6	95	72.00
	07300 DRUGS CHARGED TO PATIENTS	155, 258	0	155, 2		73.00
76.00 76.97	03020 ONCOLOGY 07697 CARDIAC REHABILITATION	116, 364 47, 134	0	116, 3 47, 1		76.00 76.97
	OUTPATIENT SERVICE COST CENTERS	47, 134	V	47,1	54	/0. //
	09000 CLINIC	271, 881	0	271, 8	81	90.00
	09100 EMERGENCY	381, 785	0	381, 7	85	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	41, 520	0	41, 5	20	101.00
	SPECIAL PURPOSE COST CENTERS	,	-1			
	11300 INTEREST EXPENSE					113.00
118.00		5, 758, 178	0	5, 758, 1	78	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	48, 136	0	48, 1	36	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	865, 532	0	865, 5		192.00
192.01	19201 SOUTH CLINIC	0	Ō		0	192.01
	19202 WEST CLINIC	0	0	_	0	192.02
	19203 DI ABETES CENTER 19300 NONPAI D WORKERS	7,450	0	7,4	.50	192. 03 193. 00
	19300 ADULT/CHILD CARE	58, 363	0	58, 3	63	193.00
	19302 PHYSI CI AN OFFICE BUILDING	00,000	0	55,6	0	193.02
193.03	19303 OPTI FAST/FOUNDATI ON	0	О		0	193.03
	07950 PARTNERSHI P HFC	36, 629	0	36, 6		194.00
	07951 TRAFALGAR CLINIC 07952 EDINBURGH	0	0		0	194. 01 194. 02
174.02	07952 EDINBURGH 07953 JAI L	50	0		50	194.02
194.03			Ŭ	1		
	07954 ATHLETI C TRAI NERS	124	0	I	24	194.04
194. 04 200. 00	Cross Foot Adjustments	0	0 0		0	200.00
194.04	Cross Foot Adjustments Negative Cost Centers	124 0 397, 041 7, 171, 503	0 0 0 0	ا 397, C 7, 171, 5	0 041	

CUST A	LLOCATION - STATISTICAL BASIS	JOHNSON MEMORI	Provi der C	CN: 15-0001 F	Period: From 01/01/2020	u of Form CMS-2 Worksheet B-1	
					To 12/31/2020	Date/Time Pre 7/30/2021 11:	
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	COMMUNI CATI ON S (# NON PT PHONES)	DATA PROCESSING (WORK ORDERS)	
		1.00	2.00	4.00	4.01	4.02	
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	273, 798		1	1		1.00
2.00 4.00 4.01 4.02 4.03 4.04 4.04	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	2, 984 393 6, 260 3, 826 2, 239 6, 650 9, 526	2, 575, 452 1, 147 0 1, 207, 398 5, 720 0 10, 096 25, 341	31, 350, 147 89, 875 738, 078 364, 737 791, 259	5 1,357 3 135 7 29 9 34 4 88	4, 018 87 141 339 482	2.00 4.00 4.01
8.00 9.00 10.00 11.00 13.00 14.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	28, 905 2, 404 1, 867 3, 917 4, 171 9, 867 1, 699	38, 869 4, 280 3, 851 17, 925 0 28, 254 28, 498	104, 011 706, 399 279, 194 408, 475 1, 249, 915 73, 918	I 5 P 14 4 26 5 0 5 46 3 0	67 25 0 55 0 74 0	10.00 11.00 13.00 14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 046 3, 879	4, 817 6, 960			68 145	
	INPATIENT ROUTINE SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·				1
31. 00 41. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04300 NURSERY	27, 577 7, 886 0 625	129, 459 30, 741 0 0	1, 200, 518 (3 28 0 18	222 138 0 0	41.00
50.00	ANCI LLARY SERVI CE COST CENTERS	45, 761	384, 940	1, 797, 408	88	361	50.00
53.00 54.00 60.00 65.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY	394 16, 532 8, 049 374	12, 257 296, 632 121, 958 13, 372	0 1, 972, 415 2, 109, 124	0 0 5 52 4 68 1 18	0 151 180 112	53.00 54.00
67.00 68.00 69.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 338 1, 335 83 1, 080	8, 722 2, 061 323 29, 313	273, 289 134, 167 275, 640	9 6 7 6 0 43	42 18 10 129	67.00 68.00 69.00
71.00 72.00 73.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	182 0 0 0	1, 597 12, 117 0 0			0 0 0 0	71.00 72.00 73.00
	03020 ONCOLOGY 07697 CARDI AC REHABI LI TATI ON	6, 999 2, 511	1, 868 8, 920			48 0	
90. 00 91. 00	OUTPATI ENT SERVICE COST CENTERS 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 516 9, 934	14, 265 26, 855			147 159	90.00 91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	1, 305	56	574, 994	4 23	42	101.00
	SPECIAL PURPOSE COST CENTERS	.,				12	
118.00	NONREI MBURSABLE COST CENTERS	239, 114		1	1 1		113.00 118.00
192. 00 192. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 SOUTH CLINIC	1, 297 25, 925 0	3, 854 92, 517 0	1, 525, 817 (7 164	707 0	190.00 192.00 192.01
192. 03 193. 00	19202 WEST CLINIC 19203 DIABETES CENTER 19300 NONPAID WORKERS 19301 ADULT/CHILD CARE	0 402 0 4, 832	0 469 0 0		0 4 3 0 0 0 5	3 0	192. 02 192. 03 193. 00 193. 01
193. 03 194. 00 194. 01 194. 02	19302 PHYSI CI AN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION 07950 PARTNERSHIP HFC 07951 TRAFALGAR CLINIC 07952 EDINBURGH	0 0 2, 228 0 0	0 0 0 0 0	((1, 183 ((0 0	0 18 0 0	193. 02 193. 03 194. 00 194. 01 194. 02
194.03	07953 JAIL 07954 ATHLETIC TRAINERS Cross Foot Adjustments Negative Cost Centers	0	0	48, 000 (0 0 0 0	0	194. 03 194. 04 200. 00 201. 00
202.00	5	2, 749, 215 10. 041034				5, 403, 695 1, 344. 871827	202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				rom 01/01/2020 o 12/31/2020	Date/Time Pre 7/30/2021 11:	pared: 08 am
	CAPI TAL REL	ATED COSTS				
Cost Center Description	NEW BLDG & FI XT	MVBLE EQUI P (DOLLAR	EMPLOYEE BENEFI TS	COMMUNI CATI ON S	DATA PROCESSI NG	
	(SQUARE FEET)	VALUE)	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)			31, 932	4, 038	2, 137, 224	204.00
205.00 Unit cost multiplier (Wkst. B, Part		-	0. 001019	2. 975682	531. 912394	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems LLOCATION - STATISTICAL BASIS	JOHNSON MEMORIA	Provider CC		Period:	u of Form CMS-: Worksheet B-1	
				1	From 01/01/2020 To 12/31/2020	Date/Time Pre	pared
	Cost Conton Description	MATERI ALS	ADMI TTI NG	PATIENT	Reconciliatio	7/30/2021 11:	08 ar
	Cost Center Description	MANAGEMENT	(GROSS	ACCOUNTING	n	E & GENERAL	
		(SUPPLY	CHARGES)	(GROSS		(ACCUM.	
		USAGE) 4.03	4.04	CHARGES) 4.05	5A	COST) 5.00	
	GENERAL SERVICE COST CENTERS	4.03	4.04	4.05	5A	5.00	
. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
. 01 . 02	00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG						4.0
. 02	00403 MATERIALS MANAGEMENT	11, 339, 048					4.
. 04	00404 ADMI TTI NG	0	259, 559, 787				4.0
. 05	00405 PATI ENT ACCOUNTI NG	0	0	259, 559, 78		10 000 501	4.
. 00 . 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	0		0 -2,376 0 0	62, 998, 536 3, 736, 436	
. 00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0 0 0	290, 950	
. 00	00900 HOUSEKEEPI NG	0	0		0 0	1, 009, 488	
0.00	01000 DI ETARY	0	0		0 0	627, 635	
1.00		0	0		0 0	508, 576	
3.00 4.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	60, 418	0		0 0 0 0	1, 991, 775 248, 224	
4.00 5.00	01500 PHARMACY	4, 370, 208	0		0 0	248, 224	
6.00	01600 MEDI CAL RECORDS & LI BRARY	2, 658	0		0 0	918, 665	
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS	218, 502	13, 037, 493	13, 037, 49			
1.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	63, 825	1, 914, 317	1, 914, 31		1, 893, 898	
1.00 3.00	04100 SUBPROVIDER - TRF 04300 NURSERY	0	0 1, 888, 157	1, 888, 15	-	4, 734 533, 627	
5.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	1,000,107	1,000,10	/ 0	555, 627	
0.00	05000 OPERATING ROOM	330, 967	34, 136, 721	34, 136, 72	1 0	4, 644, 873	50.
3.00	05300 ANESTHESI OLOGY	191	5, 163, 809	5, 163, 80		146, 741	
4.00	05400 RADI OLOGY-DI AGNOSTI C	172, 302	56, 428, 806	56, 428, 80		4, 969, 699	
0.00		1, 709, 810	41, 931, 779	41, 931, 77		6, 765, 665	
5.00 6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	158, 930 20, 517	5, 986, 282 3, 604, 582	5, 986, 28 3, 604, 58		1, 761, 165 1, 164, 098	
7.00	06700 OCCUPATI ONAL THERAPY	20, 317	1, 185, 057	1, 185, 05		399, 859	
8.00	06800 SPEECH PATHOLOGY	110	345, 899	345, 89		188, 742	
9.00	06900 ELECTROCARDI OLOGY	9, 195	3, 849, 339	3, 849, 33		676, 720	
0.00	07000 ELECTROENCEPHALOGRAPHY	473	75, 636	75, 63		10, 054	
1.00 2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	3, 434, 529 0	11, 641, 998 7, 585, 621	11, 641, 99 7, 585, 62		2, 549, 562 2, 630, 498	
3.00	07300 DRUGS CHARGED TO PATIENTS	0	24, 646, 971	24, 646, 97		4, 578, 333	
6.00	03020 ONCOLOGY	17,076	1,001,841	1,001,84		677, 581	
6. 97	07697 CARDI AC REHABI LI TATI ON	11, 092	533, 218	533, 21		249, 132	76.
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
		496, 192	12,029,851				
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	244, 907	31, 721, 247	31, 721, 24	7 0	3, 613, 889	91.
2.00	OTHER REIMBURSABLE COST CENTERS	II	1				72.
01.00	10100 HOME HEALTH AGENCY	11,008	851, 163	851, 16	3 0	898, 814	101.
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		050 550 707	050 550 70		50 7/0 000	113.
18.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	11, 332, 910	259, 559, 787	259, 559, 78	7 -2, 376	58, 763, 999	118.
90 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 398	0		0 0	157, 236	190
	19200 PHYSI CI ANS' PRI VATE OFFI CES	40	0		0 0	3, 799, 266	
	19201 SOUTH CLINIC	0	0		0 0		192.
	19202 WEST CLINIC	0	0		0 0		192.
	19203 DI ABETES CENTER	495	0		0 0	99, 208	
	19300 NONPAI D WORKERS 19301 ADULT/CHI LD CARE	0	0		0 0 0 0	0 49, 794	193.
	19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING	0	0		0 0		193.
	19303 OPTI FAST/FOUNDATI ON	0	0		0 0		193.
94.00	07950 PARTNERSHI P HFC	205	0		0 0	69, 176	194.
	07951 TRAFALGAR CLINIC	0	0		0 0		194.
	07952 EDI NBURGH	0	0		0 0		194.
	07953 JAI L 07954 ATHLETI C TRAI NERS	0	0			59, 857	194. 194.
94.04 00.00		0	U		0	0	200.
00.00 01.00							200.
02.00		653, 506	1, 214, 594	2, 274, 17	8	2, 376	
	Part I)						
03.00		0. 057633 94, 973	0. 004679 98, 389	0. 00876 265, 58		0. 000038 397, 773	
04.00	Cost to be allocated (per Wkst. B,						

Health Fir	nancial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020		epared: 08 am
	Cost Center Description	MATERI ALS	ADMI TTI NG	PATI ENT	Reconciliatio	ADMI NI STRATI V	
		MANAGEMENT	(GROSS	ACCOUNTI NG	n	E & GENERAL	
		(SUPPLY	CHARGES)	(GROSS		(ACCUM.	
		USAGE)		CHARGES)		COST)	
		4. 03	4.04	4.05	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 008376	0. 000379	0. 00102	3	0. 000012	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

COST ALLOCATION - STATISTICAL BASIS			AL HOSPITAL Provider C		Period:	u of Form CMS-: Worksheet B-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	pare
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	7/30/2021 11: CAFETERI A (HOURS PAI D)	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						1.
00 (00) 00 (01) 02 (02) 03 (03) 04 (03) 05 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00) 00 (00)	00100 NEW CAP KEE COSTS-BUDG & TTAT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG 00403 MATERI ALS MANAGEMENT 00404 ADMI TTI NG 00404 ADMI TTI NG 00405 PATI ENT ACCOUNTI NG 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	213, 015 2, 404 1, 867 3, 917 4, 171 9, 867 1, 699 2, 046 3, 879	384, 432 71, 642 8, 495 0 0 0 0 0 0 0	208, 74 3, 91 4, 17 9, 86 1, 69 2, 04	7 17,862 1 0 7 0 9 0 6 0	853, 717 27, 263 4, 073 16, 821 21, 571	2. 4. 4. 4. 4. 5. 7. 8. 9. 10. 11. 13. 14. 15.
	03000 ADULTS & PEDIATRICS	27, 577	104, 516	27, 57	7 16, 353	92, 959	30.
	03100 I NTENSI VE CARE UNI T	7, 886				34, 072	
	04100 SUBPROVI DER – I RF 04300 NURSERY	0 625	0		0 5 0	0 12, 151	41.
ŀ	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	45, 761 394	52, 622			56, 231 0	
	05400 RADI OLOGY-DI AGNOSTI C	16, 532	-			57, 952	
0.00	06000 LABORATORY	8, 049				80, 204	
	06500 RESPIRATORY THERAPY	374	0			29, 560	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 338 1, 335				21, 744 6, 739	
	06800 SPEECH PATHOLOGY	83				3, 241	
1	06900 ELECTROCARDI OLOGY	1, 080				10, 250	
		182				0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	-	1		0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	03020 ONCOLOGY	6, 999				9, 708	
	07697 CARDIAC REHABILITATION DUTPATIENT SERVICE COST CENTERS	2, 511	0	2, 51	1 0	3, 930	76.
	09000 CLINIC	11, 516	1, 575	11, 51	6 0	28, 338	90
1.00	09100 EMERGENCY	9, 934					91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS	1, 305	0	1, 30	5 0	15, 514	101
0	SPECIAL PURPOSE COST CENTERS	,	-				
18.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	178, 331	378, 916	174,060	0 17, 862	596, 325	113 118
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 297	0	1, 29	7 0	3, 212	1190
	19200 PHYSI CI ANS' PRI VATE OFFI CES	25, 925				248, 188	
	19201 SOUTH CLINIC	0	0		o o		192
	19202 WEST CLINIC 19203 DIABETES CENTER	0 402	0	402		0 1, 826	192
	19300 NONPAI D WORKERS	402	0		0 0		192
	19301 ADULT/CHILD CARE	4, 832	0	4, 83	2 0		193
1	19302 PHYSI CI AN OFFI CE BUI LDI NG	0	0		0 0		193
	19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI P HFC	2, 228		2, 22		2, 083	193 194
	07950 PARTNERSHIP HPC 07951 TRAFALGAR CLINIC	0	0	2,220			194
4. 02	07952 EDI NBURGH	0	0		0 0	0	194
	07953 JAI L 07954 ATHLETI C TRAI NERS	0	0			0 2, 083	194.
94.040 00.00	Cross Foot Adjustments	0				2, 083	200
01.00	Negative Cost Centers						201
02.00	Cost to be allocated (per Wkst. B, Part I)	3, 736, 578					
03.00 04.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	17. 541384 393, 727				0. 707292 50, 787	

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0001	Period: From 01/01/2020	Worksheet B-1	
				To 12/31/2020		
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET) (MEALS	(HOURS	
	(SQUARE FEET)	(POUNDS OF		SERVED)	PAID)	
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
205.00 Unit cost multiplier (Wkst. B, Part	1.848353	0. 128379	0. 18578	6. 090751	0. 059489	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems LOCATION - STATISTICAL BASIS	JOHNSON MEMORI	AL HOSPITAL Provider CCI		Period:	u of Form (Worksheet	
					From 01/01/2020 To 12/31/2020	Date/Time 7/30/2021	
	Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS) 13. 00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14. 00	PHARMACY (COSTED REQUIS.) 15.00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	17/30/2021	
	GENERAL SERVICE COST CENTERS	1					1.00
2.00 (4.00 (4.01 (4.02 (4.03 (4.04 (5.00 (7.00 (8.00 (10.00 (11.00 (13.00 (13.00 (15.00 (13.00 (15.00 (15.00 (13.00 (15.00 (D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0401 COMMUNI CATI ONS D0402 DATA PROCESSI NG D0403 MATERI ALS MANAGEMENT D0404 ADMI TTI NG D0405 PATI ENT ACCOUNTI NG D0500 ADMI NI STRATI VE & GENERAL D0700 OPERATI ON OF PLANT D0800 LAUNDRY & LI NEN SERVI CE D09000 DI ETARY D1100 CAFETERI A D1300 NURSI NG ADMI NI STRATI ON D1400 CENTRAL SERVI CES & SUPPLY D1500 PHARMACY	263, 490 4, 073 0	100 0	10			2.00 4.00 4.00 4.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 259, 559, 787		16.00
30.00 0 31.00 0 41.00 0 43.00 0	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D4100 SUBPROVIDER - IRF D4300 NURSERY	92, 183 34, 072 0 12, 927	0 0 0 0		0 13, 037, 493 0 1, 914, 317 0 0 0 0 1, 888, 157		30.00 31.00 41.00 43.00
	ANCILLARY SERVICE COST CENTERS	56, 231	0		0 34, 136, 721		50.00
53.00	D5300 ANESTHESI OLOGY	0	0		0 5, 163, 809		53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	0		0 56, 428, 806 0 41, 931, 779		54.00 60.00
		0	0		0 5, 986, 282		65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 604, 582 0 1, 185, 057		66.00 67.00
68.00	D6800 SPEECH PATHOLOGY	0	0		0 345, 899		68.0
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		0 3, 849, 339 0 75, 636		69.0 70.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100		0 11, 641, 998		71.0
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0	10	0 7, 585, 621 0 24, 646, 971		72.0
76.00	D3020 ONCOLOGY	0	0		0 1, 001, 841		76.00
	07697 CARDIAC REHABILITATION DUTPATIENT SERVICE COST CENTERS	0	0		0 533, 218		76.9
90.00	D9000 CLINIC	0	0		0 12, 029, 851		90.00
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	64, 004	0		0 31, 721, 247		91.00 92.00
C	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 851, 163		101.00
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	263, 490	100	10	0 259, 559, 787		118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 SOUTH CLINI C	0	0		0 0 0 0		192.00 192.0
192. 02 ⁻	19202 WEST CLINIC	0	0		0 0		192.0
1	19203 DI ABETES CENTER 19300 NONPAI D WORKERS	0	0		0 0 0 0		192.0 193.0
193. 01 ⁻	19301 ADULT/CHI LD CARE	0	Ō		0 0		193.0
	19302 PHYSI CI AN OFFI CE BUILDI NG 19303 OPTI FAST/FOUNDATI ON	0	0		0 0		193. 0 193. 0
194.00	07950 PARTNERSHI P HFC	0	0		0 0		194.0
	07951 TRAFALGAR CLINIC 07952 EDINBURGH	0	0		0 0		194.0 194.0
	07953 JAI L	0	0		0 0		194.0
	07954 ATHLETI C TRAINERS	0	0		0 0		194.0
200.00	Cross Foot Adjustments Negative Cost Centers						200. 0 201. 0
	Cost to be allocated (per Wkst. B,	2, 236, 416	324, 476	2, 217, 28	8 1, 022, 522		201.0
202.00		1					
202.00 203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	8. 487669	3, 244. 760000	22 172 88000	0 0.003939		203.00

Health Fin	nancial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-	1
					From 01/01/2020 To 12/31/2020		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &		
		N	SUPPLY	REQUIS.)	LI BRARY		
		(DI RECT	(COSTED		(GROSS		
		NRSING HRS)	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 797298	735. 230000	1, 075. 60000	0 0. 000531		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 MEMORI				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0001	Period: From 01/01/2020	Worksheet C Part I	
				To 12/31/2020		epared:
					7/30/2021 11:	08 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)	2.00	2.00	4.00	5.00	
INDATIENT DOUTINE CEDVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	8, 933, 101		8, 933, 10	0	8, 933, 101	30.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	2, 479, 968		2, 479, 96		2, 479, 968	
41. 00 04100 SUBPROVIDER - IRF	2, 479, 988		2, 479, 98		2, 479, 988 4, 734	
41. 00 04100 SUBPROVIDER - TRP 43. 00 04300 NURSERY	673, 668		673,66		673, 668	
ANCI LLARY SERVICE COST CENTERS	073,000		073,00		073,000	43.00
50. 00 05000 OPERATING ROOM	6, 386, 964		6, 386, 96	4 0	6, 386, 964	50.00
53. 00 05300 ANESTHESI OLOGY	176, 082		176, 08		176, 082	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 634, 654		5, 634, 65		5, 634, 654	
60. 00 06000 LABORATORY	7, 171, 576		7, 171, 57		7, 171, 576	
65. 00 06500 RESPIRATORY THERAPY	1, 814, 259		1, 814, 25		1, 814, 259	
66. 00 06600 PHYSI CAL THERAPY	1, 344, 039		1, 344, 03		1, 344, 039	
67. 00 06700 OCCUPATI ONAL THERAPY	439, 789		439, 78		439, 789	
68.00 06800 SPEECH PATHOLOGY	194, 298		194, 29		194, 298	
69. 00 06900 ELECTROCARDI OLOGY	726, 184		726, 18		726, 184	
70.00 07000 ELECTROENCEPHALOGRAPHY	14, 508		14, 50	0 8	14, 508	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 919, 993		2, 919, 99	3 0	2, 919, 993	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 660, 478		2, 660, 47	8 0	2, 660, 478	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 892, 879		6, 892, 87		6, 892, 879	
76.00 03020 ONCOLOGY	848, 219		848, 21		944, 594	
76. 97 07697 CARDI AC REHABILI TATI ON	311, 351		311, 35	1 0	311, 351	76.97
OUTPATIENT SERVICE COST CENTERS	-					
90. 00 09000 CLINIC	2, 597, 910		2, 597, 91		2, 597, 910	
91.00 09100 EMERGENCY	4, 619, 858		4, 619, 85		4, 619, 858	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 732, 712		1, 732, 71	2	1, 732, 712	92.00
OTHER REIMBURSABLE COST CENTERS				-		
101.00 10100 HOME HEALTH AGENCY	942, 970		942, 97	0	942, 970	101.00
SPECIAL PURPOSE COST CENTERS						110.00
113.00 11300 INTEREST EXPENSE	50 500 101		50 500 17			113.00
200.00 Subtotal (see instructions)	59, 520, 194				59, 616, 569	
201.00 Less Observation Beds	1, 732, 712		1, 732, 71		1, 732, 712	
202.00 Total (see instructions)	57, 787, 482	0	57, 787, 48	96, 375	57, 883, 857	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 1 Title XVI Charges	<u> </u>	Period: From 01/01/2020 To 12/31/2020 Hospital	Worksheet C Part I Date/Time Pre 7/30/2021 11: PPS	pared: 08 am
	/111 tal (col. 6	To 12/31/2020 Hospi tal	Date/Time Pre 7/30/2021 11:	pared: 08 am
	/111 tal (col. 6	Hospi tal	7/30/2021 11:	08 am
	tal (col. 6		PPS	
Charges		Cost on Other		
Charges		Coot on Other		
	+ col. 7)		TEFRA	
+		Ratio	I npati ent	
			Ratio	
6.00 7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		
30. 00 03000 ADULTS & PEDI ATRI CS 10, 141, 841	10, 141, 84			30.00
31. 00 03100 I NTENSI VE CARE UNI T 1, 914, 317	1, 914, 31			31.00
41. 00 04100 SUBPROVIDER - IRF 0	(41.00
43. 00 04300 NURSERY 1, 888, 157	1, 888, 15	7		43.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 0PERATI NG ROOM 5, 591, 422 28, 545, 299	34, 136, 72		0.000000	
53. 00 05300 ANESTHESI OLOGY 803, 056 4, 360, 753	5, 163, 809		0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 7, 111, 084 49, 317, 722	56, 428, 800		0.000000	
60. 00 06000 LABORATORY 8, 778, 833 33, 152, 946	41, 931, 779		0.000000	
65. 00 06500 RESPI RATORY THERAPY 3, 263, 031 2, 723, 251	5, 986, 282		0.000000	
66. 00 06600 PHYSI CAL THERAPY 396, 501 3, 208, 081	3, 604, 582		0.000000	1
67. 00 06700 OCCUPATI ONAL THERAPY 365, 952 819, 105	1, 185, 05		0.000000	
68. 00 06800 SPEECH PATHOLOGY 133, 702 212, 197	345, 899		0.00000	
69. 00 06900 ELECTROCARDI OLOGY 976, 263 2, 873, 076	3, 849, 339		0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY 21, 571 54, 065	75, 636		0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,958,783 8,683,215	11, 641, 998		0.000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 2, 340, 505 5, 245, 116	7, 585, 62		0.00000	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 6, 751, 263 17, 895, 708	24, 646, 97		0.00000	
76. 00 03020 0NC0L0GY 3, 201 998, 640	1, 001, 84		0.00000	
76. 97 07697 CARDI AC REHABILITATION 362 532, 856	533, 218	0. 583909	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC 32, 389 11, 997, 462	12, 029, 85		0.00000	
91. 00 09100 EMERGENCY 4, 109, 262 27, 611, 985	31, 721, 24		0.00000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 180, 368 2, 715, 284	2, 895, 652	0. 598384	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS				
101. 00 10100 HOME HEALTH AGENCY 0 851, 163	851, 163	3		101.00
SPECIAL PURPOSE COST CENTERS				4
113.00 11300 INTEREST EXPENSE				113.00
	259, 559, 78	7		200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions) 57,761,863 201,797,924 2	259, 559, 78	/		202.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lieu	J of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0001	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/30/2021 11:08 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 I NTENSI VE CARE UNI T				31.00
41.00 04100 SUBPROVIDER - IRF				41.00
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 187100			50.00
53.00 05300 ANESTHESI OLOGY	0. 034099			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 099854			54.00
60.00 06000 LABORATORY	0. 171030			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 303069			65.00
66.00 06600 PHYSI CAL THERAPY	0. 372870			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 371112			67.00
68.00 06800 SPEECH PATHOLOGY	0. 561719			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 188652			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 191813			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 250815			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 350726			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 279664			73.00
76. 00 03020 ONCOLOGY	0. 942858			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 583909			76.97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 215955			90.00
91. 00 09100 EMERGENCY	0. 145639			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 598384			92.00
OTHER REIMBURSABLE COST CENTERS	0.070001			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS	I I			
113. 00 11300 INTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
	I I			1202.00

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2020 To 12/31/2020		nared.
				10 12/01/2020	7/30/2021 11:	08 am
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	8, 933, 101		8, 933, 10	0	8, 933, 101	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 479, 968		2, 479, 96		2, 479, 968	
41. 00 04100 SUBPROVI DER – I RF	4, 734		4, 73		4, 734	
43. 00 04300 NURSERY	673, 668		673, 66		673, 668	
ANCI LLARY SERVICE COST CENTERS	070,000	1	0,0,00		070,000	10.00
50. 00 05000 OPERATING ROOM	6, 386, 964		6, 386, 96	4 0	6, 386, 964	50.00
53. 00 05300 ANESTHESI OLOGY	176, 082		176, 08		176, 082	
54.00 05400 RADI OLOGY-DI AGNOSTI C	5, 634, 654		5, 634, 65		5, 634, 654	
60. 00 06000 LABORATORY	7, 171, 576		7, 171, 57		7, 171, 576	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 814, 259	(C	1, 814, 25	9 0	1, 814, 259	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 344, 039	(C	1, 344, 03	9 0	1, 344, 039	66.00
67.00 06700 OCCUPATI ONAL THERAPY	439, 789	(C	439, 78	9 0	439, 789	67.00
68.00 06800 SPEECH PATHOLOGY	194, 298	0	194, 29	8 0	194, 298	68.00
69. 00 06900 ELECTROCARDI OLOGY	726, 184		726, 18		726, 184	
70.00 07000 ELECTROENCEPHALOGRAPHY	14, 508		14, 50		14, 508	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 919, 993		2, 919, 99		2, 919, 993	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 660, 478		2, 660, 47		2, 660, 478	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 892, 879		6, 892, 87		6, 892, 879	
76.00 03020 ONCOLOGY	848, 219		848, 21		944, 594	
76. 97 07697 CARDIAC REHABILITATION	311, 351		311, 35	1 0	311, 351	76.97
OUTPATIENT SERVICE COST CENTERS	0 507 010	1	0 507 04		0 507 010	00.00
90. 00 09000 CLINIC	2, 597, 910		2, 597, 91		2, 597, 910	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 619, 858		4, 619, 85		4, 619, 858	
0THER REIMBURSABLE COST CENTERS	1, 732, 712		1, 732, 71	2	1, 732, 712	92.00
101.00 10100 HOME HEALTH AGENCY	942, 970		942, 97		942, 970	101 00
SPECIAL PURPOSE COST CENTERS	942,970		942, 97	0	942, 970	101.00
113. 00 11300 INTEREST EXPENSE	1	1	1			113.00
200.00 Subtotal (see instructions)	59, 520, 194	0	59, 520, 19	4 96, 375	59, 616, 569	
201.00 Less Observation Beds	1, 732, 712		1, 732, 71		1, 732, 712	
202.00 Total (see instructions)	57, 787, 482					
	01,101,482	1 (ין טו, וסו, 48	90,375	57,003,857	1202. U

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0001	Period:	Worksheet C	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	narod.
				10 12/31/2020	7/30/2021 11:	08 am
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
		·	+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	10, 141, 841		10, 141, 84	¥1		30.00
31.00 03100 INTENSIVE CARE UNIT	1, 914, 317		1, 914, 31	7		31.00
41. 00 04100 SUBPROVI DER – I RF	0			0		41.00
43. 00 04300 NURSERY	1, 888, 157		1, 888, 15	57		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 591, 422	28, 545, 299			0. 000000	
53. 00 05300 ANESTHESI OLOGY	803, 056	4, 360, 753			0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 111, 084	49, 317, 722			0.000000	
60. 00 06000 LABORATORY	8, 778, 833	33, 152, 946			0.000000	
65. 00 06500 RESPI RATORY THERAPY	3, 263, 031	2, 723, 251			0.000000	
66. 00 06600 PHYSI CAL THERAPY	396, 501	3, 208, 081	3, 604, 58		0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	365, 952	819, 105			0.000000	
68.00 06800 SPEECH PATHOLOGY	133, 702	212, 197			0.000000	
69. 00 06900 ELECTROCARDI OLOGY	976, 263	2, 873, 076			0.000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	21, 571	54,065			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 958, 783	8, 683, 215			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 340, 505	5, 245, 116			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 751, 263	17, 895, 708			0.000000	
76. 00 03020 ONCOLOGY	3, 201	998, 640			0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	362	532, 856	533, 21	0. 583909	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	32, 389	11, 997, 462				
91. 00 09100 EMERGENCY	4, 109, 262	27, 611, 985			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	180, 368	2, 715, 284	2, 895, 65	0. 598384	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.0010100 HOME HEALTH AGENCY	0	851, 163	851, 16	J3		101.00
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	57, 761, 863	201, 797, 924	259, 559, 78	37		200.00
201.00 Less Observation Beds						201.00 202.00
202.00 Total (see instructions)	57, 761, 863	201, 797, 924	259, 559, 78			

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lieu	of Form CMS-2552-10)
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0001	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/30/2021 11:08 am	_
		Title XIX	Hospi tal	Cost	_
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	· ·				-
30. 00 03000 ADULTS & PEDIATRICS				30.00	j
31.00 03100 INTENSIVE CARE UNIT				31.00	j
41.00 04100 SUBPROVIDER - IRF				41.00)
43. 00 04300 NURSERY				43.00)
ANCI LLARY SERVICE COST CENTERS	1 1				
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00)
53.00 05300 ANESTHESI OLOGY	0. 000000			53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00	
60. 00 06000 LABORATORY	0. 000000			60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00	
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00	
76. 00 03020 ONCOLOGY	0. 000000			76.00	
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76.97	
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000			90.00)
91.00 09100 EMERGENCY	0. 000000			91.00)
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00	
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	
	1 1			1-021 00	

Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2020	Worksheet D Part I	
				To 12/31/2020	Date/Time Pre 7/30/2021 11:	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	898, 174	0	898, 17	4 5, 965	150. 57	30.00
31.00 INTENSIVE CARE UNIT	268, 905		268, 90	5 815	329.94	31.00
41.00 SUBPROVIDER - IRF	54	0	5	4 0	0.00	41.00
43.00 NURSERY	22, 617		22, 61	7 611	37.02	43.00
200.00 Total (lines 30 through 199)	1, 189, 750		1, 189, 75	0 7, 391		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	1, 644	247, 537				30.00
31.00 INTENSIVE CARE UNIT	169	55, 760				31.00
41.00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	1, 813	303, 297	1			200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPI TAL COSTS	Provider C	F	Period: From 01/01/2020 Fo 12/31/2020	Worksheet D Part II Date/Time Pre 7/30/2021 11:	
		Title	XVIII	Hospi tal	PPS	_
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 531, 413	34, 136, 721	0. 04486	1, 293, 174	58, 013	50.00
53. 00 05300 ANESTHESI OLOGY	35, 789	5, 163, 809	0. 006931	176, 893	1, 226	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	909, 088	56, 428, 806	0. 016110	2, 312, 378	37, 252	54.00
60. 00 06000 LABORATORY	504, 901	41, 931, 779	0. 012041	2, 938, 375	35, 381	60.00
65. 00 06500 RESPI RATORY THERAPY	102, 877	5, 986, 282	0. 017185	861, 436	14, 804	65.00
66. 00 06600 PHYSI CAL THERAPY	123, 989	3, 604, 582	0. 034398	3 176, 125	6, 058	66.00
67.00 06700 OCCUPATIONAL THERAPY	32, 226	1, 185, 057	0. 027194	162, 706	4, 425	67.00
68.00 06800 SPEECH PATHOLOGY	7, 895	345, 899	0. 022825	5 56, 399	1, 287	68.00
69.00 06900 ELECTROCARDI OLOGY	140, 886	3, 849, 339	0. 036600	710, 974	26, 022	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	5, 095	75, 636	0.067362	13, 433	905	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS 145, 632	11, 641, 998	0. 012509	758, 401	9, 487	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	14, 695	7, 585, 621	0.001937	1, 053, 008	2,040	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	155, 258	24, 646, 971	0.006299	2, 345, 264	14, 773	73.00
76.00 03020 ONCOLOGY	116, 364	1, 001, 841	0. 116150	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	47, 134		0. 088395	5 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	· · ·		·			1
90. 00 09000 CLINIC	271, 881	12, 029, 851	0. 022601	28, 194	637	90.00
91.00 09100 EMERGENCY	381, 785	31, 721, 247	0. 012036	1, 450, 803	17, 462	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	RT) 174, 214	2, 895, 652	0.060164	180, 368	10, 852	92.00
200.00 Total (lines 50 through 199)	4, 701, 122			14, 517, 931	240, 624	•

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdown	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•	-		
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0 0	0	
41. 00 04100 SUBPROVI DER – I RF	0	0			0	
43. 00 04300 NURSERY	0				0	
200.00 Total (lines 30 through 199)	0			0 0	-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien ⁻	Per Diem	Inpati ent	200.00
cost center bescription	Adj ustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Days	col. 6)	Frogram Days	
		minus col. 4)		COI. 0)		
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	5, 96	5 0.00	1, 644	30.00
	0	0				
31. 00 03100 I NTENSI VE CARE UNI T		0	81			
41.00 04100 SUBPROVI DER - I RF	0	-		0 0.00		
43.00 04300 NURSERY		0				
200.00 Total (lines 30 through 199)		0	7,39	1	1, 813	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1					

						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	RVICE OTHER PAS	S Provider C	CN: 15-0001	Period: From 01/01/2020	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2020		nared
				10 12/01/2020	7/30/2021 11:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	-		1			
50. 00 05000 OPERATING ROOM	0	C	D	0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	C	D	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	D	0 0	0	54.00
50. 00 06000 LABORATORY	0	C	D	0 0	0	60.00
55. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
56. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
57.00 06700 OCCUPATI ONAL THERAPY	0	C	D	0 0	0	67.00
58.00 06800 SPEECH PATHOLOGY	0	C	D	0 0	0	68.00
59. 00 06900 ELECTROCARDI OLOGY	0	C	D	0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76. 00 03020 ONCOLOGY	0	C		0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0	C)	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Titlo	xvi i	Hospi tal	7/30/2021 11: PPS	<u>08 am</u>
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges	
	Education	1, 2, 3, and			(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
			, í		instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0	0		0 34, 136, 721		
53. 00 05300 ANESTHESI OLOGY	0	0		0 5, 163, 809	0. 000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 56, 428, 806	0.00000	54.00
60. 00 06000 LABORATORY	0	0		0 41, 931, 779	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 5, 986, 282		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 604, 582		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 185, 057		
68.00 06800 SPEECH PATHOLOGY	0	0		0 345, 899		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 3, 849, 339		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 75, 636		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 11, 641, 998		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 7, 585, 621		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 24, 646, 971		
76.00 03020 ONCOLOGY	0	0		0 1, 001, 841		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 533, 218	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS			1	1	-	
90. 00 09000 CLINIC	0	0		0 12, 029, 851		
91.00 09100 EMERGENCY	0	0		0 31, 721, 247		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 895, 652		
200.00 Total (lines 50 through 199)	0	0	1	0 244, 764, 309		200.00

APPORTI ONMENT OF I NPATI ENT/OUTPATI ENT ANCI LLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0001 Period: From 01/01/2020 To 12/31/2020 Worksheet D Part IV Date/Time Prepar 7/30/2021 11:08 Image: Cost Center Description Outpati ent Ratio of Cost to Charges Inpati ent Program Charges Inpati ent Program Charges Inpati ent Program Charges Outpati ent Program Charges Outpati ent Program Charges Outpati ent Program Charges Outpati ent Program Charges Outpati ent Program Charges Outpati ent Program Charges Program Charges Outpati ent Program Charges Program Charges Outpati ent Program Charges Program Charges Program Charges Program Charges Program Charges Outpati ent Program Charges Program Charges Program C
Innocial costs To 12/31/2020 Date/Time Prepara Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Program Pass-Through Costs (col. 8 Outpatient Program Charges Program Pass-Through Costs (col. 9 Pass-Through Costs (col. 9 50.00 05300 OPERATING ROOM 0.000000 1, 293, 174 0 5, 271, 999 0 55 50.00 05300 ANESTHESI OLOGY 0.000000 2, 312, 378 0 10, 104, 804 0 54 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2, 312, 378 0 10, 104, 804 0 54 60.00 06000 LABORATORY 0.000000 2, 938, 375 0 2, 637, 884 0 66 66.00 06500 RESPI RATORY THERAPY 0.000000 162, 706 0 5, 165 0 66
ANCILLARY SERVICE COST CENTERS Outpati ent Ratio of Cost to Charges Inpati ent Program (col. 6 + col. 7) Inpati ent Program (col. 6 + col. 7) Inpati ent Program (charges) Outpati ent Program (charges) Outpati ent Program (charges) Program Charges Outpati ent Program (charges) Program Charges Outpati ent Program (charges) Program Pass-Through (col. 6 + col. 7) Outpati ent Program Program Pass-Through (col. 6 + col. 7) Outpati ent Program Program Pass-Through (col. 9) Outpati ent Program Program Pass-Through (col. 9) Outpati ent Program 50.00 05000 OPERATI NG ROOM 0.000000 11.00 12.00 13.00 53.00 05300 ANESTHESI OLOGY 0.000000 17,6,893 0 53,3,974 0 5 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2,938,375 0 2,637,884 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 176,125 0 9,062 0 66 66.00 06600 PHYSI CAL THERAPY 0.000000 162,706 0 5,165 0 66 67.
Itile XVIII Hospital PPS Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Outpatient Program Charges Program Charges Charges Charges Outpatient Program Program Charges Outpatient Program Program Charges Charges Charges <td< td=""></td<>
ANCI LLARY SERVICE COST CENTERS Ratio of Cost to Charges (col. 6 ÷ col. 7) Program Charges Program Pass-Through Costs (col. 8 x col. 10) Program Charges Program Pass-Through Costs (col. 9 x col. 10) Program Pass-Through Costs (col. 9 x col. 10) ANCI LLARY SERVICE COST CENTERS 0 10.00 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 0 0.000000 1,293,174 0 5,271,999 0 50.00 50.00 05000 OPERATI NG ROOM 0.000000 1,293,174 0 5,271,999 0 50.00 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.000000 2,312,378 0 10,104,804 0 54.00 60.00 06000 LABORATORY 0.000000 2,938,375 0 2,637,884 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 176,125 0 9,062 0 66.00 67.00 06700 OCCUPATI NAL THERAPY 0.000000 162,706 0 5,165 0 67.00 69.00 06800 SPEECH PATHOLOGY 0.0000000 10,974 0
to Charges (col. 6 ÷ col. 7) Charges (col. 6 ÷ col. 7) Pass-Through Costs (col. 8 x col. 10) Charges Pass-Through Costs (col. 9 x col. 12) ANCI LLARY SERVI CE COST CENTERS 9.00 10.00 11.00 12.00 13.00 ANCI LLARY SERVI CE COST CENTERS 0.000000 1,293,174 0 5,271,999 0 50.00 53.00 05300 ANESTHESI OLOGY 0.000000 176,893 0 533,974 0 53 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2,312,378 0 10,104,804 0 54 60.00 06600 LABORATORY 0.000000 2,938,375 0 2,637,884 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 176,125 0 9,062 0 66 66.00 06600 PHYSI CAL THERAPY 0.000000 162,706 0 5,165 0 67 67.00 06700 OCUPATI ONAL THERAPY 0.000000 162,706 0 5,165 0 67
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$
Image: col row of col
P. 00 10.00 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 05000 0PERATING ROOM 0.000000 1,293,174 0 5,271,999 0 50 53.00 05300 ANESTHESI OLOGY 0.000000 176,893 0 53,974 0 54 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2,312,378 0 10,104,804 0 54 60.00 06600 LABORATORY 0.000000 2,938,375 2,637,884 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 176,125 0 9,062 0 66 66.00 06600 PHYSI CAL THERAPY 0.000000 176,125 0 9,062 0 66 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 162,706 0 5,165 0 67 69.00 06800S SPEECH PATHOLOGY 0.000000 56,399 0 5,165 0 67 69.00<
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.000000 1, 293, 174 0 5, 271, 999 0 50 53.00 05300 ANESTHESI OLOGY 0.000000 176, 893 0 533, 974 0 53 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2, 312, 378 0 10, 104, 804 0 54 60.00 066000 LABORATORY 0.000000 2, 938, 375 0 2, 637, 884 0 60 65.00 06500 RESPI RATORY THERAPY 0.000000 861, 436 0 427, 504 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 176, 125 0 9, 062 0 66 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 162, 706 0 5, 165 0 67 69.00 06800 SPEECH PATHOLOGY 0.000000 56, 399 0 <t< td=""></t<>
50.00 05000 0PERATI NG ROOM 0.000000 1, 293, 174 0 5, 271, 999 0 50 53.00 05300 ANESTHESI OLOGY 0.000000 176, 893 0 533, 974 0 53 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2, 312, 378 0 10, 104, 804 0 54 60.00 06000 LABORATORY 0.000000 2, 938, 375 0 2, 637, 884 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 861, 436 0 427, 504 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 176, 125 0 9, 062 0 66 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 162, 706 0 5, 165 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 56, 399 0 5, 165 0 68 69 0 06000 710, 974 0 906, 544 0 67 69.00 06900 ELECTROENCEPHALOGRAPHY 0.000000 710, 974
53.00 05300 ANESTHESI OLOGY 0.000000 176,893 0 533,974 0 53 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2,312,378 0 10,104,804 0 54 60.00 06000 LABORATORY 0.000000 2,938,375 0 2,637,884 0 65 65.00 06500 RESPI RATORY THERAPY 0.000000 861,436 0 427,504 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 176,125 0 9,062 0 66 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 162,706 0 5,165 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 162,706 0 5,165 0 67 69.00 06900 ELECTROCARDI OLOGY 0.000000 710,974 0 906,544 0 67 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 13,433 0 11,382 0 71 71.00 07100 MEDI CAL SUPPLI ES
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2,312,378 0 10,104,804 0 54 60.00 06000 LABORATORY 0.000000 2,938,375 0 2,637,884 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 861,436 0 427,504 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 176,125 0 9,062 0 66 67.00 06700 OCUPATI ONAL THERAPY 0.000000 162,706 0 5,165 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 56,399 0 5,165 0 67 69.00 CLECTROCARDI OLOGY 0.000000 710,974 0 906,544 0 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 13,433 0 11,382 0 71 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 758,401 0 1,167,268 0 71
60.00 06000 LABORATORY 0.000000 2,938,375 0 2,637,884 0 66 65.00 06500 RESPI RATORY THERAPY 0.000000 861,436 0 427,504 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 176,125 0 9,062 0 66 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 162,706 0 5,165 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 56,399 0 5,165 0 67 69.00 06900 ELECTROCARDI OLOGY 0.000000 710,974 0 906,544 0 69 70.00 07000 ELECTROCKEPHALOGRAPHY 0.000000 13,433 0 11,182 0 71 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 758,401 0 1,167,268 0 71
65.00 06500 RESPIRATORY THERAPY 0.000000 861,436 0 427,504 0 65 66.00 06600 PHYSI CAL THERAPY 0.000000 176,125 0 9,062 0 66 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 162,706 0 5,165 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 162,706 0 5,165 0 67 69.00 06900 ELECTROCARDI OLOGY 0.000000 710,974 0 906,544 0 69 70.00 07000 ELECTROCKEPHALOGRAPHY 0.000000 13,433 0 11,382 0 71 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 758,401 0 1,167,268 0 71
66.00 06600 PHYSI CAL THERAPY 0.000000 176, 125 0 9, 062 0 66 67.00 06700 0CUPATI ONAL THERAPY 0.000000 162, 706 0 5, 165 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 56, 399 0 5, 165 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 710, 974 0 906, 544 0 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 13, 433 0 11, 382 0 71 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 758, 401 0 1, 167, 268 0 71
67.00 06700 OCCUPATI ONAL THERAPY 0.000000 162,706 0 5,165 0 67 68.00 06800 SPEECH PATHOLOGY 0.000000 56,399 0 5,165 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 710,974 0 906,544 0 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 13,433 0 11,382 0 71 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 758,401 0 1,167,268 0 71
68.00 06800 SPEECH PATHOLOGY 0.000000 56, 399 0 5, 165 0 68 69.00 06900 ELECTROCARDI OLOGY 0.000000 710, 974 0 906, 544 0 69 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 13, 433 0 11, 382 0 70 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 758, 401 0 1, 167, 268 0 71
69. 00 06900 ELECTROCARDI OLOGY 0.000000 710, 974 0 906, 544 0 69 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 13, 433 0 11, 382 0 70 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 758, 401 0 1, 167, 268 0 71
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 13, 433 0 11, 382 0 70 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 758, 401 0 1, 167, 268 0 71
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 758, 401 0 1, 167, 268 0 71
72.00 07200 IMPL DEV. CHARGED TO PATIENT 0.000000 1.053.008 0 1.045.179 0 72
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 2, 345, 264 0 6, 663, 481 0 73
76. 00 03020 ONCOLOGY 0. 000000 0 0 114, 528 0 76
76. 97 07697 CARDIAC REHABILITATION 0. 000000 0 0 75, 977 0 76
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC 0. 000000 28, 194 0 2, 650, 682 0 90
91. 00 09100 EMERGENCY 0. 000000 1, 450, 803 0 3, 845, 487 0 91
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 180, 368 0 683, 507 0 92
200.00 Total (Lines 50 through 199) 14, 517, 931 0 36, 159, 592 0 200

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 11:	
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 187100			0 0	986, 391	50.00
53. 00 05300 ANESTHESI OLOGY	0. 034099			0 0	18, 208	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 099854			0 0	1, 009, 005	54.00
60. 00 06000 LABORATORY	0. 171030			0 0	451, 157	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 303069			0 0	129, 563	
66. 00 06600 PHYSI CAL THERAPY	0. 372870	9, 062		0 0	3, 379	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 371112	5, 165		0 0	1, 917	67.00
68.00 06800 SPEECH PATHOLOGY	0. 561719	5, 165		0 0	2, 901	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 188652	906, 544		0 0	171, 021	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 191813	11, 382		0 0	2, 183	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 250815	1, 167, 268		0 0	292, 768	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 350726	1, 045, 179		0 0	366, 571	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 279664	6, 663, 481		0 0	1, 863, 536	73.00
76.00 03020 ONCOLOGY	0. 846660	114, 528		0 0	96, 966	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 583909	75, 977		0 0	44, 364	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 215955	2, 650, 682		0 0	572, 428	90.00
91.00 09100 EMERGENCY	0. 145639	3, 845, 487		0 0	560, 053	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 598384	683, 507	27	8 0	409, 000	92.00
200.00 Subtotal (see instructions)		36, 159, 592	27	8 0	6, 981, 411	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		36, 159, 592	27	8 0	6, 981, 411	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0001 Period: From 01/01/2020 To 12/31/2020 Worksheet D Date/Time Prepared: 12/31/2020 Cost Center Description Cost S Title XVIII Hospital PPS Cost Center Description Cost Cost Reinbursed Services Subject To Ded & Coins. (see inst.) Cost Reinbursed Services Not Subject To Ded & Coins. (see inst.) Cost Center Description Form 01/01/2020 Date/Time Prepared: 70/2021 11:08 an PPS 0.00 Cost Center Description Cost Cost Center S Cost Center Description Form 01/01/2020 Date/Time Prepared: 70/2021 11:08 an PPS 0.00 Cost Center Description Cost Center Cost Center S Cost Center Description Form 01/01/2020 Form 01/01/2020 0.00 GSO00 PERATING ROOM 0 O Subject To Ded & Coins. (see inst.) Subject To O = 0 Subject To Ded & Coins. (see inst.) Subject To Ded & Coins. (see inst.) Subject To O = 0 Subject To Ded & Coins. (see inst.) 0.00 Coond RESPIRATORY THERAPY	Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lieu	ı of Form CMS-	2552-10
Cost Center Description Cost Strike Cost Reimbursed Services Obd. & Coins. Reimbursed Services Obd. & Coins. Cost Reimbursed Services Obd. & Coins. Cost Subject To Ded. & Coins. Cost Subject To Subject To Subject To Subject To Subject To Ded. & Coins. Cost & Cost & Coins. Cost & Cost & Cost & Coins & Cost &	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			From 01/01/2020 To 12/31/2020	Part V Date/Time Pro 7/30/2021 11	
Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 0 50.00 05000 [DERATING ROOM 0 0 51.00 05000 [DERATING ROOM 0 0 52.00 05000 [DERATING ROOM 0 0 54.00 06400 [RADIOLOGY - DIANDATINERAPY 0 0 65.00 06500 [RESPI RATORY THERAPY 0 0 66.00 66.00 06500 [RESPI RATORY] 0 0 66.00 67.00 67.00 0000 [DELETRORACRIDIOLOGY 0 0 0 72.00 70.00 07000 [ELECTROENCHOLOGRAPHY 0 0 0				XVIII	Hospi tal	PPS	
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76.00 03020 ONCOLOGY 0 0 76.00 76.07 07697 CARDI AC_REHABILITATION 0 0 76.97 OUTPATI ENT SERVICE COST CENTERS 0 0 0 90.00 90.00 09100 CLINIC 0 0 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 166 0 92.00 920.00 Subtotal (see instructions) 166 0 200.00 201.00 201.00 Urarges 0 0 0 201.00 201.00		0	0				
76.97 07697 CARDI AC REHABILITATION 0 0 76.97 OUTPATI ENT SERVICE COST CENTERS 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 92.00 92.00 085ERVATION BEDS (NON-DI STINCT PART) 166 0 92.00		0	0				
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 166 0 92.00 200.00 Subtotal (see instructions) 166 0 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 201.00		0	-				
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92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 166 0 92.00 200.00 Subtotal (see instructions) 166 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00			0				
200.00Subtotal (see instructions)1660200.00201.00Less PBP Clinic Lab. Services-Program00201.000nl y Charges0000		0	0				
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 0			0				
Only Charges		166	0				
		0					201.00
202.00 Net Charges (line 200 - line 201) 166 0 202.00							
	202.00 Net Charges (line 200 - line 201)	166	0				202.00

	Financial Systems JOHNSON MEMORIAL ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	pare
		T 1.1. NA(1.1.		7/30/2021 11:	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed day			5, 965	1.
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	rivate room davs	5, 965 0	2	
00	do not complete this line.	ijoj. Tri jou nuve oni j p	rivate room adys,	0	
00	Semi-private room days (excluding swing-bed and observation b			4, 808	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	on days) through Decemb	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roc	m days) through Decembe	r 31 of the cost	0	7
00	reporting period	in days) thi dayn becembe	i si oi the cost	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excludin	a swing-bed and	1, 644	9
	newborn days) (see instructions)	0	0 0		
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	3 /		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
00	after December 31 of the cost reporting period (if calendar y				
00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT	an through December 21	of the cost	0.00	1 1 7
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31	or the cost	0.00	' /
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
~~	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction			8, 933, 101	21
. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
00	x line 20) Total swing had cast (can instructions)			0	24
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 933, 101	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1 1			
. 00 . 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	harges)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	pue line 22) (coo instru	ations)	0.00	
00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	LISTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see			1, 497. 59	38
. 00	Program general inpatient routine service cost (line 9 x line	2 38)		2, 462, 038	39
	Medically necessary private room cost applicable to the Progr			0	
. 00	Total Program general inpatient routine service cost (line 39	+ iine 40)		2, 462, 038	41

) UYMC	Financial Systems TATION OF INPATIENT OPERATING COST		AL HOSPITAL Provider C		eriod:	u of Form CMS- Worksheet D-1	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	
				e XVIII	Hospi tal	7/30/2021 11: PPS	08 a
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.
00	Intensive Care Type Inpatient Hospital Units	2 470 0/0	015	3, 042, 91	1/0	F14 0F0	1 42
. 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	2, 479, 968	815	3, 042. 91	169	514, 252	43.
. 00	BURN I NTENSI VE CARE UNI T						45.
	SURGI CAL I NTENSI VE CARE UNI T						46.
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description				1		
	1					1.00	
00	Program inpatient ancillary service cost (Wk					3, 077, 680	
00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		6, 053, 970	49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	sorvicos (fro	m Wkst D sum	of Parts L and	303, 297	50
. 00			Services (110	m wkst. D, sum		505,277	50
. 00	Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst. D. s	um of Parts II	240, 624	51
-	and IV)		J (.	. , -			
. 00	Total Program excludable cost (sum of lines					543, 921	
. 00	Total Program inpatient operating cost exclu	5 1	elated, non-ph	ysician anesth	etist, and	5, 510, 049	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	ine 53)	0	
. 00	Bonus payment (see instructions)	0	0 .			0	58
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59
~ ~	market basket						
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					0	61
	amount (line 56), otherwise enter zero (see		.5 (TTHES 54 X	00), 01 1% 01	the target		
. 00		,				0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST					-	
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decomb	or 21 of the	cost roporting	poriod (Soo	0	65
. 00	instructions) (title XVIII only)			cost reporting	period (See	0	05
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	only). For	0	66
	CAH (see instructions)		•		57		
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after L	December 31 of	the cost repo	rting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (′line 67 ₊lin	e 68)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N		•	,		0	4 07
. 00	Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service c	ost per diem (l	ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost applic						73
. 00	Total Program general inpatient routine serv						74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	WORKSneet B, Pa	art II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces						79
00	Total Program routine service costs for comp		cost limitatio	n (line 78 min	us line 79)		80
. 00	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (I						82
. 00 . 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83
. 00	Utilization review - physician compensation		ons)				85
. 00	Total Program inpatient operating costs (sum						86
-	PART IV - COMPUTATION OF OBSERVATION BED PAS						
. 00	Total observation bed days (see instructions)				1, 157	
	Adjusted general innetiont routing sect per	diem (line 27 ÷	line 2)			1, 497. 59	88
	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	,			1, 732, 712	

Health Financial Systems	AL_HOSPI TAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 7/30/2021 11:	pared: 08 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	898, 174	8, 933, 101	0. 10054	4 1, 732, 712	174, 214	90.00
91.00 Nursing School cost	0	8, 933, 101	0.00000	0 1, 732, 712	0	91.00
92.00 Allied health cost	0	8, 933, 101	0.00000	0 1, 732, 712	0	92.00
93.00 All other Medical Education	0	8, 933, 101	0.00000	0 1, 732, 712	0	93.00

	Financial Systems JOHNSON MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Peri od:	i of Form CMS-2 Worksheet D-1	
			From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 11:	pare 08 a
	Cost Contor Deceription	Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		5, 965	1 1.
	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			5, 965	
	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.
	do not complete this line.			4 000	
	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	4, 808 0	45
	reporting period			0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roc	m dave) through Docombo	r 21 of the cost	0	7
50	reporting period	in days) through becembe	I SI UI LINE COST	0	'
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			0.5.7	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excludin	g swing-bed and	257	9
00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruc				
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period			0	1.2
	Swing-bed NF type inpatient days applicable to titles V or XI	5 (51	<i>,</i>	0	13
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	/ear, enter 0 on this li	ne)	0	14
	Total nursery days (title V or XIX only)	alli (excluding swing-bed	uays)	611	14
	Nursery days (title V or XIX only)			52	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	after December 31 of	the cost	0.00	20
	reporting period			01.00	20
	Total general inpatient routine service cost (see instruction			8, 933, 101	
. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line 6	0	23
	x line 18)			-	
	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25
. 00	x line 20)	ST OF the cost reportin	g period (The o	0	23
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 933, 101	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)		nul gcs)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li		,	0.00	35
	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	itterential (line	8, 933, 101	37
ł	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			1, 497. 59	
	Program general inpatient routine service cost (line 9 x line	38)		384, 881	39
	Medically necessary private room cost applicable to the Progr			0	

	ATION OF INPATIENT OPERATING COST		Provider C		eri od:	Worksheet D-1	2552-
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	
				e XIX	Hospi tal	7/30/2021 11: Cost	08 a
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	673, 668	611	1, 102. 57	52	57, 334	42.
	Intensive Care Type Inpatient Hospital Units	0.470.040		0.040.04			1
3.00 4.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	2, 479, 968	815	3, 042. 91	0	0	43. 44.
5.00	BURN INTENSIVE CARE UNIT						44.
	SURGI CAL I NTENSI VE CARE UNI T						46.
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description	·					
00	Dragnam innationt anaillanu aanuiga aast (WK	at D 2 and 2	Line 200)			1.00	40
3.00 9.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			anc)		228, 860 671, 075	
. 00	PASS THROUGH COST ADJUSTMENTS	41 through 48) (see mistruction	51157		0/1,0/5	47.
. 00	Pass through costs applicable to Program inp	atient routine	services (fro	n Wkst. D, sum	of Parts I and	0	50.
	111)						
. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	0	51.
	and IV)						
2.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-nh	vsician anosth	atist and	0	
5.00	medical education costs (line 49 minus line		nateu, non-pri	ysi ci an anestri		l U	35.
	TARGET AMOUNT AND LIMIT COMPUTATION						1
	Program discharges					0	
	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)				Line 50)	0	
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (The so minus	The 53)	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996	updated and co	mpounded by the		
	market basket	por tring por rou	sharing 1990,		inpoundou by the		
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	60
. 00	If line 53/54 is less than the lower of line					0	61.
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		is (lines 54 x	60), or 1% of	the target		
2.00	Relief payment (see instructions)	riisti ucti olis)				0	62.
	0 Allowable Inpatient cost plus incentive payment (see instructions)						
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
1.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decomb	or 21 of the	cost roporting	pariod (Soo	0	65.
5. 00	instructions)(title XVIII only)			Just Tepor tring	period (See	U	05.
5.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.
	CAH (see instructions)				•		
7.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	porting period	0	67.
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	a costs after D	ecombor 31 of	the cost repo	rting period	0	68.
. 00	(line 13 x line 20)			the cost repo	r tring per rou	Ŭ	00.
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER N						1 - 0
). 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.
2.00	Program routine service cost (line 9 x line		THE /U ÷ THE	2)			72.
. 00	Medically necessary private room cost applic		line 14 x l	ne 35)		1	73
. 00	Total Program general inpatient routine serv						74
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Norksheet B, P	art II, column		75
00	26, line 45) Por diam capital related costs (line 75 : li	no 2)				ł	7/
0. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line					1	76
. 00	Inpatient routine service cost (line 74 minu					1	78
. 00	Aggregate charges to beneficiaries for exces		rovi der recor	ds)		l	79
. 00	Total Program routine service costs for comp	arison to the c	ost limitatio	n (line 78 min	us line 79)	l	80
. 00	Inpatient routine service cost per diem limi		`			1	81
. 00	Inpatient routine service cost limitation (I					ł	82
. 00 . 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)			l -	83
. 00	Utilization review - physician compensation		ns)			1	84
. 00	Total Program inpatient operating costs (sum					1	86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
	Total observation bed days (see instructions)				1, 157	87
7.00	Adjusted general inpatient routine cost per					1, 497. 59	88.

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		pared: 08 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	898, 174	8, 933, 101	0. 10054	4 1, 732, 712	174, 214	90.00
91.00 Nursing School cost	0	8, 933, 101	0.00000	0 1, 732, 712	0	91.00
92.00 Allied health cost	0	8, 933, 101	0.00000	0 1, 732, 712	0	92.00
93.00 All other Medical Education	0	8, 933, 101	0.00000	0 1, 732, 712	0	93.00

Health Financial Systems JOHNSC	N MEMORIAL	HOSPI TAL			In Lieu	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0001	Fre	riod: om 01/01/2020	Worksheet D-3	
				То	12/31/2020	Date/Time Pre 7/30/2021 11:	
		Title	XVIII		Hospi tal	PPS	
Cost Center Description			Ratio of Cos	st	Inpatient	I npati ent	
			To Charges		Program	Program Costs	
					Charges	(col. 1 x	
						col. 2)	
			1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1				
30. 00 03000 ADULTS & PEDIATRICS					2, 884, 072		30.00
31.00 03100 I NTENSI VE CARE UNI T					398, 301		31.00
41.00 04100 SUBPROVIDER - IRF					0		41.00
43. 00 04300 NURSERY							43.00
ANCI LLARY SERVI CE COST CENTERS							
50. 00 05000 OPERATI NG ROOM			0. 1871		1, 293, 174	241, 953	1
53. 00 05300 ANESTHESI OLOGY			0. 0340		176, 893	6, 032	
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 0998		2, 312, 378	230, 900	
60.00 06000 LABORATORY			0. 1710		2, 938, 375	502, 550	
65. 00 06500 RESPI RATORY THERAPY			0. 3030		861, 436	261, 075	
66. 00 06600 PHYSI CAL THERAPY			0. 3728		176, 125	65, 672	1
67.00 06700 OCCUPATI ONAL THERAPY			0. 3711		162, 706	60, 382	67.00
68.00 06800 SPEECH PATHOLOGY			0. 5617		56, 399	31, 680	1
69. 00 06900 ELECTROCARDI OLOGY			0. 1886		710, 974	134, 127	•
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 1918		13, 433	2, 577	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 2508		758, 401	190, 218	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 3507		1, 053, 008	369, 317	•
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 2796		2, 345, 264	655, 886	
76.00 03020 ONCOLOGY			0. 9428		0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 5839	09	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C			0. 2159		28, 194	6, 089	
91. 00 09100 EMERGENCY			0. 1456		1, 450, 803	211, 293	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 5983	84	180, 368	107, 929	
200.00 Total (sum of lines 50 through 94 and 96 thro					14, 517, 931	3, 077, 680	
201.00 Less PBP Clinic Laboratory Services-Program o	nly charges	6 (line 61)			0		201.00
202.00 Net charges (line 200 minus line 201)					14, 517, 931		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CON: 15-0001 Period: Provider CON: 15-0001 Period: Provider CON: 15-0001 Period: Provider CON: 15-0001 Worksheet D-3 Date/Time Prepared: 7/30/2021 Title XIX Hospital Cost Date/Time Prepared: 7/30/2021 Date/Time	Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
To 12/31/2020 Date/Time Prepared: 7/30/2021 Date/Time Prepared: 7/30/2021 Cost Cost Inpatient Program (Carges) Cost Inpatient Program (Costs) (col . 1 x) Cost 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 10.00 03000 INTENSIVE CARE UNIT 11.00 2.00 3.00 41.00 04100 SUBPROVIDER - IRF 899,848 30.00 30.00 05000 OPERATINC COST CENTERS 899,848 30.00 41.00 04100 SUBPROVIDER - IRF 17,188 31.00 43.00 000 OS000 OPERATINC ROOM 0.187100 464,061 86,826 50.00 50.00 05000 OPERATINC ROOM 0.187100 464,061 86,826 50.00 50.00 05000 RAPCHESTORY 0.372870 3.302,213,212 39,544 40.00 65.00 06500 RESPI RATORY THERAPY 0.372870 3.3652 1.436 65.00 66.00 06000 PHYSI CAL THERAPY 0.372870 3.952 1.436 65.00 66.00 <t< td=""><td>INPATIENT ANCILLARY SERVICE COST APPORTIONMENT</td><td></td><td>Provider C</td><td>CN: 15-0001</td><td></td><td></td><td></td></t<>	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0001			
INPATI ENT ROUTINE SERVICE COST CENTERS Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Col. 1 x col. 2) 0.00 03000 ADULTS & PEDI ATRICS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRICS 899,848 31.00 11.00 04000 SUBPROVIDER - 1 IFF 0 43.00 30.00 03000 ADULTS & PEDI ATRICS 899,848 31.00 31.00 04000 SUBPROVIDER - 1 IFF 0 43.00 43.00 04300 RURSERY 0 43.00 43.00 05300 APETHESI OLOGY 0.0887HCF AUGOR 0.187100 464,061 86,826 50.00 50.00 05000 RESPI RATORY 0.034099 62,990 2,144 53.00 43.00 65.00 06000 RESPI RATORY THERAPY 0.171030 231,212 39,544 60.00 66.00 66.00 06000 RESPI RATORY THERAPY 0.372870 3,852 1,436 66.00 66.00 69.00 0.09884 103,887 7112 3,98 4 1,817, 70.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>norod.</td>							norod.
INPATI ENT Hospital Cost 0.00 03000 AULTS & PEDI ATRICS Program Costs (col. 1 x 0.00 03000 NULTS & PEDI ATRICS 1.00 2.00 3.00 1.00 02.00 3.00 1.00 3.00 3.00 1.00 02.00 NULTS & PEDI ATRICS 899.648 30.00 1.00 04100 NUBROVIDER - 1.RF 1.7,188 31.00 41.00 04300 NURSERY 0 44.00 AXCILLARY SERVICE COST CENTERS 0 1.7,188 31.00 50.00 05000 ARCILLARY SERVICE COST CENTERS 0 44.00 50.00 05000 AURONTORY 0.187100 464.061 86.826 50.00 50.00 05000 ALBARY 0.330369 44.112 13.369 65.00 66.00 06500 RESPIRATORY THERAPY 0.372870 3.852 1.435 66.00 69.00 06000 COUTOALT THERAPY 0.372870 3.9652 1.436 67.00							
INPATLENT ROUTINE SERVICE COST CENTERS To Charges Program Costs (col. 2) 30.00 03000 ADULTS & PEDIATRICS 899,848 31.00 31.00 03000 ADULTS & PEDIATRICS 899,848 31.00 31.00 04100 NUBPROVIDER - IRF 0 41.00 43.00 05000 PREATING ROOM 0.187100 464,061 86,826 50.00 05000 OPERATING ROOM 0.187100 464,061 86,826 50.00 51.00 05000 OPERATING ROOM 0.187100 464,061 86,826 50.00 52.00 05000 OPERATING ROOM 0.187100 464,061 86,826 50.00 53.00 05000 ADRINESI OLOCY 0.304099 62,890 2,144 53.00 54.00 054000 ADRINESI OLOCY 0.303069 44,112 13.360 66.00 65.00 06500 PESPI RATORY THERAPY 0.317112 3,185 1,374 64.00 60.00 66.00 06600 PHERAPY 0.			Ti tl	e XIX	Hospi tal		00 4111
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	202.00 Net charges (line 200 minus line 201)			l	1, 232, 080	2	202.00

	Financial Systems JOHNSON MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Period: From 01/01/2020	u of Form CMS-: Worksheet E Part A	-
			To 12/31/2020		
		Title XVIII	Hospi tal	PPS	
			-	1.00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1.00	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	3, 091, 497	
1. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	1, 234, 215	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	for discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	for discharges occurring	on or after	0	
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00
2.01	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1			64, 439	
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		51, 155	
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	orting period (see instr	ructions)	0 45. 71	3.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos		, 1		5.00
	or before 12/31/1996. (see instructions)		, o		
6.00	FTE count for allopathic and osteopathic programs that meet 1 new programs in accordance with 42 CFR 413.79(e)				6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA \S 5503 reduction amount to the IME cap as specified under	0.00 0.00			
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	0.00	8.00		
0.00	affiliated programs in accordance with 42 CFR 413.75(b), 413.			0.00	0.00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap sl	0.00	8.0		
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital				
9.00	under § 5506 of ACA. (see instructions) Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin	0.00	9.00		
10.00	instructions) FTE count for allopathic and osteopathic programs in the curr			0.00	
11.00	FTE count for residents in dental and podiatric programs.	ent year from your rece		0.00	11.00
12.00 13.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00 0.00	
14.00	Total allowable FTE count for the penultimate year if that ye	ear ended on or after Se	ptember 30, 1997,	0.00	
15.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15.00
	Adjustment for residents in initial years of the program				16.0
17.00	Adjustment for residents displaced by program or hospital clo	osure		0.00	
	Adjusted rolling average FTE count				18.0
	Current year resident to bed ratio (line 18 divided by line 4 Prior year resident to bed ratio (see instructions)	•).		0. 000000 0. 000000	
20.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22.0
23. 00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.00
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or lin	ne 24 (see	0.00	25.00
26.00	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	28.0
	IME add-on adjustment amount - Managed Care (see instructions Total IME payment (sum of lines 22 and 28)			0	
	Total IME payment - Managed Care (sum of lines 22.01 and 28.0)1)		0	
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instru	ictions)	1. 71	30.0
31.00	Percentage of Medicaid patient days (see instructions)	actione days (see mistre		23. 92	
32.00	Sum of lines 30 and 31			25.63	
33.00	Allowable disproportionate share percentage (see instructions	5)		10.36	
34 00	Disproportionate share adjustment (see instructions)			112, 036	1 34.0

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period:	Worksheet E	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title XVIII	Hospi tal	7/30/2021 11:0 PPS	08 alli
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)		0	0	35.0
35.01	Factor 3 (see instructions)		0.00000000	0.00000000	
35.02	Hospital uncompensated care payment (If line 34 is zero, entrinstructions)	er zero on this line) (se	e 731, 656	980, 940	35.0
35.03	Pro rata share of the hospital uncompensated care payment am	ount (see instructions)	547, 743	247, 251	35.0
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.)	. ,	794, 994	2177201	36.0
	Additional payment for high percentage of ESRD beneficiary di				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683,	684 and 685. (see	0		40.0
	instructions)				
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683, 684 an 685. (see	0		41.0
41.01	instructions) Total ESRD Medicare covered and paid discharges excluding MS		0		41.0
τι. UΙ	an 685. (see instructions)	002, 002, 003, 084	0		+1.0
42.00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42.0
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 6				43.0
	instructions)				
14.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.0
45.00	days) Average weekly cost for dialysis treatments (see instruction:		0.00		45.0
46.00	Total additional payment (line 45 times line 44 times line 4		0.00		46.0
47.00	Subtotal (see instructions)	1.01)	5, 348, 336		47.0
18.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. C
	only. (see instructions)	·			
				Amount 1.00	
19.00	Total payment for inpatient operating costs (see instruction	()		5, 348, 336	49.0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I a			340, 890	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt			0	51.0
52.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		0	52.0
53.00	Nursing and Allied Health Managed Care payment			0	53.0
54.00	Special add-on payments for new technologies			0	54.0
54.01	Islet isolation add-on payment	(0)		0	54.0 55.0
55.00 56.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line Cost of physicians' services in a teaching hospital (see int			0	56.0
57.00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35)	0	57.0
58.00	Ancillary service other pass through costs from Wkst. D, Pt.			0	58.0
59.00	Total (sum of amounts on lines 49 through 58)			5, 689, 226	59.0
50.00	Primary payer payments			10, 382	60.0
51.00	Total amount payable for program beneficiaries (line 59 minu:	is line 60)		5, 678, 844	
52.00	Deductibles billed to program beneficiaries			571, 296	
53.00	Coinsurance billed to program beneficiaries			2, 112	
54.00 55.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			15, 869 10, 315	
55.00 56.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		15, 869	
50.00 57.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			5, 115, 751	
58.00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0,110,701	
59.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)		· · · · · · · · · · · · · · · · · · ·	0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	
70.50	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	70.
70. 87	Demonstration payment adjustment amount before sequestration	I		0	70.
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)		_	70.
70.89	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 90				01	70.
70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			-	
70. 90 70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70.
70. 90 70. 91	HSP bonus payment HRR adjustment amount (see instructions)			-	70. °

LCULATI ON	Incial Systems JOHNSON MEMORIAL OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0001	Peri od:	u of Form CMS-2 Worksheet E	
				From 01/01/2020 To 12/31/2020	Part A Date/Time Pre	
		Title	e XVIII	Hospi tal	7/30/2021 11: PPS	08 an
				(yyyy)	Amount	
				0	1.00	
	volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70. 9
). 97 Low	corresponding federal year for the period prior to 10/1) volume adjustment for federal fiscal year (yyyy) (Enter i corresponding federal year for the period ending on or af			0	0	70. 9
	Volume Payment-3	10, 10, 1)			0	70. 9
	adjustment amount (see instructions)				0	
	nt due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			5, 153, 602	
	estration adjustment (see instructions)				34, 014	
	nstration payment adjustment amount after sequestration				0	
	estration adjustment-PARHM pass-throughs				4 070 144	71.
	rim payments rim payments-PARHM				4, 879, 164	72.
	ative settlement (for contractor use only)				0	
	ative settlement-PARHM (for contractor use only)				0	73.
	nce due provider/program (line 71 minus lines 71.01, 71.0)2 72 and			240, 424	
73)	····· ···· ···· ····· ················	_,,			,	
1.01 Bala	nce due provider/program-PARHM (see instructions)					74.
	ested amounts (nonallowable cost report items) in accorda	nce with			0	75.
	Pub. 15-2, chapter 1, §115.2 E COMPLETED BY CONTRACTOR (lines 90 through 96)			I		
	ating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.
pl us	2.04 (see instructions)					
. 00 Capi	tal outlier from Wkst. L, Pt. I, line 2				0	
	ating outlier reconciliation adjustment amount (see instr				0	
	tal outlier reconciliation adjustment amount (see instruc				0	
	rate used to calculate the time value of money (see instr	ructions)			0.00	94.
					0	0
	value of money for operating expenses (see instructions)				0	
	value of money for operating expenses (see instructions) value of money for capital related expenses (see instruct			Prior to 10/1	0	
	, , , , , , , , , , , , , , , , , , ,			Prior to 10/1 1.00	0	
5.00 Time HSP E	e value of money for capital related expenses (see instructions) Bonus Payment Amount			1.00	0 0n/After 10/1 2.00	96.
0. 00 Time HSP E 00. 00 HSP	e value of money for capital related expenses (see instruct Bonus Payment Amount bonus amount (see instructions)				0 0n/After 10/1 2.00	
0. 00 Time HSP E HSP HVBP	e value of money for capital related expenses (see instruct Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment			1.00	0 0n/After 10/1 2.00 0	96. 100.
. 00 Ti me HSP E 0. 00 HSP HVBP 1. 00 HVBP	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions)	ctions)		1.00 0 0.0000000000	0 0n/After 10/1 2.00 0 0.000000000	96. 100.
0. 00 Ti me HSP E HVBP 1. 00 HVBP 2. 00 HVBP	Adjustment for HSP bonus payment (see instructions) adjustment for HSP bonus payment (see instructions)	ctions)		1.00	0 0n/After 10/1 2.00 0 0.000000000	96. 100.
. 00 Ti me HSP E 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP HRR /	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions)	ctions)		1.00 0 0.0000000000	0 0n/After 10/1 2.00 0 0.000000000	96. 100. 101. 102.
. 00 Ti me HSP E 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP HRR 7 3. 00 HRR	Bonus Payment Amount Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment	ns)		1.00 0 0.000000000 0	0 0n/After 10/1 2.00 0 0.0000000000 0 0.00000000000000	96. 100. 101. 102. 103.
. 00 Ti me HSP E HVBP 1. 00 HVBP 2. 00 HVBP HRR / 3. 00 HRR 4. 00 HRR Rural	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions)	s) ration) Adju		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.0000000000 0 0.00000000000000	96. 100. 101. 102.
. 00 Time HSP E 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP HRR / 3. 00 HRR Rural 0. 00 Is t	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment factor (see instructions) adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) his the first year of the current 5-year demonstration pe	s) ration) Adju		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104.
. 00 Time HSP E 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP HRR / 3. 00 HRR 4. 00 HRR Rural 0. 00 I s t Cent	Bonus Payment Amount Bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) tommuni ty Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no.	s) ration) Adju		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103.
. 00 Ti me HSP I 0. 00 HSP 1. 00 HVBP 2. 00 HVBP 4. 00 HRR 4. 00 HRR 0. 00 Is t Cent Cost	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment 'adjustment for Gee instructions) 'adjustment factor (see instructions) 'adjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment factor (see instructions) adjustment factor (see instructions) adjustment factor (see instructions) I community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration per ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement	ns) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0	96. 100. 101. 102. 103. 104. 200.
. 00 Time HSP I 0. 00 HSP 1. 00 HVBP 2. 00 HVBP HRR / 3. 00 HRR 4. 00 HRR Rural 0. 00 Is t Cent Cost 1. 00 Medi	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment for HSP bonus payment (see instructions) community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lir	ns) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201.
. 00 Time HSP E 0. 00 HSP 1. 00 HVBP 2. 00 HVBP HRR 7 3. 00 HRR 4. 00 HRR Rural 0. 00 Is t Cent Cost 1. 00 Medi 2. 00 Medi	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment for HSP bonus payment (see instructions) adjustment for HSP bonus payment (see instructions) community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration peury cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lir care discharges (see instructions)	ns) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S		1.00 0 0.000000000 0 0.0000	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202.
. 00 Time HSP I 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 3. 00 HRR 4. 00 HRR Rural 0. 00 I s t Cost 1. 00 Medi 2. 00 Medi 3. 00 Case	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment factor (see instructions) adjustment service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) -mix adjustment factor (see instructions)	s) (s) (s) (ration) Adju (riod under (s) (s) (s) (s) (s) (s) (s) (s) (s) (s)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0	96. 100. 101. 102. 103. 104. 200. 201. 202.
NOO Ti me 00 00 HSP If 00 00 HSP If 10 00 HSP If 11 00 HVBP If 12 00 HVBP If 13 00 HRR If 10 00 If S T 10 00 Is t Cost 11 00 Medi If If 12 00 Medi If If	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment for HSP bonus payment (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment factor (see instructions) adjustment service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) -mix adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in	s) (s) (s) (ration) Adju (riod under (s) (s) (s) (s) (s) (s) (s) (s) (s) (s)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203.
. 00 Time HSP E 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 4. 00 HRR 4. 00 HRR Cost 1. 00 Medi 2. 00 Medi 3. 00 Case Compu peri (4. 00 Medi	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment for Gee instructions) adjustment for HSP Bonus Payment (see instructions) adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, Iir care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount	s) (s) (s) (ration) Adju (ration) Adju (riod under (riod under) (riod under) (riod under)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204.
.00 Time Image: Image state stat	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration per ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in po) care target amount -mix adjusted target amount (line 203 times line 204)	etions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 204. 205.
. 00 Time HSP I 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 3. 00 HRR 4. 00 HRR 4. 00 HRR Cent Cost 1. 00 Medi 2. 00 Medi 3. 00 Case 6. 00 Medi	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment 'adjustment for HSP Bonus Payment 'adjustment for HSP Bonus Payment (see instructions) 'adjustment amount for HSP bonus payment (see instruction Adjustment factor (see instructions) adjustment factor (see instructions) adjustment for HSP bonus payment (see instructions I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration per ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) mix adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205)	etions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202.
.00 Time .00 Time .00 HSP .00 HSP .00 HSP .00 HVBP 1.00 HVBP 2.00 HVBP .00 HRR 3.00 HRR .00 Ist .00 Ist .00 Ist .00 Ist .00 Ist .00 Ist .00 Cost .00 Cost .00 Case .00 Case .00 Case .00 Case .00 Adj us	Adjustment for HSP Bonus Payment adjustment for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment factor (see instructions) community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe- ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount -mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement	s) ration) Adju ration) Adju riod under ne 49) i first year	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 0.0000	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
OO Time HSP HSP 0.00 HSP HVBP HVBP 0.00 HVBP 1.00 HVBP 4.00 HRR 4.00 HRR 6.00 Is t Cont Cost 1.00 HRR 6.00 HRR 7.00 Prog	<pre>e value of money for capital related expenses (see instruct Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment factor (see instructions) adjustment gear of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lir care discharges (see instructions) mix adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement ram reimbursement under the §410A Demonstration (see instructions)</pre>	ns) rration) Adju rration) Adju rriod under ne 49) n first year rructions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206.
.00 Time HSP II HSP II HVBP HVBP 1.00 HVBP 2.00 HVBP HRR / 3.00 HRR Rural 0.00 Is t Cost 1.00 Medi 2.00 Medi 2.00 Medi 3.00 Case Compu period 4.00 Medi 5.00 Case Compu period 4.00 Medi 5.00 Case Compu period 4.00 Medi 5.00 Case 0.00 Cas	Bonus Payment Amount Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) i Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lir care discharges (see instructions) -mix adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount -mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement ram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A,	ns) rration) Adju rration) Adju rriod under ne 49) n first year rructions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
. 00 Time HSP I 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 3. 00 HRR 4. 00 HRR Cost 1. 00 Medi 2. 00 Medi 3. 00 Case 6. 00 Medi 5. 00 Case 6. 00 Medi 5. 00 Case 6. 00 Medi 5. 00 Case 6. 00 Medi 7. 00 Prog 8. 00 Medi 9. 00 Adju	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment for HSP Bonus Payment (see instructions) adjustment for HSP Bonus Payment (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lir care discharges (see instructions) -mix adjustment factor (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount -mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement iram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, stment to Medicare IPPS payments (see instructions)	ns) rration) Adju rration) Adju rriod under ne 49) n first year rructions)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209.
. 00 Time HSP I 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 4. 00 HRR 4. 00 HRR 0. 00 Is t Cost 1. 00 Medi 2. 00 Medi 3. 00 Case 6. 00 Medi 5. 00 Case 6. 00 Medi 6. 00 Medi 7. 00 Prog	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment for Gee instructions) adjustment factor (see instructions) adjustment factor (see instructions) adjustment factor (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration peury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, Iir care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in do) care target amount -mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement ram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, stment to Medicare IPPS payments (see instructions) erved for future use	ns) rration) Adju rration) Adju rration under he 49) first year rructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 207. 207. 207. 207. 209. 209. 210.
.00 Time	Bonus Payment Amount Bonus Payment Amount Bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment for HSP Bonus Payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration per ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, Iir care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount -mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement ram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, stment to Medicare IPPS payments (see instructions) rved for future use 1 adjustment to Medicare IPPS payments (see instructions)	ns) rration) Adju rration) Adju rration under he 49) first year rructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 207. 207. 207. 207. 207. 207. 207
. 00 Time HSP II 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP HRR / 3. 00 HRR Rural 0. 00 Ist Cost 0. 00 Ist Cost 0. 00 Case 0. 00 Medi 3. 00 Case 0. 00 Medi 5. 00 Case 0. 00 Medi 5. 00 Case 0. 00 Medi 5. 00 Case 0. 00 Medi 0. 00 Rese 1. 00 Tota	Bonus Payment Amount bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment factor (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment adjustment for HSP Bonus payment (see instructions) adjustment for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) I Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration pe- ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, lin care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount -mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement ram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, stment to Medicare IPPS payments (see instructions) rived for future use I adjustment to Medicare IPPS payments (see instructions) arision of PPS versus Cost Reimbursement	s) ration) Adju ration) Adju riod under ne 49) first year first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0.000000000 0 0.0000 0 0.0000 0 0	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 204. 205.
. 00 Time HSP II 0. 00 HSP HVBP 1. 00 HVBP 2. 00 HVBP 2. 00 HRR 4. 00 HRR 0. 00 Is t Cost 1. 00 Medi 3. 00 Case Compu peri 0 4. 00 Medi 5. 00 Case Compu peri 0 4. 00 Medi 5. 00 Case Compu peri 0 4. 00 Medi 5. 00 Case 0. 00 Medi 5. 00 Case 0. 00 Medi 4. 00 Medi 5. 00 Case 0. 00 Medi 4. 00 Medi 5. 00 Case 0. 00 Medi 0. 00 Medi 0. 00 Rese 0. 00 Adj u 0. 00 Adj u 0. 00 Tota Compu 0. 00 Tota	Bonus Payment Amount Bonus Payment Amount Bonus amount (see instructions) Adjustment for HSP Bonus Payment adjustment factor (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment for HSP Bonus Payment adjustment for HSP Bonus Payment (see instructions) adjustment for HSP Bonus Payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment factor (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) adjustment amount for HSP bonus payment (see instructions) Community Hospital Demonstration Project (§410A Demonst his the first year of the current 5-year demonstration per ury Cures Act? Enter "Y" for yes or "N" for no. Reimbursement care inpatient service costs (from Wkst. D-1, Pt. II, Iir care discharges (see instructions) utation of Demonstration Target Amount Limitation (N/A in od) care target amount -mix adjusted target amount (line 203 times line 204) care inpatient routine cost cap (line 202 times line 205) stment to Medicare Part A Inpatient Reimbursement ram reimbursement under the §410A Demonstration (see inst care Part A inpatient service costs (from Wkst. E, Pt. A, stment to Medicare IPPS payments (see instructions) rved for future use 1 adjustment to Medicare IPPS payments (see instructions)	s) ration) Adju ration) Adju riod under ne 49) first year first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	0 0n/After 10/1 2.00 0 0.000000000 0 0.0000 0 0 trati on	96. 100. 101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.

VOLUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2020 To 12/31/2020		pare
	W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	XVIII Period Prior to 10/01	Hospi tal Peri od On/After 10/01	PPS Total (Col 2 through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
DRG amounts other than out	tlier 1.00	0	0		0 0	0	1.
payments DRG amounts other than out payments for discharges		3, 091, 497	0	3, 091, 49	7	3, 091, 497	1.
occurring prior to October DRG amounts other than out payments for discharges occurring on or after Octo	tlier 1.02	1, 234, 215	0		1, 234, 215	1, 234, 215	1.
1 3 DRG for Federal specific operating payment for Mode BPCI occurring prior to	1. 03 el 4	O	0		0	0	1.
October 1 DRG for Federal specific operating payment for Mode BPCI occurring on or after October 1		0	0		0	0	1.
Outlier payments for	2.00						2.
discharges (see instruction Outlier payments for	2. 02	0	0		0 0	0	2.
discharges for Model 4 BPC Outlier payments for discharges occurring prior	2.03	64, 439	0	64, 43	9	64, 439	2.
October 1 (see instruction Outlier payments for discharges occurring on or after October 1 (see	2. 04	51, 155	0		51, 155	51, 155	2.
instructions) Operating outlier reconciliation	2.01	0	0		0 0	0	3.
Managed care simulated payments	3.00	0	0		0 0	0	4.
D Amount from Worksheet E, F	Part 21.00	0. 000000	0. 000000	0. 00000	0 0. 000000		5.
A, line 21 (see instruction IME payment adjustment (see instructions)		0	0		0 0	0	6.
 IME payment adjustment for managed care (see instructions) 	- 22.01	0	0		0 0	0	6
Indirect Medical Education	Adiustment for th	ne Add-on for Se	ection 422 of	the MMA			1
) IME payment adjustment fac (see instructions)		0. 000000			0 0. 000000		7
D IME adjustment (see instructions)	28.00	0	0		0 0	0	
 IME payment adjustment add for managed care (see instructions) 	d on 28.01	0	0		0 0	0	8
Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	
1 Total IME payment for mana care (sum of lines 6.01 ar 8.01)	nd	0	0		0 0	0	9
Disproportionate Share Adj		0.100	0.101	0.100	(1
Allowable disproportionate share percentage (see instructions)	e 33.00	0. 1036	0. 1036	0. 103	6 0. 1036		10
Disproportionate share adjustment (see instructionate)	34.00	112, 036	0	80, 07	0 31, 966	112, 036	11.
01 Uncompensated care payment Additional payment for hig	ts 36.00	794, 994 SRD beneficiary		547, 74	3 247, 251	794, 994	11.
00 Total ESRD additional payr	nent 46.00	0	0		0 0	0	12.
(see instructions) 00 Subtotal (see instructions) 00 Hospital specific payments	48.00	5, 348, 336 0	0	3, 783, 74	9 1, 564, 587 0 0	5, 348, 336 0	
(completed by SCH and MDH, small rural hospitals only (see instructions) DO Total payment for inpatier operating costs (see	/.)	5, 348, 336	0	3, 783, 74	9 1, 564, 587	5, 348, 336	15

	Financial Systems		JOHNSON MEMORI	Provider C	CN· 15-0001	Peri od:	u of Form CMS-2 Worksheet E	2002-10
						From 01/01/2020 To 12/31/2020	Part A Exhibi	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	340, 890					16.00
	Special add-on payments for new technologies	54.00	0	0		0 0	0	
17.01 17.02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	О	0		0 0	0	17.01 17.02
18.00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see		0	0		0 0	0	18.00
19 00	instructions) SUBTOTAL			0	3, 688, 84	47 2,000,379	5, 689, 226	19 00
		W/S L, line	(Amounts from L)		0,000,0		0,007,220	17100
	1	0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		332, 110 0	0		33 422, 843 0 0	332, 110 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	8, 780 0		.,	69 12, 949 0 0	8, 780 0	
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	340, 890	0	-94, 90	435, 792	340, 890	26.00
		W/S E, Part A						
		line 0	<u>E, Part A)</u> 1.00	2.00	2 00	4.00	E 00	
27.00	Low volume adjustment factor	0	1.00	2.00	3.00	4.00 00 0.000000	5.00	27.00
28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.0000	0	0	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Ν					100.00

	Financial Systems	JOHNSON MEMORI				u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2020	Worksheet E Part A Exhibi	+ 5
					To 12/31/2020	Date/Time Pre	pared:
					llooni tol	7/30/2021 11:0 PPS	08 am_
		Wkst. E, Pt.	Amt. from	XVIII Period to	Hospital Period on	Total (cols.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00	1.00	2.00	0.00	1.00	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	3, 091, 497	3, 091, 497	7	3, 091, 497	1.01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	1, 234, 215		1, 234, 215	1, 234, 215	1.02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	С		0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0	C	0 0	0	2.01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	64, 439	64, 439		64, 439	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	51, 155		51, 155	51, 155	2.03
3.00	Operating outlier reconciliation	2.01	0	C		0	3.00
4.00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	0	(0 0	0	4.00
5.00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 000000	0. 000000		5.00
6.00	(see instructions) IME payment adjustment (see instructions)	22.00	0	C	0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)		0	C		0	6.01
	Indirect Medical Education Adjustment for the	e Add-on for Se	ection 422 of 1	the MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000		7.00
3.00	IME adjustment (see instructions)	28.00	0	C		0	8.00
3. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	C	0 0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0		0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	C	0 0	0	9.01
	Disproportionate Share Adjustment						
0.00	Allowable disproportionate share percentage	33.00	0. 1036	0. 1036	o. 1036		10.00
11.00	(see instructions) Disproportionate share adjustment (see	34.00	112, 036	80, 070	31, 966	112, 036	11.00
11.01	instructions) Uncompensated care payments	36.00	794, 994			794, 994	
11.01	Additional payment for high percentage of ESI			547,745	247,231	794, 994	11.01
12.00	Total ESRD additional payment (see instructions)	46.00	0	C	0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	5, 348, 336	3, 783, 749	1, 564, 587	5, 348, 336	
4.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0	C	0 0	0	14.00
5.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	5, 348, 336	3, 783, 749	9 1, 564, 587	5, 348, 336	15.00
6. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	340, 890	-94, 902	435, 792	340, 890	16.00
17.00 17.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0	C	0 0	0	17.00 17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	С	0 0	0	
					1		
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	С	0 0	0	18.00

	Financial Systems	JOHNSON MEMORI			In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/30/2021 11:	epared:
				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	332, 110	-90, 7	33 422, 843	332, 110	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	8, 780	-4, 1	69 12, 949	8, 780	21.00
	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.00	0. 0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.00	0. 0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	340, 890	-94, 9	02 435, 792	340, 890	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
30.00	Low volume adjustment prior to October 1 Low volume adjustment on or after October 1 HVBP payment adjustment (see instructions)	70. 96 70. 97 70. 93	0 0 42, 179	26, 8	0 0 78 15, 301	0	29.00 30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30.01
	HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-4, 328 0	-4, 3	28 0 0 0	-4, 328 0	1
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instru 3.00 OPPS payments	Provider CCN: 15-0001	Peri od: From 01/01/2020 To 12/31/2020 Hospi tal		
 Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru 	Title XVIII	Hospi tal		<u>08 am</u>
 Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru 				
 Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru 			1.00	
 Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru 			1.00	
			166	
	ictions)		6, 981, 411 5, 677, 688	
4.00 Outlier payment (see instructions)			20, 882	
4.01 Outlier reconciliation amount (see instructions)			0	
5.00 Enter the hospital specific payment to cost ratio (see instr 6.00 Line 2 times line 5	ructions)		0. 000 0	1
7.00 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00 Transitional corridor payment (see instructions)			0	
9.00 Ancillary service other pass through costs from Wkst. D, Pt. 10.00 Organ acquisitions	IV, col. 13, line 200		0	9.00 10.00
11.00 Total cost (sum of lines 1 and 10) (see instructions)			166	
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges 12.00 Ancillary service charges			278	12.00
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	
14.00 Total reasonable charges (sum of lines 12 and 13)			278	14.00
Customary charges 15.00 Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	15.00
16.00 Amounts that would have been realized from patients liable f	1 3	0	0	
had such payment been made in accordance with 42 CFR §413.13		0		
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions)			0. 000000 278	
19.00 Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds li	ne 11) (see	112	•
instructions)				
20.00 Excess of reasonable cost over customary charges (complete o instructions)	only it line il exceeds il	ne 18) (see	0	20.00
21.00 Lesser of cost or charges (see instructions)			166	1
22.00 Interns and residents (see instructions) 23.00 Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			5, 698, 570	
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 Deductibles and coinsurance amounts (for CAH, see instructio 26.00 Deductibles and Coinsurance amounts relating to amount on li	-	cuctions)	0 1, 098, 281	
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•		4, 600, 455	
instructions)	1: 50)			20.00
28.00 Direct graduate medical education payments (from Wkst. E-4, 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36			0	
30.00 Subtotal (sum of lines 27 through 29)	,		4, 600, 455	
31.00 Primary payer payments			176	
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	(ICES)		4, 600, 279	32.00
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	,		0	
34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions)			65, 537 42, 599	
36.00 Allowable bad debts for dual eligible beneficiaries (see ins	structions)		42, 599 65, 537	
37.00 Subtotal (see instructions)	-		4, 642, 878	
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			159 0	1
39.50 Pioneer ACO demonstration payment adjustment (see instructio	ns)		0	39.50
39.97 Demonstration payment adjustment amount before sequestration			0	
39.98 Partial or full credits received from manufacturers for repl 39.99 RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instruc	ctions)	0	
40.00 Subtotal (see instructions)			4, 642, 719	
40.01 Sequestration adjustment (see instructions)			30, 642	
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs			0	40.02
41.00 Interim payments			4, 638, 097	1
41.01 Interim payments-PARHM				41.01
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only)			0	42.00 42.01
43.00 Balance due provider/program (see instructions)			-26, 020	
43.01 Balance due provider/program-PARHM (see instructions)				43.01
44.00 Protested amounts (nonallowable cost report items) in accord §115.2	ance with CMS Pub. 15-2,	cnapter 1,	0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00 Original outlier amount (see instructions)			0	
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money			0 0.00	
93.00 Time Value of Money (see instructions)			0	93.00
94.00 Total (sum of lines 91 and 93)			0	94.00

ANALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0001	Period: From 01/01/2020 To 12/31/2020		pared:
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A		тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		4, 861, 3	0	4, 572, 183 0	1.00 2.00 3.00
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	12/31/2020	17, 79	73 12/31/2020	65, 914	3.01
3.01	ADJUSTMENTS TO PROVIDER	12/ 31/ 2020	17,75	0	05, 914	3.02
3.03				0	0	3.03
3. 04				0	0	3.04
3.05				0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.50
3.50	ADJUSTINENTS TO PROGRAM			0	0	3.5
3. 52				0	0	3.5
3.53				0	0	3.53
3.54			47.7	0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		17, 79		65, 914	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)		4, 879, 10	54	4, 638, 097	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
	Program to Provider					
5.01 5.02	TENTATI VE TO PROVIDER			0	0	5.01 5.02
5.02				0	0	5.02
	Provider to Program			-1	0	
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	
5.52 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.5 5.9
J. 77	5. 50-5. 98)			0	0	5.7
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5. 01	SETTLEMENT TO PROVIDER		240, 42	24	0	6.0
5. 02	SETTLEMENT TO PROGRAM			0	26, 020	6.0
7.00	Total Medicare program liability (see instructions)		5, 119, 58	38 Contractor	4,612,077 NPR Date	7.0
				Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems JOHNSON MEMOR	REAL HOSPETAL	In Lie	u of Form CMS	-2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0001	Peri od:	Worksheet E-	1		
			From 01/01/2020 To 12/31/2020		oparod		
			10 12/31/2020	7/30/2021 11			
		Title XVIII	Hospi tal	PPS			
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	5					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA	ΓΙ ON					
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00		
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines				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-10, col.				6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00		
8.00	Calculation of the HIT incentive payment (see instructions	2)			8.00		
9,00	Sequestration adjustment amount (see instructions)	<i>)</i>			9.00		
10.00	Calculation of the HIT incentive payment after sequestrat	on (see instructions)			10.00		
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				10.00		
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00		
31.00	Other Adjustment (specify)				31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	nd line 31) (see instructio	ins)		32.00		
		, , , , , , , , , , , , , , , , , , , ,	<i>,</i>				

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2020 To 12/31/2020		pare
			lloopitol	7/30/2021 11:	08 a
		Title XIX	Hospital	Cost Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR 2		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		671, 075		1 1.
00	Medical and other services			0	2.
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		671, 075	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		671, 075	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
00	Routine service charges		917, 036	-	8
00	Ancillary service charges		1, 232, 080	0	
). 00	Organ acquisition charges, net of revenue		0		10
. 00 2. 00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		-	0	11
. 00	CUSTOMARY CHARGES		2, 149, 116	0	1 12
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
. 00	basi s	services on a charge	0	0	'3
. 00	Amounts that would have been realized from patients liable for	payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with 42	1 5		0	
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15
. 00	Total customary charges (see instructions)		2, 149, 116	0	16
. 00	Excess of customary charges over reasonable cost (complete only	/ifline 16 exceeds	1, 478, 041	0	17
	line 4) (see instructions)				
3.00	Excess of reasonable cost over customary charges (complete only	/ifline 4 exceeds li	ne 0	0	18
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	
). 00	Cost of physicians' services in a teaching hospital (see instru		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 16		671, 075	0	21
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	completed for PPS provi		0	1 22
2.00 3.00	Other than outlier payments Outlier payments		0	0	
. 00	Program capital payments		0	0	24
5.00	Capital exception payments (see instructions)		0		25
b. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	27
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	28
9.00	Titles V or XIX (sum of lines 21 and 27)		671, 075	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
0. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		671, 075	0	31
. 00	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0		35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	671, 075	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37
. 00	Subtotal (line 36 ± line 37)		671, 075	0	38
00	Direct graduate medical education payments (from Wkst. E-4)		0	-	39
0. 00	Total amount payable to the provider (sum of lines 38 and 39)		671,075	0	
. 00	Interim payments Palance due provider (program (line 40 minus line 41)		1, 088, 276	0	
2.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance	a with CMS Dub 15 2	-417, 201	0	
8.00	chapter 1, §115.2	C WITH OWS PUD 13-2,	0	0	43

	SHEET (If you are nonproprietary and do not maintain	AL HOSPITAL Provider CC		<u>In Lie</u> riod: com 01/01/2020	Worksheet G	
una-ty nly)	pe accounting records, complete the General Fund column		To		Date/Time Pre 7/30/2021 11:	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
C	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	16, 577, 522	0	0	0	1.
	Temporary investments	0	0	0	0	
	Notes receivable Accounts receivable	0 7, 928, 784	0	0	0	3. 4.
	Other receivable	2, 386, 608	0	0	0	
	Allowances for uncollectible notes and accounts receivable	0	0	0	0	
	Inventory	2, 766, 319	0	0	0	
	Prepaid expenses Other current assets	106, 355, 851	0	0	0	
	Due from other funds	0	0	0	0	10
	Total current assets (sum of lines 1-10)	136, 015, 084	0	Ő	0	
-	TIXED ASSETS			1		
	Land	4, 743, 426	0	0	0	
	Land improvements Accumulated depreciation	2, 886, 743 -1, 543, 163	0	0	0	
	Buildings	-1, 545, 105	0	0	0	
	Accumulated depreciation	-32, 214, 939	0	0	0	
	Leasehold improvements	69, 291, 605	0	0	0	
	Accumulated depreciation	0	0	0	0	18
	Fixed equipment Accumulated depreciation	13, 109, 967 -11, 746, 893	0	0	0	19 20
	Automobiles and trucks	-11, 740, 893	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Major movable equipment	95, 927, 734	0	0	0	
	Accumulated depreciation	-42, 222, 561	0	0	0	
	Vinor equipment depreciable Accumulated depreciation	0	0	0	0	
	HIT designated Assets	0	0	0	0	20
	Accumulated depreciation	0	0	0	0	28
	Minor equipment-nondepreciable	0	0	0	0	29
	Total fixed assets (sum of lines 12-29)	98, 231, 919	0	0	0	30
	Investments	-7, 000, 016	0	0	0	31
	Deposits on leases	0	0	0	0	
	Due from owners/officers	0	0	0	0	33
	Other assets Total other assets (sum of lines 31-34)	35, 514, 844 28, 514, 828	0	0	0	34 35
	Total assets (sum of lines 11, 30, and 35)	262, 761, 831	0	0	0	
C	CURRENT LIABILITIES			- 1		
	Accounts payable	4, 235, 838		0	0	
	Salaries, wages, and fees payable	4, 277, 127	0	0	0	
	Payroll taxes payable Notes and loans payable (short term)	2, 616, 669	0	0	0	
	Deferred income	0	0	0	0	
. 00 /	Accelerated payments	0				42
	Due to other funds	20, 838, 882	0	0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	26, 519, 677	0	0	0	
	ONG TERM LIABILITIES	58, 488, 193	0	0	0	40
	Mortgage payable	0	0	0	0	46
	Notes payable	15, 167, 520	0	0	0	47
	Unsecured Loans	0	0	0	0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	0 15, 167, 520	0	0	0	
	Total liabilities (sum of lines 45 and 50)	73, 655, 713		0	0	50
	CAPITAL ACCOUNTS	10,000,110				1 .
. 00 🛛	General fund balance	189, 106, 118				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55
	Plant fund balance - invested in plant			0	0	
	Plant fund balance - reserve for plant improvement,				0	
1	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	189, 106, 118		0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	262, 761, 831	0	0	0	60

Health Financial Systems STATEMENT OF CHANGES IN FUND BALANCES	JOHNSON MEMORIA	Provi der CC	CN: 15-0001	Period: From 01/01/2020	u of Form CMS- Worksheet G-	
				To 12/31/2020	Date/Time Pr 7/30/2021 11	
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)		2, 00 194, 416, 710 2, 683, 948 197, 100, 658 0 197, 100, 658 0 197, 100, 658	3.00	4.00 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
	Endowment Fund	PI ant	Fund			
	6.00	7.00	8.00	_		
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.009.00	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 10	00	0 0 0 0 0 0		0		9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

Heal th	Financial Systems JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0001	Period: From 01/01/2020 To 12/31/2020		pared:
	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		11, 606, 34	15	11, 606, 345	1.00
2.00	SUBPROVIDER - IPF		11,000,34	40	11,000,345	2.00
3.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVI DER			0	Ū	4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		11, 606, 34	45	11, 606, 345	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T		1, 959, 0	71	1, 959, 071	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN I NTENSI VE CARE UNI T					13.00
14.00 15.00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)					14.00 15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 959, 0 ⁻	71	1, 959, 071	16.00
10.00	11-15)	TTHE5	1, 757, 0	/ 1	1, 757, 071	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13, 565, 4	16	13, 565, 416	17.00
18.00	Ancillary services	/	43, 183, 18		247, 378, 671	18.00
19.00	Outpatient services			0 0	0	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY			851, 163	851, 163	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)	to Wkot	E4 740 44		0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	IU WKSI.	56, 748, 60	205, 046, 648	261, 795, 250	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			73, 763, 212		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00 40.00				0 0		39.00 40.00
40.00				0		40.00
41.00	Total deductions (sum of lines 37-41)			0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		73, 763, 212		43.00
.5. 55	to Wkst. G-3, line 4)			, ,		
		·				

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0001	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Pre 7/30/2021 11:	pared:
					1.00	
1.00	Total patient revenues (from Wkst. G-2,	Part I, column 3, lin	e 28)		261, 795, 250	1.00
2.00	Less contractual allowances and discounts	s on patients' accoun	ts		195, 192, 683	2.00
3.00	Net patient revenues (line 1 minus line :	2)			66, 602, 567	3.00
4.00	Less total operating expenses (from Wkst		43)		73, 763, 212	4.00
5.00	Net income from service to patients (line	e 3 minus line 4)			-7, 160, 645	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscel		servi ces		0	8.00
9.00	Revenue from television and radio service	e			0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and	guests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical		han patients		0	16.00
17.00	Revenue from sale of drugs to other than				0	17.00
18.00	Revenue from sale of medical records and				0	18.00
19.00	Tuition (fees, sale of textbooks, uniform				0	19.00
20.00	Revenue from gifts, flowers, coffee shops	s, 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 OPERATING INCOME				2, 972, 098	
24.01	NON-OPERATING INCOME				1, 486, 972	
24.50	COVI D-19 PHE Fundi ng				1, 555, 871	24.50
25.00	Total other income (sum of lines 6-24)				6, 014, 941	
26.00					-1, 145, 704	
27.00					-3, 829, 652	
28.00	Total other expenses (sum of line 27 and	1 2			-3, 829, 652	
29.00	Net income (or loss) for the period (line	e 26 minus line 28)			2, 683, 948	29.00

Heal th	Financial Systems		JOHNSON MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS	5	Provider C	F	eriod: rom 01/01/2020	Worksheet H	
				HHA CCN:	15-7510 T	o 12/31/2020	Date/Time Pre 7/30/2021 11:	
						Home Health Agency I	PPS	
		Sal ari es	Employee Benefits	Transportatio n (see	Contracted/Pu rchased		Total (sum of cols. 1 thru	
		1.00		instructions)	Servi ces	5.00	5)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable			O		0	0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	C	c	0	0	
4.00 5.00	Transportation Administrative and General	0 152, 562	0	0 31, 706	-	-	0 246, 990	
	HHA REIMBURSABLE SERVICES				1	1		
6.00 7.00	Skilled Nursing Care Physical Therapy	210, 825 114, 175		0		-	210, 825 114, 175	
8.00 9.00	Occupational Therapy Speech Pathology	61, 281 0	0		-	-	61, 281 0	1
10.00	Medical Social Services	0	0	0	C C	0	0	10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	36, 152 0	0		-	-	36, 152 8, 755	
13.00 14.00	Drugs	0	0	C C		-	0	13.00
14.00	HHA NONREI MBURSABLE SERVI CES	0				-		14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	-			-	0	
17.00	Private Duty Nursing	0	0	0	-	-	0	17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0		-	0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0	0	-	0	
21.00	Homemaker Service	0	0	0	c c	0	0	22.00
23.00 23.50	All Others (specify) Telemedicine	0	0	0		-	0	
	Total (sum of lines 1-23)	574, 995	0	31, 706	C	-	678, 178	
		Reclassificat ion	Reclassified Trial Balance	Adjustments	Net Expenses for			
			(col. 6 + col.7)		Allocation (col. 8 +			
		7.00	8.00	9.00	<u>col. 9)</u> 10.00	-		-
	GENERAL SERVICE COST CENTERS				1			
1.00	Capital Related - Bldg. & Fixtures	0	0	C	C			1.00
2.00	Capital Related - Movable Equipment	0	0	0	C			2.00
3.00	Plant Operation & Maintenance	0	0	0				3.00
4.00 5.00	Transportation Administrative and General	0	0 246, 990	0				4.00 5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	-9, 027	201, 798	0	201, 798			6.00
7.00	Physical Therapy	0	114, 175	0	114, 175			7.00
8.00 9.00	Occupational Therapy Speech Pathology	0	61, 281 0					8.00 9.00
10.00	Medical Social Services	0	0	0	-			10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	0	36, 152 8, 755					11.00 12.00
13.00 14.00	Drugs DME	0	0	0				13.00 14.00
	HHA NONREI MBURSABLE SERVI CES							
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0						15.00 16.00
17.00	Private Duty Nursing	0	0	0	C			17.00
18. 00 19. 00	Clinic Health Promotion Activities	0	0	0	-			18.00 19.00
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0	0				20.00 21.00
22.00	Homemaker Service	0	0	0	C			22.00
	All Others (specify) Telemedicine	0	0	0				23.00 23.50
	Total (sum of lines 1-23)	-9, 027	669, 151					24.00

Heal th	Financial Systems		JOHNSON MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	LLOCATION - HHA GENERAL SERVICE	E COST		Provi der C	CN: 15-0001	Period:	Worksheet H-1	
				HHA CCN:	15-7510	From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
						Home Health	7/30/2021 11: PPS	<u>08 am</u>
						Agency I		
			Capital Rela	ited Costs				
		Net Expenses	BI dgs &	Movabl e	Plant	Transportatio	Subtotal	1
		for Cost Allocation	Fi xtures	Equi pment	Operation & Maintenance		(cols. 0-4)	
		(from Wkst.						
		H, col. 10) 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS				1			
1.00	Capital Related - Bldg. & Fixtures	0	0				C	1.00
2.00	Capital Related - Movable	0		C			0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	C		0	C	3.00
4.00	Transportation	0	0	0	1	0 0		4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	246, 990	0	0	1	0 0	246, 990	5.00
6.00	Skilled Nursing Care	201, 798	0	0	1	0 0		•
7.00 8.00	Physical Therapy Occupational Therapy	114, 175 61, 281	0	0		0 0	114, 175 61, 281	•
9.00	Speech Pathology	0	0	0		0 0	0	9.00
10. 00 11. 00	Medical Social Services Home Health Aide	0 36, 152	0	0		0 0	0 36, 152	
12.00	Supplies (see instructions)	8, 755	0	0		0 0		12.00
13.00 14.00	Drugs DME	0	0	0		0 0		
14.00	HHA NONREI MBURSABLE SERVI CES			0				14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	1			
17.00	Private Duty Nursing	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	0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0	0		0 0		
23.50	Tel emedi ci ne	0	0	0		0 0	-	23.50
24.00	Total (sum of lines 1-23)	669,151 Administrativ	0 Total (cols.	0	1	0 0	669, 151	24.00
		e & 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	246, 990						5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	118, 065	319, 863					6.00
7.00	Physi cal Therapy	66, 799	180, 974					7.00
8.00 9.00	Occupational Therapy Speech Pathology	35, 853 0	97, 134 0					8.00 9.00
10.00	Medical Social Services	0	Ő					10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	21, 151 5, 122	57, 303 13, 877					11.00 12.00
13.00	Drugs	0	0					13.00
14.00	DME HHA NONREIMBURSABLE SERVICES	0	0					14.00
15.00	Home Dialysis Aide Services	0	0					15.00
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0					16.00 17.00
17.00		0	0					17.00
19.00	Health Promotion Activities	0	o					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		0	0					23.00 23.50
	Total (sum of lines 1-23)		669, 151					24.00

Heal th	Financial Systems		JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	SI S		Provider C	CN: 15-0001	Peri od:	Worksheet H-1	
						From 01/01/2020		
				HHA CCN:	15-7510	To 12/31/2020	Date/Time Pre 7/30/2021 11:	pared:
						Home Health	PPS	
						Agency I	110	
		Capital Rel	ated Costs					
		BIdgs &	Movabl e	Plant	Transportati	Reconciliatio	Administrativ	-
		Fixtures	Equipment	Operation &	n (MI LEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Maintenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
F 00	instructions)		0				400.4/4	F 00
5.00	Administrative and General	0	0	0		0 -246, 990	422, 161	5.00
6 00	HHA REIMBURSABLE SERVICES	0	0	0	1	0 0	201, 798	6 00
6.00 7.00	Skilled Nursing Care Physical Therapy	0	0	-		0 0		
8.00	Occupational Therapy	0	0				61, 281	
9.00	Speech Pathology	0	0				01,201	
10.00	Medical Social Services	0	0				0	
11.00	Home Heal th Ai de	0	0	0		0 0	, o	11.00
12.00	Supplies (see instructions)	0	0	0		0 0		12.00
13.00	Drugs	0	0	0		0	0	
14.00	DME	0	0	0		0 0	0	14.00
	HHA NONREI MBURSABLE SERVI CES							
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20100
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	22100
23.00	All Others (specify)	0	0	0		0 0	0	
23.50	Telemedicine	0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	0	0			0 -246, 990		
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0				246, 990	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.00000	о	0. 585061	26.00

		\cap HHA COCI CLM	TFDC	Drovidor ()	$N 15_0001$	ari ad	Workchoot U 7	
	TION OF GENERAL SERVICE COSTS T	U TITA CUST CEN		Provider CO	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet H-2 Part I Date/Time Pre 7/30/2021 11:0	pared:
						Home Health	PPS	
			CAPITAL REL	ATED COSTS		Agency I		
	Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ON S	DATA PROCESSI NG	
		0	1.00	2.00	4. 00	4.01	4.02	
. 00	Administrative and General	0	13, 104	96	142, 035	5, 868	56, 485	
2.00	Skilled Nursing Care	319, 863	0	0	0	0	0	2.00
8.00 4.00	Physical Therapy Occupational Therapy	180, 974	0	0	0	0	0	3.00 4.00
F. 00 5. 00	Speech Pathology	97, 134 0	0	0	0	0	0	5.00
. 00 . 00	Medi cal Soci al Servi ces	0	0	0	C	0	0	6.0
. 00	Home Health Aide	57, 303	0	0	C	0	0	7.00
8. 00	Supplies (see instructions)	13, 877	0	0	C	0	0	8.00
. 00	Drugs	0	0	0	0	0	0	
0.00	DME Home Dialysis Aide Services	0	0	0	0	0	0	
2.00	Respi ratory Therapy	0	0	0	0	0	0	
3.00	Private Duty Nursing	0	0	0	C	0	0	
4.00	Clinic	0	0	0	C	0	0	
5.00	Health Promotion Activities	0	0	0	C	0	0	
6.00	Day Care Program	0	0	0	C	0	0	
7.00	Home Delivered Meals Program	0	0	0	0	0	0	
8.00 9.00	Homemaker Service All Others (specify)	0	0	0	0	0	0	
9.00	Tel emedici ne	0	0	0	0	0	0	
20.00	Total (sum of lines 1-19) (2)	669, 151	13, 104	96	142, 035	5, 868	56, 485	
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to							21.00
	6 decimal places.							
	Cost Center Description	MATERI ALS MANAGEMENT	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	
		4. 03	4.04	4.05	4A. 05	5.00	7.00	
. 00	Administrative and General	634	3, 983	7, 458	229, 663		22, 892	1.0
. 00	Skilled Nursing Care	0	0	0	319, 863		0	
. 00	Physical Therapy	0	0	0	180, 974		0	3.0
00	Occupational Therapy Speech Pathology	0	0	0	97, 134 0		0	4.C
. 00	Medical Social Services	0	0	0	0	0	0	6.0
. 00	Home Health Aide	0	0	0	57, 303	2	0	7.0
. 00	Supplies (see instructions)	0	0	0	13, 877	1	0	8. C
00	Drugs	0	0	0	0	0	0	
0.00	DME Home Dialysis Aide Services	0	0	0	0	0	0	1
1.00 2.00	Respiratory Therapy	0	0	0		0	0	
	Private Duty Nursing	0	0	0	0	0	0	
4.00	Clinic	0	0	0	0	0	0	
5.00	Health Promotion Activities	0	0	0	C	0	0	15.0
6.00	Day Care Program	0	0	0	C	0	0	
7.00	Home Delivered Meals Program	0	0	0	0	0	0	
8.00	Homemaker Service	0	0	0	0	0	0	
9.00 9.50	All Others (specify) Telemedicine	0	0	0		0	0	
0.00 1.00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	634	3, 983	7, 458	898, 814 0. 000000		22, 892	

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

Heal th	Financial Systems		JOHNSON MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOC	ATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	ITERS	Provider CO	CN: 15-0001 15-7510	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared [.]
						Home Health	7/30/2021 11: PPS	08 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	Agency I NURSI NG	CENTRAL	
		LINEN SERVICE				ADMI NI STRATI O N	SERVI CES & SUPPLY	
		8.00	9.00	10.00	11.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 21.\ 00\\ 21.\ 00\\ \end{array}$	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0 0 0 0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 50\\ \end{array}$
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		Allocated HHA A&G (see Part II)	
1.00	Administrative and General	15.00	16.00 3,353	24.00 273,794	25.00	26.00 0 273,794	27.00	1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine			273, 194 319, 874 180, 981 97, 138 0 57, 305 13, 878 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 213, 794 0 319, 874 0 180, 981 0 97, 138 0 0 0 57, 305 0 13, 878 0 0 0 <t< td=""><td>130, 877 74, 049 39, 744 0 23, 446 5, 678 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td><td>$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\ 15.\$</td></t<>	130, 877 74, 049 39, 744 0 23, 446 5, 678 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\ 15.\$

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

Heal th	Financial Systems		JOHNSON MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provi der	CCN:	15-0001	Peri od:	Worksheet H-2	
				HHA CCN:		15-7510	From 01/01/2020 To 12/31/2020	Date/Time Pre	
							Home Health	7/30/2021 11: PPS	<u>08 am</u>
							Agency I	FF J	
	Cost Center Description	Total HHA					Ageney I		
		Costs							
		28.00							
1.00	Administrative and General								1.00
2.00	Skilled Nursing Care	450, 751							2.00
3.00	Physical Therapy	255, 030							3.00
4.00	Occupational Therapy	136, 882							4.00
5.00	Speech Pathology	0							5.00
6.00	Medical Social Services	0							6.00
7.00	Home Health Aide	80, 751							7.00
8.00	Supplies (see instructions)	19, 556							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
	Clinic	0							14.00
15.00	Health Promotion Activities	0							15.00
	Day Care Program	0							16.00
	Home Delivered Meals Program	0							17.00
18.00	Homemaker Service	0							18.00
	All Others (specify)	0							19.00
19.50	Tel emedi ci ne	0							19.50
20.00	Total (sum of lines 1-19) (2)	942, 970							20.00
21.00	Unit Cost Multiplier: column								21.00
	26, line 1 divided by the sum								
	of column 26, line 20 minus								
	column 26, line 1, rounded to								
	6 decimal places.								

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

BASIS	TION OF GENERAL SERVICE COSTS			AL Provider C		Period:	Worksheet H-2	
				HHA CCN:		From 01/01/2020 To 12/31/2020		pared:
						Home Health	PPS	
		CAPI TAL REL	ATED COSTS			Agency I		
						DATA		-
	Cost Center Description	NEW BLDG & FIXT	MVBLE EQUIP (DOLLAR	EMPLOYEE BENEFI TS	COMMUNI CATI ON S	N DATA PROCESSI NG	MATERIALS MANAGEMENT	
		(SQUARE FEET)	VALUE)	DEPARTMENT	(# NON PT	(WORK	(SUPPLY	
				(GROSS SALARI ES)	PHONES)	ORDERS)	USAGE)	
		1.00	2.00	4.00	4.01	4. 02	4.03	
1.00	Administrative and General	1, 305	56	574, 994			11, 008	
2.00 3.00	Skilled Nursing Care Physical Therapy	0	0	0		0 0 0 0	0	2.00 3.00
3.00 4.00	Occupational Therapy	0	0	0		0 0	0	
5.00	Speech Pathology	0	0	0		0 0	0	1
6.00	Medical Social Services	0	0	0		0 0	0	1
7.00 8.00	Home Health Aide Supplies (see instructions)	0	0	0		0 0 0 0	0	
9.00	Drugs	0	0	0		0 0	0	
10.00	DME	0	0	0		0 0	0	10.00
11.00 12.00	Home Dialysis Aide Services	0	0	0		0 0 0 0	0	11.00
12.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
14.00	Clinic	0	0	0		0 0	0	
	Health Promotion Activities	0	0	0		0 0	0	1
	Day Care Program Home Delivered Meals Program	0	0	0		0 0 0 0	0	16.00
	Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	0	0	0		0 0	0	
	Telemedicine	0	0	0	2	0 0	0	19.50
20.00 21.00	Total (sum of lines 1–19) Total cost to be allocated	1, 305 13, 104	56 96	574, 994 142, 035			11, 008 634	
	Unit cost multiplier	10. 041379	1. 714286	0. 247020	255. 13043	5 1, 344. 880952	0. 057594	
	Cost Center Description	ADMI TTI NG		Reconciliatio			LAUNDRY &	
		(GROSS CHARGES)	ACCOUNTING (GROSS	n	E & GENERAL (ACCUM.	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	
			CHARGES)		COST)	. ,	LAUNDRY)	
1 00		4.04	4.05	5A	5.00	7.00	8.00	1.00
1.00 2.00	Administrative and General Skilled Nursing Care	851, 163 0	851, 163 0	0			0	
3.00	Physical Therapy	0	0	0	180, 97		Ő	
4.00	Occupational Therapy	0	0	0	97, 13		0	
5.00 6.00	Speech Pathology Medical Social Services	0	0	0		0 0 0 0	0	
7.00	Home Health Aide	0	0	0	57, 30	-	0	
8.00	Supplies (see instructions)	0	0	0			0	
	Drugs	0	0	0		0 0	0	
10.00 11.00	DME Home Dialysis Aide Services	0	0	0		0 0 0 0	0	1
	Respiratory Therapy	0	0	0		0 0	0	1
	Private Duty Nursing	0	0	0		0 0	0	1
	Clinic Health Promotion Activities		0	0		0 0 0 0	0	
16.00	Day Care Program	0	0	0		0 0	0	16.00
	Home Delivered Meals Program	0	0	0		0 0	0	1
	Homemaker Service All Others (specify)	0	0	0		0 0 0 0	0	
	Tel emedi ci ne	0	0	0		o o	0	1
19.00			054 4/0		000.01	4 4 9 9 5		00 00
20.00	Total (sum of lines 1-19)	851, 163	851, 163		898, 81		0	
20. 00 21. 00	Total (sum of lines 1-19) Total cost to be allocated Unit cost multiplier	851, 163 3, 983 0. 004679	7, 458			4 22, 892	0	21.00

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	JOHNSON MEMORIA TERS STATISTICA		CN: 15-0001	Period:	u of Form CMS-2 Worksheet H-2	
BASIS			HHA CCN:	15-7510	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre 7/30/2021 11:	pared:
					Home Health Agency I	PPS	
Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS PAI D)	NURSI NG ADMI NI STRATI N (DI RECT NRSI NG HRS)	CENTRAL 0 SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	
	9.00	10.00	11.00	13.00	14.00	15.00	
 Administrative and General OO Skilled Nursing Care NO Physical Therapy OO Occupational Therapy OO Speech Pathology OO Medical Social Services OO Home Health Aide NO Supplies (see instructions) OO Drugs OO DME OO Respiratory Therapy OO Private Duty Nursing OO Linic OO Day Care Program OO Home Delivered Meals Program OO Home Delivered Meals Program OO All Others (specify) So Telemedicine OO Total (sum of lines 1-19) OO Total cost to be allocated OO Unit cost multiplier 	1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		15, 514 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0		7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00
Cost Center Description1.00Administrative and General2.00Skilled Nursing Care3.00Physical Therapy4.00Occupational Therapy5.00Speech Pathology6.00Medical Social Services7.00Home Health Aide8.00Supplies (see instructions)9.00Drugs10.00DME11.00Home Dialysis Aide Services12.00Respiratory Therapy13.00Private Duty Nursing14.00Clinic15.00Health Promotion Activities16.00Day Care Program17.00Home Delivered Meals Program18.00Homes Service19.00All Others (specify)19.50Telemedicine20.00Total cost to be allocated22.00Unit cost multiplier	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 0 0 0 0 0 0 0 0 0 0 0 0						1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 15.00 16.00 17.00 18.00 19.50 20.00 21.00 22.00

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	FIONMENT OF PATIENT SERVICE COS	TS		Provider C		Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2020 To 12/31/2020		pared:
				Title	e XVIII	Home Health Agency I	PPS	00 811
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
	i i i i i i i i i i i i i i i i i i i	H-2, Part I,	Costs (from	Ancillary	Costs (cols.		Per Visit	
		col. 28, line		Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)			col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION	OF AGGREGATE	FROGRAW COST, A	AGGREGATE OF T	IL FRUGRAM LI	WITATION COST, C	IN DENETICIANT	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	450, 751		450, 75	1 2,039	221.06	1.00
2.00	Physical Therapy	3.00						2.00
3.00	Occupational Therapy	4.00	136, 882	0	136, 88	2 521	262.73	
4.00	Speech Pathology	5.00	0	0		0 0	0.00	4.00
5.00	Medical Social Services	6.00	0			0 1	0.00	5.00
6.00	Home Health Aide	7.00	80, 751		80, 75	1 10	8, 075. 10	6.00
7.00	Total (sum of lines 1-6)	,	923, 414	0				7.00
7.00	Total (suil of Triles 1-6)		923, 414					7.00
					Program Visit	S		
						irt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	Subject to		
					to	Deducti bl es		
					Deductibles a	8		
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	0	79	0		8.00
9.00	Physical Therapy		18020	0	45	5		9.00
10.00	Occupational Therapy		18020	0				10.00
			18020	-	1	0		11.00
11.00	Speech Pathology			0				
12.00	Medical Social Services		18020	0		0		12.00
13.00	Home Health Aide		18020	0		0		13.00
14.00	Total (sum of lines 8-13)			0	1, 48			14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges	Ratio (col. 3	
		H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHA	÷ col. 4)	
		col. 28, line		Costs (from	1 + 2)	Records)	, í	
			Part I)	Part II)				
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput	-	1.00	2.00	5.00	4.00	5.00	
15.00	Cost of Medical Supplies	8.00	19, 556	0	19, 55	6 0	0. 000000	15 00
16.00		9.00				0 0		
10.00	COST OF DEUGS	7.00	Program Visits		Cost of	0 0	0.000000	10.00
			Program visits					
			D		Servi ces	D. I.D.		
			Par			Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	C	790			0 174, 637		1.00
1.00					1			
0 00	Physical Therapy	0			1	0 114, 551		2.00
2.00					1	0 (2.210		3.00
3.00	Occupational Therapy	0				0 63, 318		
	Occupational Therapy Speech Pathology					0 63, 318		
3.00	Occupational Therapy		0					4.00
3.00 4.00 5.00	Occupational Therapy Speech Pathology	0	0			0 0		4.00 5.00
3.00 4.00	Occupational Therapy Speech Pathology Medical Social Services		0 0 0			0 0 0 0		4.00

	nancial Systems		JOHNSON MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI ON	MENT OF PATIENT SERVICE COST	ſS		Provider CO	CN: 15-0001	Peri od:	Worksheet H-3	3
				HHA CCN:	15-7510	From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 7/30/2021 11:	
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	mitation Cost Computation							
	illed Nursing Care							8.00
	ysi cal Therapy							9.00
10.00 Occ	cupational Therapy							10.00
11.00 Spe	eech Pathology							11.00
12.00 Mec	di cal Soci al Servi ces							12.00
	me Health Aide							13.00
	tal (sum of lines 8-13)							14.00
14.00 100		Prog	am Covered Char	005	Cost of			14.00
		FIOG	alli covereu chai	yes	Servi ces			
					Services			
			Devet	D		Davet D		-
			Part			Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
				eductibles &		to	Deductibles &	
				Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6. 00	7.00	8.00	9.00	10.00	11.00	
	oplies and Drugs Cost Comput							
	st of Medical Supplies	0		0		0 0	(0 15.00
16.00 Cos	st of Drugs		0	0		0	(16.00
	Cost Center Description	Total Program						
		Cost (sum of						
		cols. 9-10)						
		12.00						1
	RT I - COMPUTATION OF LESSER ST LIMITATION	OF AGGREGATE	PROGRAM COST, AG	GREGATE OF TH	IE PROGRAM LI	MITATION COST, O	R BENEFICIARY	
	st Per Visit Computation							
								- · · ·
	illed Nursing Care	174, 637						
2.00 Phy	ysi cal Therapy	114, 551						2.00
2.00 Phy 3.00 Occ	ysical Therapy cupational Therapy							2.00
2.00 Phy 3.00 Occ	ysi cal Therapy	114, 551						2.00 3.00
2.00 Phy 3.00 Occ 4.00 Spe	ysi cal Therapy cupati onal Therapy eech Pathol ogy	114, 551 63, 318						2.00 3.00 4.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mee	ysi cal Therapy cupational Therapy eech Pathology di cal Social Servi ces	114, 551 63, 318 0 0						2.00 3.00 4.00 5.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide	114, 551 63, 318 0 0 0						2.00 3.00 4.00 5.00 6.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6)	114, 551 63, 318 0 0						2.00 3.00 4.00 5.00 6.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide	114, 551 63, 318 0 0 0 352, 506						2.00 3.00 4.00 5.00 6.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon 7.00 Tot	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description	114, 551 63, 318 0 0 0						2.00 3.00 4.00 5.00 6.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon 7.00 Tot	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description mitation Cost Computation	114, 551 63, 318 0 0 0 352, 506						2.00 3.00 4.00 5.00 6.00 7.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon 7.00 Tot	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description mitation Cost Computation illed Nursing Care	114, 551 63, 318 0 0 0 352, 506						2.00 3.00 4.00 5.00 6.00 7.00 8.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon 7.00 Tot 8.00 Ski 9.00 Phy	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description mitation Cost Computation illed Nursing Care ysical Therapy	114, 551 63, 318 0 0 0 352, 506						2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon 7.00 Tot 8.00 Ski 9.00 Phy 10.00 Occ	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description mitation Cost Computation illed Nursing Care ysical Therapy cupational Therapy	114, 551 63, 318 0 0 0 352, 506						2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
2.00 Phy 3.00 Occ 5.00 Mec 5.00 Hon 7.00 Tot 8.00 Ski 9.00 Phy 10.00 Occ 11.00 Spe	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology	114, 551 63, 318 0 0 0 352, 506						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 Phy 3.00 Occ 5.00 Mec 6.00 Hon 7.00 Tot 8.00 Ski 9.00 Phy 10.00 Occ 11.00 Spe	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description mitation Cost Computation illed Nursing Care ysical Therapy cupational Therapy	114, 551 63, 318 0 0 0 352, 506						2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 Phy 3.00 Occ 4.00 Spe 5.00 Mec 6.00 Hon 7.00 Tot 8.00 Ski 9.00 Phy 9.00 Phy 10.00 Occ	ysical Therapy cupational Therapy eech Pathology dical Social Services me Health Aide tal (sum of lines 1-6) Cost Center Description nitation Cost Computation illed Nursing Care ysical Therapy cupational Therapy eech Pathology	114, 551 63, 318 0 0 0 352, 506						1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00

Health Financial Systems		JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0001	Peri od:	Worksheet H-3	
			HHA CCN:	15-7510	From 01/01/2020 To 12/31/2020		
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	Charge (from	Ancillary	Part I as		
	9, line	-	provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED	BY SHARED HOSP	ITAL DEPARTME	INTS		
1.00 Physical Therapy	66.00	0. 372870	0		0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 371112	0		Ocol. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 561719	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 250815	0		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 279664	0		0 col. 2, line 1	6.00	5.00
-							

	Financial Systems JOHNSON MEMORIAL ATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0001	Peri od:	Worksheet H-4	
		HHA CCN:	15-7510	From 01/01/2020 To 12/31/2020) Part I-II	epar
		Title	XVIII	Home Health	PPS	00
				Agency I	rt B	
			Part A	Not Subject to	Subject to Deductibles &	
				Deductibles & Coinsurance	Coi nsurance	
			1.00	2.00	3.00	+
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	FOMARY CHARGE	S			
~~	Reasonable Cost of Part A & Part B Services					1 1
00 00	Reasonable cost of services (see instructions) Total charges					
00	Customary Charges				1	4 6
00	Amount actually collected from patients liable for payment for	or services		0 0	0	0 3
~~	on a charge basis (from your records)					
00	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in with 42 CFR §413.13(b)			0 0	0	4
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00 0. 000000	0. 000000	
00	Total customary charges (see instructions)	(assumption to a		0 0	-	
00	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)	(complete		0 0	0	7
00	Excess of reasonable cost over customary charges (complete or 1 exceeds line 6)	nlyifline		0 0	0	3 (
00	Primary payer amounts			0 0		
				Part A Services	Part B Services	
				1.00	2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			Ĩ		
. 00	Total reasonable cost (see instructions)			0) 10) 11
00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0		
00	Total PPS Reimbursement - LUPA Episodes			0		
00	Total PPS Reimbursement - PEP Episodes			0	2, 894	14
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	5		0	0	
	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
00	Total Other Payments			0	0	
00	Total Other Payments DME Payments			0		18
00 00 00	Total Other Payments DME Payments				0	18
00 00 00 00 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins	surance)) 18) 19) 20) 21
00 00 00 00 00 00 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)	surance)			0 0 0 0 0 0 426, 350) 18) 19) 20) 21
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)	surance)		0	0 0 0 0 426, 350 0) 18) 19) 20) 21) 22) 23
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)	surance)			0 0 0 0 0 426, 350 0 426, 350 0 426, 350) 18) 19) 20) 21) 22) 22) 23) 24
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	surance)		0	0 0 0 0 0 426, 350 0 426, 350 0 426, 350 0 0	$\begin{array}{c c} 18\\ 19\\ 20\\ 21\\ 22\\ 22\\ 23\\ 24\\ 25\\ 25\\ 25\\ 25\\ 25\\ 25\\ 25\\ 25\\ 25\\ 25$
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)	surance)		0	0 0 0 0 0 426, 350 0 426, 350 0 426, 350 0 0	$\begin{array}{c c} 18\\ 18\\ 19\\ 20\\ 21\\ 22\\ 23\\ 23\\ 24\\ 25\\ 26\\ 26\\ 26\\ 26\\ 26\\ 26\\ 26\\ 26\\ 26\\ 26$
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i	instructions))	000000000000000000000000000000000000000	0 0 0 0 426, 350 0 426, 350 0 426, 350 0 426, 350	$\begin{array}{c c} 18\\ 19\\ 20\\ 21\\ 22\\ 23\\ 24\\ 25\\ 24\\ 25\\ 26\\ 27\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28\\ 28$
 00 	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin	instructions))	0 0 0	0 0 0 0 0 0 0 0 0 426, 350 0 426, 350 0 426, 350 0 426, 350	$\begin{array}{c} 18\\ 19\\ 20\\ 21\\ 22\\ 22\\ 23\\ 24\\ 25\\ 26\\ 27\\ 28\\ 27\\ 28\\ 29\\ 29\\ 29\\ 28\\ 29\\ 29\\ 29\\ 29\\ 29\\ 29\\ 29\\ 29\\ 29\\ 29$
 00 	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin ADJUSTMENT	nstructions) ne 27))		0 0 0 0 0 0 0 0 0 426, 350 0 426, 350 0 426, 350 0 426, 350 1 1 1 1 1 1 1 1 1 1 1 1 1	$\begin{array}{c} 18\\ 19\\ 20\\ 20\\ 21\\ 22\\ 23\\ 24\\ 25\\ 26\\ 27\\ 28\\ 27\\ 28\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30$
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin ADJUSTMENT Pioneer ACO demonstration payment adjustment (see instruction	nstructions) ne 27))	0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 18\\ 19\\ 20\\ 20\\ 21\\ 22\\ 23\\ 24\\ 25\\ 26\\ 27\\ 28\\ 27\\ 28\\ 27\\ 28\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30\\ 30$
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin ADJUSTMENT	nstructions) ne 27))) 18) 19) 20) 21) 22) 23) 22) 23) 24) 25) 26) 30)
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin ADJUSTMENT Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions)	nstructions) ne 27))) 18 19 20 211 222 222 24 24 24 24 24 24 24
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Dxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin ADJUSTMENT Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Demonstration payment adjustment amount after sequestration	nstructions) ne 27))			18 18 19 19 19 200 211 220 220 220 220 244 220 244 220 244 200 244 201 244 202 244 203 244 204 250 250 250 260 300 300 300 311 311
. 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin ADJUSTMENT Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions)	nstructions) ne 27))			18 12 14 15 15 16 17 17 18 19 12 19 12 10 11 11 12 12 12 12 12 12 12 12 12 12 12 12 12 12 12 13 13 13 12 12 12 12 12 12 12 13 13 13 14 15 16 17 12 12 12 12 12 12 12
7.00 3.00 9.00 0.00 0.50 0.99 1.00 1.01 1.02 2.00 3.00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin ADJUSTMENT Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions) Tentative settlement (for contractor use only)	nstructions; ne 27) ns))			 18 19 19 201 211 211
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see i Total costs - current cost reporting period (line 26 plus lin ADJUSTMENT Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions)	instructions) ne 27) ns) and 33)				 1 18 1 19 2 20 <li< td=""></li<>

IALYS	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-0001		eriod:	Worksheet H-5	
PR(DGRAM BENEFI CI ARI ES	HHA CCN:	15-7510	F	rom 01/01/2020 o 12/31/2020	Date/Time Prep 7/30/2021 11:0	
					Home Health Agency I	PPS	
		Inpatien	nt Part A			t B	
	-	mm/dd/yyyy 1.00	Amount 2.00		mm/dd/yyyy 3.00	Amount 4.00	
00	Total interim payments paid to provider	1.00	2.00	0		4.00	1.
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	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3
	Program to Provider						
)1)2				0 0		0	3 3
12 13				0		0	3
)4)5				0		0	3
	Provider to Program						
0				0		0	3
1				0		0	3
53				0		0	3
54				0		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		423, 006	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		1				5
.0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						
	Program to Provider						
)1)2				0 0		0	5
)2)3				0		0	5
-	Provider to Program						
50				0		0	5
51				0		0	5
2 9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0 0		0 0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)						6
)1	SETTLEMENT TO PROVIDER			0		0	6
02	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)			0		423, 006	7
			0		Contractor Number	NPR Date (Mo/Day/Yr)	
00	Name of Contractor	(0		1.00	2.00	8

al th Financial Systems JOHNSON ALCULATION OF CAPITAL PAYMENT	N MEMORIAL HOSPITAL Provider CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet L	2002-
		From 01/01/2020 To 12/31/2020		parec
			7/30/2021 11:	08 an
	Title XVIII	Hospi tal	PPS	
			1.00	
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				-
00 Capital DRG other than outlier			332, 110	1 1.
01 Model 4 BPCI Capital DRG other than outlier			0	1
00 Capital DRG outlier payments			8, 780	2.
01 Model 4 BPCI Capital DRG outlier payments			0	
DO Total inpatient days divided by number of days in t	he cost reporting period (see in	structions)	15.61	3.
00 Number of interns & residents (see instructions)	0.00	4.		
00 Indirect medical education percentage (see instruct	i ons)		0.00	5.
Indirect medical education adjustment (multiply lin 1.01) (see instructions)	e 5 by the sum of lines 1 and 1.	01, columns 1 and	0	6.
00 Percentage of SSI recipient patient days to Medicar 30) (see instructions)	e Part A patient days (Worksheet	E, part A line	0.00	7.
00 Percentage of Medicaid patient days to total days (see instructions)		0.00	8.
DO Sum of lines 7 and 8			0.00	
00 Allowable disproportionate share percentage (see in	istructions)		0.00	10.
00 Disproportionate share adjustment (see instructions	5)		0	1
00 Total prospective capital payments (see instruction	is)		340, 890	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST				
00 Program inpatient routine capital cost (see instruc	tions)		0	
00 Program inpatient ancillary capital cost (see instr			0	2.
00 Total inpatient program capital cost (line 1 plus l	ine 2)		0	
00 Capital cost payment factor (see instructions)	4		0	4.
00 Total_inpatient_program_capital_cost (line 3_x line	(4)		0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS DO Program inpatient capital costs (see instructions)			0	1 1.
00 Program inpatient capital costs (see Histidetions)	ircumstances (see instructions)		0	2.
00 Net program inpatient capital costs for extraordinary c			0	3.
00 Applicable exception percentage (see instructions)	116 2)		0.00	4.
00 Capital cost for comparison to payments (line 3 x l	ine 4)		0.00	
00 Percentage adjustment for extraordinary circumstanc			0.00	
00 Adjustment to capital minimum payment level for ext		x line 6)	0.00	7.
00 Capital minimum payment level (line 5 plus line 7)			0	
00 Current year capital payments (from Part I, line 12	, as applicable)		0	9.
00 Current year comparison of capital minimum payment		8 less line 9)	0	
00 Carryover of accumulated capital minimum payment le Worksheet L, Part III, line 14)	vel over capital payment (from p	rior year	0	11.
00 Net comparison of capital minimum payment level to	capital payments (line 10 plus l	ine 11)	0	12.
.00 Current year exception payment (if line 12 is posit	ive, enter the amount on this li	ne)	0	13.
00 Carryover of accumulated capital minimum payment le		following period	0	14.
(if line 12 is negative, enter the amount on this l				
			0	15.
	t (see instructions)		0	