This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1313	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 5/13/2020 4:35 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/13/2020 Time: 4:35 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 WOODLAWN HOSPITAL (15-1313) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) JOHN KRAFT
Officer or Administrator of Provider(s)

VICE PRESIDENT OF FINANCE/CFO
Title

(Dated when report is electronically signed.)
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	532,224	-443,646	0	28,173	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	47,324	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	579,548	-443,646	0	28,173	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 5/13/2020 4:35 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1400 EAST 9TH STREET	PO Box:			1.00
2.00	City: ROCHESTER	State: IN	Zip Code: 46975-	County: FULTON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	WOODLAWN HOSPITAL	151313	99915	1	01/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WOODLAWN HOSPITAL SWINGBED	15Z313	99915		10/23/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)	8		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 5/13/2020 4:35 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	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.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 5/13/2020 4:35 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		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 Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 5/13/2020 4:35 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	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 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		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 Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 5/13/2020 4:35 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I Date/Time Prepared: 5/13/2020 4:35 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	352,455	7,767	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part I | Date/Time Prepared: 5/13/2020 4:35 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II | Date/Time Prepared: 5/13/2020 4:35 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/01/2020	Y	04/01/2020
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 in columns 2 and 4. (see instructions)	N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-2 Part II Date/Time Prepared: 5/13/2020 4:35 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO. LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMITH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1313	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 5/13/2020 4:35 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I Date/Time Prepared: 5/13/2020 4:35 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	53,496.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	53,496.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	13,152.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	66,648.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 5/13/2020 4:35 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		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)	864	90	2,229			1.00
2.00	HMO and other (see instructions)	650	127				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	161	0	165			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	131			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,025	90	2,525			7.00
8.00	INTENSIVE CARE UNIT	239	0	548			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	326			13.00
14.00	Total (see instructions)	1,264	90	3,399	0.00	393.09	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	393.09	27.00
28.00	Observation Bed Days		122	885			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	46	100			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-3 Part I | Date/Time Prepared: 5/13/2020 4:35 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	301	37	872	1.00
2.00	HMO and other (see instructions)			158	51		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	301	37	872	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet S-10 | Date/Time Prepared: 5/13/2020 4:35 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.321611	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	951,839	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	18,573,965	6.00
7.00	Medicaid cost (line 1 times line 6)	5,973,591	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	5,021,752	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,021,752	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,243,234	0	1,243,234	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	399,838	0	399,838	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	399,838	0	399,838	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,327,972	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	656,712	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,010,326	27.01
28.00	Non-Medicare bad debt expense (see instructions)	3,317,646	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,420,605	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,820,443	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,842,195	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,323,909	2,323,909	-133,980	2,189,929	1.00
1.02	00102	AKRON BUILDING		48,137	48,137	0	48,137	1.02
1.03	00103	ARGOS BUILDING		114,728	114,728	0	114,728	1.03
1.04	00101	CLAYS BUILDING		29,783	29,783	133,980	163,763	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,087,588	4,087,588	0	4,087,588	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,168,257	6,206,459	9,374,716	-289,391	9,085,325	5.00
7.00	00700	OPERATION OF PLANT	370,957	1,198,968	1,569,925	1,395,741	2,965,666	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,818	121,614	136,432	0	136,432	8.00
9.00	00900	HOUSEKEEPING	373,898	201,413	575,311	-653	574,658	9.00
10.00	01000	DIETARY	403,398	351,492	754,890	-476,362	278,528	10.00
11.00	01100	CAFETERIA	0	0	0	469,543	469,543	11.00
13.00	01300	NURSING ADMINISTRATION	180,191	75,944	256,135	414,734	670,869	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	398,093	4,519,241	4,917,334	-51,615	4,865,719	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	615,688	422,561	1,038,249	-44,746	993,503	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,190,347	895,360	3,085,707	-668,689	2,417,018	30.00
31.00	03100	INTENSIVE CARE UNIT	479,151	243,617	722,768	-147,421	575,347	31.00
43.00	04300	NURSERY	0	0	0	208,292	208,292	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	737,523	1,328,731	2,066,254	-40,169	2,026,085	50.00
51.00	05100	RECOVERY ROOM	342,500	162,733	505,233	0	505,233	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	287,862	287,862	52.00
53.00	05300	ANESTHESIOLOGY	0	950,262	950,262	-775	949,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,706,544	1,522,648	3,229,192	-312,511	2,916,681	54.00
60.00	06000	LABORATORY	919,294	1,682,673	2,601,967	-72,393	2,529,574	60.00
65.00	06500	RESPIRATORY THERAPY	991,670	352,426	1,344,096	-13,563	1,330,533	65.00
66.00	06600	PHYSICAL THERAPY	712,830	228,972	941,802	-4,683	937,119	66.00
67.00	06700	OCCUPATIONAL THERAPY	246,121	50,929	297,050	0	297,050	67.00
68.00	06800	SPEECH PATHOLOGY	82,804	19,727	102,531	0	102,531	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	784,277	784,277	0	784,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,622,648	2,206,003	3,828,651	-102,994	3,725,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	3,246,295	1,829,437	5,075,732	-472,290	4,603,442	93.00
93.01	04951	SHAFER MEDICAL CENTER	3,243,288	1,138,792	4,382,080	0	4,382,080	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,046,315	33,098,424	55,144,739	77,917	55,222,656	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	1,527,174	1,025,639	2,552,813	0	2,552,813	192.01
192.02	19202	ARGOS MEDICAL CENTER	1,552,791	520,075	2,072,866	0	2,072,866	192.02
192.03	19203	AKRON MEDICAL CENTER	549,793	249,664	799,457	0	799,457	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	69,246	329,427	398,673	-77,917	320,756	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	25,745,319	35,223,229	60,968,548	0	60,968,548	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-60,002	2,129,927		1.00
1.02	00102	AKRON BUILDING	0	48,137		1.02
1.03	00103	ARGOS BUILDING	0	114,728		1.03
1.04	00101	CLAYS BUILDING	0	163,763		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,087,588		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,024,997	6,060,328		5.00
7.00	00700	OPERATION OF PLANT	0	2,965,666		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	136,432		8.00
9.00	00900	HOUSEKEEPING	0	574,658		9.00
10.00	01000	DIETARY	-25,477	253,051		10.00
11.00	01100	CAFETERIA	-128,506	341,037		11.00
13.00	01300	NURSING ADMINISTRATION	0	670,869		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-227,985	4,637,734		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-21,178	972,325		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,417,018		30.00
31.00	03100	INTENSIVE CARE UNIT	0	575,347		31.00
43.00	04300	NURSERY	0	208,292		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,026,085		50.00
51.00	05100	RECOVERY ROOM	0	505,233		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	287,862		52.00
53.00	05300	ANESTHESIOLOGY	-892,947	56,540		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-268,610	2,648,071		54.00
60.00	06000	LABORATORY	0	2,529,574		60.00
65.00	06500	RESPIRATORY THERAPY	-64,530	1,266,003		65.00
66.00	06600	PHYSICAL THERAPY	-65,940	871,179		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	297,050		67.00
68.00	06800	SPEECH PATHOLOGY	0	102,531		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	784,277		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,679,716	2,045,941		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	-2,363,287	2,240,155		93.00
93.01	04951	SHAFER MEDICAL CENTER	-2,785,604	1,596,476		93.01
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,608,779	43,613,877		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19201	FCMC	0	2,552,813		192.01
192.02	19202	ARGOS MEDICAL CENTER	0	2,072,866		192.02
192.03	19203	AKRON MEDICAL CENTER	0	799,457		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	ADVERTISING	0	320,756		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,608,779	49,359,769		200.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 5/13/2020 4:35 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	250,914	218,629		1.00
	0		250,914	218,629		
	B - ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	13,141	62,518		1.00
	0		13,141	62,518		
	C - DEPRECIATION					
1.00	CLAYS BUILDING	1.04	0	133,980		1.00
	0		0	133,980		
	D - NURSERY					
1.00	NURSERY	43.00	146,762	61,530		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	202,827	85,035		2.00
	0		349,589	146,565		
	E - NURSING SUPERVISOR					
1.00	NURSING ADMINISTRATION	13.00	417,010	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		417,010	0		
	F - MAINTENANCE RECLASS					
1.00	OPERATION OF PLANT	7.00	0	1,395,741		1.00
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		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
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		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	TOTALS		0	1,395,741		
500.00	Grand Total: Increases		1,030,654	1,957,433		500.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-6 | Date/Time Prepared: 5/13/2020 4:35 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	250,914	218,629	0	1.00
	0		250,914	218,629		
	B - ADVERTISING					
1.00	ADVERTISING	194.00	13,141	62,518	0	1.00
	0		13,141	62,518		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	133,980	9	1.00
	0		0	133,980		
	D - NURSERY					
1.00	ADULTS & PEDIATRICS	30.00	349,589	146,565	0	1.00
2.00		0.00	0	0	0	2.00
	0		349,589	146,565		
	E - NURSING SUPERVISOR					
1.00	ADULTS & PEDIATRICS	30.00	131,741	0	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	142,693	0	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	46,424	0	0	3.00
4.00	EMERGENCY	91.00	96,152	0	0	4.00
	0		417,010	0		
	F - MAINTENANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	365,050	0	1.00
2.00	HOUSEKEEPING	9.00	0	653	0	2.00
3.00	DIETARY	10.00	0	6,819	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	2,276	0	4.00
5.00	PHARMACY	15.00	0	51,615	0	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	44,746	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	40,794	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	4,728	0	8.00
9.00	OPERATING ROOM	50.00	0	40,169	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	775	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	266,087	0	11.00
12.00	LABORATORY	60.00	0	72,393	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	13,563	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	4,683	0	14.00
15.00	EMERGENCY	91.00	0	6,842	0	15.00
16.00	WOODLAWN MEDICAL PROFESSIONALS	93.00	0	472,290	0	16.00
17.00	ADVERTISING	194.00	0	2,258	0	17.00
	TOTALS		0	1,395,741		
500.00	Grand Total: Decreases		1,030,654	1,957,433		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part I | Date/Time Prepared: 5/13/2020 4:35 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	596,216	0	0	0	0	1.00
2.00	Land Improvements	510,775	0	0	0	0	2.00
3.00	Buildings and Fixtures	27,302,119	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,779,463	1,166,000	0	1,166,000	424,403	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,188,573	1,166,000	0	1,166,000	424,403	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	38,188,573	1,166,000	0	1,166,000	424,403	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	596,216	0	1.00
2.00	Land Improvements	510,775	0	2.00
3.00	Buildings and Fixtures	27,302,119	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,521,060	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,930,170	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	38,930,170	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part II | Date/Time Prepared: 5/13/2020 4:35 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,205,026	0	528,230	578,084	12,569	1.00
1.02	AKRON BUILDING	28,466	0	0	0	11,134	1.02
1.03	ARGOS BUILDING	51,792	0	0	27,748	14,472	1.03
1.04	CLAYS BUILDING	0	0	0	0	13,850	1.04
3.00	Total (sum of lines 1-2)	1,285,284	0	528,230	605,832	52,025	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2,323,909	1.00
1.02	AKRON BUILDING	8,537	48,137	1.02
1.03	ARGOS BUILDING	20,716	114,728	1.03
1.04	CLAYS BUILDING	15,933	29,783	1.04
3.00	Total (sum of lines 1-2)	45,186	2,516,557	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-7 Part III Date/Time Prepared: 5/13/2020 4:35 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	30,399,446	0	30,399,446	0.780871	0	1.00
1.02	AKRON BUILDING	950,483	0	950,483	0.024415	0	1.02
1.03	ARGOS BUILDING	2,036,750	0	2,036,750	0.052318	0	1.03
1.04	CLAYS BUILDING	5,543,491	0	5,543,491	0.142396	0	1.04
3.00	Total (sum of lines 1-2)	38,930,170	0	38,930,170	0.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,064,104	0	1.00
1.02	AKRON BUILDING	0	0	0	28,466	0	1.02
1.03	ARGOS BUILDING	0	0	0	51,792	0	1.03
1.04	CLAYS BUILDING	0	0	0	133,980	0	1.04
3.00	Total (sum of lines 1-2)	0	0	0	1,278,342	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	475,170	578,084	12,569	0	2,129,927	1.00
1.02	AKRON BUILDING	0	0	11,134	8,537	48,137	1.02
1.03	ARGOS BUILDING	0	27,748	14,472	20,716	114,728	1.03
1.04	CLAYS BUILDING	0	0	13,850	15,933	163,763	1.04
3.00	Total (sum of lines 1-2)	475,170	605,832	52,025	45,186	2,456,555	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 5/13/2020 4:35 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-53,060	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.02	Investment income - AKRON BUILDING (chapter 2)		0	AKRON BUILDING	1.02	0	1.02
1.03	Investment income - ARGOS BUILDING (chapter 2)		0	ARGOS BUILDING	1.03	0	1.03
1.04	Investment income - CLAYS BUILDING (chapter 2)		0	CLAYS BUILDING	1.04	0	1.04
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,990,164			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-128,469	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-21,178	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-37	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.02	Depreciation - AKRON BUILDING		0	AKRON BUILDING	1.02	0	26.02
26.03	Depreciation - ARGOS BUILDING		0	ARGOS BUILDING	1.03	0	26.03
26.04	Depreciation - CLAYS BUILDING		0	CLAYS BUILDING	1.04	0	26.04
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8 | Date/Time Prepared: 5/13/2020 4:35 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	B	-6,942	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	PHYSICIAN RECRUITMENT	A	10,107	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN RECRUITMENT	A	-38,569	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	HAF EXPENSE	A	-2,793,810	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	EDUCATION OTHER REVENUE	B	-2,375	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	CHAPLAIN - OTHER REVENUE	B	-900	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	HOME MEAL PROGRAM	B	-16,741	DIETARY	10.00	0	38.00
39.00	DIETARY SPEC EVENTS	B	-8,736	DIETARY	10.00	0	39.00
40.00	DRUG SALES	B	-227,985	PHARMACY	15.00	0	40.00
41.00	PT - OTHER REVENUE	B	-1,102	PHYSICAL THERAPY	66.00	0	41.00
42.00	OCC THER OTH REV	B	-49,838	PHYSICAL THERAPY	66.00	0	42.00
43.00	ATHLETIC TRAINING -OTH REV	B	-15,000	PHYSICAL THERAPY	66.00	0	43.00
44.00	MISC REV -OTH REV	B	-42,591	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	STAFF RENTAL AGREEMENTS	B	-64,530	RESPIRATORY THERAPY	65.00	0	45.00
45.01	IHA LOBBYING	A	-5,572	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	PART B BILLING OFFSET	A	-46,749	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	LTC EXPENSES	A	-104,538	ADMINISTRATIVE & GENERAL	5.00	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,608,779				50.00

(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 PHYSICIAN ADJUSTMENT | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet A-8-2 | Date/Time Prepared: 5/13/2020 4:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	892,947	892,947	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	268,610	268,610	0	0	0	2.00
3.00	91.00	EMERGENCY	2,342,575	1,679,716	662,859	0	0	3.00
4.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	2,363,287	2,363,287	0	0	0	4.00
5.00	93.01	SHAFER MEDICAL CENTER	2,785,604	2,785,604	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,653,023	7,990,164	662,859		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	0	0	4.00
5.00	93.01	SHAFER MEDICAL CENTER	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	0	0	892,947		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	268,610		2.00
3.00	91.00	EMERGENCY	0	0	0	1,679,716		3.00
4.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	2,363,287		4.00
5.00	93.01	SHAFER MEDICAL CENTER	0	0	0	2,785,604		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	7,990,164		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,129,927	2,129,927				1.00
1.02	00102	AKRON BUILDING	48,137	0	48,137			1.02
1.03	00103	ARGOS BUILDING	114,728	0	0	114,728		1.03
1.04	00101	CLAYS BUILDING	163,763	0	0	0	163,763	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,087,588	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,060,328	232,872	5,501	9,178	128	5.00
7.00	00700	OPERATION OF PLANT	2,965,666	202,143	3,301	10,463	37,359	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	136,432	6,298	0	0	0	8.00
9.00	00900	HOUSEKEEPING	574,658	22,928	0	0	345	9.00
10.00	01000	DIETARY	253,051	38,111	0	0	0	10.00
11.00	01100	CAFETERIA	341,037	62,713	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	670,869	51,316	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,637,734	26,885	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	972,325	31,204	0	0	34,086	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,417,018	287,064	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	575,347	41,346	0	0	0	31.00
43.00	04300	NURSERY	208,292	3,767	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,026,085	159,922	0	0	0	50.00
51.00	05100	RECOVERY ROOM	505,233	99,397	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	287,862	33,564	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	56,540	2,664	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,648,071	233,100	0	0	0	54.00
60.00	06000	LABORATORY	2,529,574	50,764	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,266,003	72,474	0	0	3,369	65.00
66.00	06600	PHYSICAL THERAPY	871,179	67,318	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	297,050	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	102,531	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	784,277	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,045,941	124,760	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2,240,155	262,535	0	0	29,369	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,596,476	0	0	0	59,107	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,613,877	2,113,145	8,802	19,641	163,763	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	11,131	0	0	0	192.00
192.01	19201	FCMC	2,552,813	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	2,072,866	0	0	95,087	0	192.02
192.03	19203	AKRON MEDICAL CENTER	799,457	0	39,335	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	320,756	5,651	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	49,359,769	2,129,927	48,137	114,728	163,763	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,087,588					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	635,768	6,943,775	6,943,775			5.00
7.00	00700	OPERATION OF PLANT	74,132	3,293,064	539,098	3,832,162		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,961	145,691	23,851	14,240	183,782	8.00
9.00	00900	HOUSEKEEPING	74,720	672,651	110,118	51,839	14,381	9.00
10.00	01000	DIETARY	30,472	321,634	52,654	86,169	2,926	10.00
11.00	01100	CAFETERIA	50,143	453,893	74,305	141,793	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,009	758,194	124,122	116,024	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	79,555	4,744,174	776,634	60,787	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	124,775	1,162,390	190,291	70,552	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	345,722	3,049,804	499,274	649,039	29,946	30.00
31.00	03100	INTENSIVE CARE UNIT	106,671	723,364	118,420	93,482	3,237	31.00
43.00	04300	NURSERY	29,329	241,388	39,517	8,518	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	147,387	2,333,394	381,993	361,582	28,202	50.00
51.00	05100	RECOVERY ROOM	68,445	673,075	110,187	224,736	12,016	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,533	361,959	59,255	75,887	0	52.00
53.00	05300	ANESTHESIOLOGY	0	59,204	9,692	6,023	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	341,036	3,222,207	527,498	527,036	32,311	54.00
60.00	06000	LABORATORY	183,712	2,764,050	452,494	114,777	0	60.00
65.00	06500	RESPIRATORY THERAPY	198,175	1,540,021	252,112	163,862	17,619	65.00
66.00	06600	PHYSICAL THERAPY	142,452	1,080,949	176,959	152,204	5,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	49,185	346,235	56,681	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16,548	119,079	19,494	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	784,277	128,392	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	310,139	2,480,840	406,131	282,081	37,852	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	154,431	2,686,490	439,797	593,587	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	108,705	1,764,288	288,826	0	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,351,005	42,726,090	5,857,795	3,794,218	183,782	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	11,131	1,822	25,167	0	192.00
192.01	19201	FCMC	305,190	2,858,003	467,875	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	310,310	2,478,263	405,709	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	109,871	948,663	155,303	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	11,212	337,619	55,271	12,777	0	194.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,087,588	49,359,769	6,943,775	3,832,162	183,782	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	848,989					9.00
10.00	01000	DIETARY	3,102	466,485				10.00
11.00	01100	CAFETERIA	14,298	0	684,289			11.00
13.00	01300	NURSING ADMINISTRATION	2,080	0	28,655	1,029,075		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	10,932	0	20,813	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,695	0	49,498	21,439	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	206,302	385,920	102,451	755,736	0	30.00
31.00	03100	INTENSIVE CARE UNIT	51,972	80,565	38,495	134,819	0	31.00
43.00	04300	NURSERY	0	0	6,441	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	99,428	0	66,524	0	0	50.00
51.00	05100	RECOVERY ROOM	69,561	0	19,560	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	8,886	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	82,157	0	88,559	0	0	54.00
60.00	06000	LABORATORY	26,705	0	56,535	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	31,131	0	43,862	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17,513	0	28,387	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	9,214	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,803	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	94,110	0	47,619	117,081	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	59,235	0	63,512	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	70,772	0	0	0	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	845,993	466,485	681,814	1,029,075	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	2,232	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	764	0	2,475	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	848,989	466,485	684,289	1,029,075	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part I | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	5,613,340					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,500,865				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	72,332	5,750,804	0	5,750,804	30.00
31.00	03100	INTENSIVE CARE UNIT	0	17,198	1,261,552	0	1,261,552	31.00
43.00	04300	NURSERY	0	2,722	298,586	0	298,586	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	169,009	3,440,132	0	3,440,132	50.00
51.00	05100	RECOVERY ROOM	0	19,068	1,128,203	0	1,128,203	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,960	508,947	0	508,947	52.00
53.00	05300	ANESTHESIOLOGY	0	22,099	97,018	0	97,018	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	341,398	4,821,166	0	4,821,166	54.00
60.00	06000	LABORATORY	0	284,372	3,698,933	0	3,698,933	60.00
65.00	06500	RESPIRATORY THERAPY	0	96,537	2,145,144	0	2,145,144	65.00
66.00	06600	PHYSICAL THERAPY	0	29,192	1,490,496	0	1,490,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,747	424,877	0	424,877	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,305	146,681	0	146,681	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,729	935,398	0	935,398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,613,340	285,939	5,899,279	0	5,899,279	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	73,281	3,538,995	0	3,538,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	20,571	3,863,192	0	3,863,192	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	23,406	2,147,292	0	2,147,292	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,613,340	1,500,865	41,596,695	0	41,596,695	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	2,232	0	2,232	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	38,120	0	38,120	192.00
192.01	19201	FCMC	0	0	3,325,878	0	3,325,878	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	2,883,972	0	2,883,972	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	1,103,966	0	1,103,966	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	408,906	0	408,906	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,613,340	1,500,865	49,359,769	0	49,359,769	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
			0	1.00	1.02	1.03	1.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	232,872	5,501	9,178	128	5.00
7.00	00700	OPERATION OF PLANT	0	202,143	3,301	10,463	37,359	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,298	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	22,928	0	0	345	9.00
10.00	01000	DIETARY	0	38,111	0	0	0	10.00
11.00	01100	CAFETERIA	0	62,713	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	51,316	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	26,885	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	31,204	0	0	34,086	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	287,064	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	41,346	0	0	0	31.00
43.00	04300	NURSERY	0	3,767	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	159,922	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	99,397	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,564	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,664	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	233,100	0	0	0	54.00
60.00	06000	LABORATORY	0	50,764	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	72,474	0	0	3,369	65.00
66.00	06600	PHYSICAL THERAPY	0	67,318	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	124,760	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	262,535	0	0	29,369	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	59,107	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,113,145	8,802	19,641	163,763	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	11,131	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	95,087	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	39,335	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	5,651	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,129,927	48,137	114,728	163,763	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	247,679	0	247,679			5.00
7.00	00700	OPERATION OF PLANT	253,266	0	19,228	272,494		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,298	0	851	1,013	8,162	8.00
9.00	00900	HOUSEKEEPING	23,273	0	3,928	3,686	639	9.00
10.00	01000	DIETARY	38,111	0	1,878	6,127	130	10.00
11.00	01100	CAFETERIA	62,713	0	2,650	10,083	0	11.00
13.00	01300	NURSING ADMINISTRATION	51,316	0	4,427	8,250	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	26,885	0	27,714	4,322	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,290	0	6,787	5,017	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,064	0	17,808	46,151	1,330	30.00
31.00	03100	INTENSIVE CARE UNIT	41,346	0	4,224	6,647	144	31.00
43.00	04300	NURSERY	3,767	0	1,409	606	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	159,922	0	13,625	25,711	1,253	50.00
51.00	05100	RECOVERY ROOM	99,397	0	3,930	15,980	534	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,564	0	2,113	5,396	0	52.00
53.00	05300	ANESTHESIOLOGY	2,664	0	346	428	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,100	0	18,814	37,476	1,435	54.00
60.00	06000	LABORATORY	50,764	0	16,139	8,161	0	60.00
65.00	06500	RESPIRATORY THERAPY	75,843	0	8,992	11,652	782	65.00
66.00	06600	PHYSICAL THERAPY	67,318	0	6,312	10,823	235	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,022	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	695	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,579	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	124,760	0	14,486	20,058	1,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	291,904	0	15,686	42,208	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	59,107	0	10,302	0	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,305,351	0	208,945	269,795	8,162	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	11,131	0	65	1,790	0	192.00
192.01	19201	FCMC	0	0	16,688	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	95,087	0	14,471	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	39,335	0	5,539	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	5,651	0	1,971	909	0	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,456,555	0	247,679	272,494	8,162	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	31,526					9.00
10.00	01000	DIETARY	115	46,361				10.00
11.00	01100	CAFETERIA	531	0	75,977			11.00
13.00	01300	NURSING ADMINISTRATION	77	0	3,182	67,252		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	406	0	2,311	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	249	0	5,496	1,401	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,660	38,354	11,374	49,389	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,930	8,007	4,274	8,811	0	31.00
43.00	04300	NURSERY	0	0	715	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,692	0	7,386	0	0	50.00
51.00	05100	RECOVERY ROOM	2,583	0	2,172	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	987	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,051	0	9,833	0	0	54.00
60.00	06000	LABORATORY	992	0	6,277	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,156	0	4,870	0	0	65.00
66.00	06600	PHYSICAL THERAPY	650	0	3,152	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,023	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	311	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,495	0	5,287	7,651	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2,200	0	7,052	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	2,628	0	0	0	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,415	46,361	75,702	67,252	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	83	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	28	0	275	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	31,526	46,361	75,977	67,252	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B Part II Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	61,638					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	84,240				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,058	463,188	0	463,188	30.00
31.00	03100	INTENSIVE CARE UNIT	0	965	76,348	0	76,348	31.00
43.00	04300	NURSERY	0	153	6,650	0	6,650	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,482	221,071	0	221,071	50.00
51.00	05100	RECOVERY ROOM	0	1,070	125,666	0	125,666	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	166	42,226	0	42,226	52.00
53.00	05300	ANESTHESIOLOGY	0	1,240	4,678	0	4,678	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,190	322,899	0	322,899	54.00
60.00	06000	LABORATORY	0	15,954	98,287	0	98,287	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,416	108,711	0	108,711	65.00
66.00	06600	PHYSICAL THERAPY	0	1,638	90,128	0	90,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	715	3,760	0	3,760	67.00
68.00	06800	SPEECH PATHOLOGY	0	298	1,304	0	1,304	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,275	5,854	0	5,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	61,638	16,042	77,680	0	77,680	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	4,111	181,528	0	181,528	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,154	360,204	0	360,204	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	1,313	73,350	0	73,350	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,638	84,240	2,263,532	0	2,263,532	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	83	0	83	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	12,986	0	12,986	192.00
192.01	19201	FCMC	0	0	16,688	0	16,688	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	109,558	0	109,558	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	44,874	0	44,874	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	8,834	0	8,834	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	61,638	84,240	2,456,555	0	2,456,555	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	AKRON BUILDING (SQUARE FEET)	ARGOS BUILDING (SQUARE FEET)	CLAYS BUILDING (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.02	1.03	1.04	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	111,942					1.00
1.02	00102	AKRON BUILDING	0	3,500				1.02
1.03	00103	ARGOS BUILDING	0	0	7,500			1.03
1.04	00101	CLAYS BUILDING	0	0	0	20,414		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	20,454,313	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,239	400	600	16	3,181,398	5.00
7.00	00700	OPERATION OF PLANT	10,624	240	684	4,657	370,957	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	331	0	0	0	14,818	8.00
9.00	00900	HOUSEKEEPING	1,205	0	0	43	373,898	9.00
10.00	01000	DIETARY	2,003	0	0	0	152,484	10.00
11.00	01100	CAFETERIA	3,296	0	0	0	250,914	11.00
13.00	01300	NURSING ADMINISTRATION	2,697	0	0	0	180,191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,413	0	0	0	398,093	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,640	0	0	4,249	624,376	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,087	0	0	0	1,729,996	30.00
31.00	03100	INTENSIVE CARE UNIT	2,173	0	0	0	533,780	31.00
43.00	04300	NURSERY	198	0	0	0	146,762	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,405	0	0	0	737,523	50.00
51.00	05100	RECOVERY ROOM	5,224	0	0	0	342,500	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,764	0	0	0	202,827	52.00
53.00	05300	ANESTHESIOLOGY	140	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,251	0	0	0	1,706,544	54.00
60.00	06000	LABORATORY	2,668	0	0	0	919,294	60.00
65.00	06500	RESPIRATORY THERAPY	3,809	0	0	420	991,670	65.00
66.00	06600	PHYSICAL THERAPY	3,538	0	0	0	712,830	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	246,121	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	82,804	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,557	0	0	0	1,551,939	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	13,798	0	0	3,661	772,772	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	7,368	543,959	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,060	640	1,284	20,414	16,768,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	585	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	0	1,527,174	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	6,216	0	1,552,791	192.02
192.03	19203	AKRON MEDICAL CENTER	0	2,860	0	0	549,793	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	297	0	0	0	56,105	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,129,927	48,137	114,728	163,763	4,087,588	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.027059	13.753429	15.297067	8.022093	0.199840	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000000	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 | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF S ERVIC)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,943,775	42,415,994				5.00
7.00	00700	OPERATION OF PLANT	0	3,293,064	89,079			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	145,691	331	2,952		8.00
9.00	00900	HOUSEKEEPING	0	672,651	1,205	231	112,224	9.00
10.00	01000	DIETARY	0	321,634	2,003	47	410	10.00
11.00	01100	CAFETERIA	0	453,893	3,296	0	1,890	11.00
13.00	01300	NURSING ADMINISTRATION	0	758,194	2,697	0	275	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	4,744,174	1,413	0	1,445	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,162,390	1,640	0	885	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,049,804	15,087	481	27,270	30.00
31.00	03100	INTENSIVE CARE UNIT	0	723,364	2,173	52	6,870	31.00
43.00	04300	NURSERY	0	241,388	198	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,333,394	8,405	453	13,143	50.00
51.00	05100	RECOVERY ROOM	0	673,075	5,224	193	9,195	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	361,959	1,764	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	59,204	140	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,222,207	12,251	519	10,860	54.00
60.00	06000	LABORATORY	0	2,764,050	2,668	0	3,530	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,540,021	3,809	283	4,115	65.00
66.00	06600	PHYSICAL THERAPY	0	1,080,949	3,538	85	2,315	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	346,235	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	119,079	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	784,277	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	2,480,840	6,557	608	12,440	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	2,686,490	13,798	0	7,830	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	1,764,288	0	0	9,355	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-6,943,775	35,782,315	88,197	2,952	111,828	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	295	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	11,131	585	0	0	192.00
192.01	19201	FCMC	0	2,858,003	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	2,478,263	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	948,663	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	337,619	297	0	101	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		6,943,775	3,832,162	183,782	848,989	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.163707	43.019814	62.256775	7.565129	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		247,679	272,494	8,162	31,526	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.005839	3.059015	2.764905	0.280920	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 | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	AKRON BUILDING						1.02
1.03	00103	ARGOS BUILDING						1.03
1.04	00101	CLAYS BUILDING						1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	3,173					10.00
11.00	01100	CAFETERIA	0	22,949				11.00
13.00	01300	NURSING ADMINISTRATION	0	961	52,561			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	3,059,798		14.00
15.00	01500	PHARMACY	0	698	0	2,696	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,660	1,095	3,379	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,625	3,436	38,600	90,158	0	30.00
31.00	03100	INTENSIVE CARE UNIT	548	1,291	6,886	28,688	0	31.00
43.00	04300	NURSERY	0	216	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,231	0	840,848	0	50.00
51.00	05100	RECOVERY ROOM	0	656	0	54,162	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	298	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	25,356	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,970	0	164,112	0	54.00
60.00	06000	LABORATORY	0	1,896	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,471	0	23,836	0	65.00
66.00	06600	PHYSICAL THERAPY	0	952	0	8,192	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	309	0	113	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	94	0	14	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	784,277	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,597	5,980	80,655	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	2,130	0	448,169	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	104,818	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,173	22,866	52,561	2,659,473	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	0	0	0	243,044	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	116,761	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	40,178	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	83	0	342	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	466,485	684,289	1,029,075	0	5,613,340	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	147.017019	29.817813	19.578680	0.000000	56,133.400000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,361	75,977	67,252	0	61,638	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.611094	3.310689	1.279504	0.000000	616.380000	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 | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet B-1 | Date/Time Prepared: 5/13/2020 4:35 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.02	00102	AKRON BUILDING			1.02
1.03	00103	ARGOS BUILDING			1.03
1.04	00101	CLAYS BUILDING			1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	129,338,610		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,233,408		30.00
31.00	03100	INTENSIVE CARE UNIT	1,482,108		31.00
43.00	04300	NURSERY	234,591		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	14,564,706		50.00
51.00	05100	RECOVERY ROOM	1,643,262		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	255,091		52.00
53.00	05300	ANESTHESIOLOGY	1,904,402		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,418,946		54.00
60.00	06000	LABORATORY	24,506,356		60.00
65.00	06500	RESPIRATORY THERAPY	8,319,264		65.00
66.00	06600	PHYSICAL THERAPY	2,515,689		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,098,461		67.00
68.00	06800	SPEECH PATHOLOGY	457,191		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,958,722		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,641,409		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	6,315,152		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1,772,777		93.00
93.01	04951	SHAFER MEDICAL CENTER	2,017,075		93.01
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,338,610		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		192.00
192.01	19201	FCMC	0		192.01
192.02	19202	ARGOS MEDICAL CENTER	0		192.02
192.03	19203	AKRON MEDICAL CENTER	0		192.03
193.00	19300	NONPAID WORKERS	0		193.00
194.00	07950	ADVERTISING	0		194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,500,865		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011604		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	84,240		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000651		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,750,804		5,750,804	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,261,552		1,261,552	0	0	31.00
43.00	04300	NURSERY	298,586		298,586	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,440,132		3,440,132	0	0	50.00
51.00	05100	RECOVERY ROOM	1,128,203		1,128,203	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	508,947		508,947	0	0	52.00
53.00	05300	ANESTHESIOLOGY	97,018		97,018	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,821,166		4,821,166	0	0	54.00
60.00	06000	LABORATORY	3,698,933		3,698,933	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,145,144	0	2,145,144	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,490,496	0	1,490,496	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	424,877	0	424,877	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	146,681	0	146,681	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	935,398		935,398	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,899,279		5,899,279	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,538,995		3,538,995	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,547,573		1,547,573		0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	3,863,192		3,863,192	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	2,147,292		2,147,292	0	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	43,144,268	0	43,144,268	0	0	200.00
201.00		Less Observation Beds	1,547,573		1,547,573		0	201.00
202.00		Total (see instructions)	41,596,695	0	41,596,695	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,101,836		3,101,836			30.00
31.00	03100	INTENSIVE CARE UNIT	1,482,108		1,482,108			31.00
43.00	04300	NURSERY	234,591		234,591			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,258,671	10,306,035	14,564,706	0.236196	0.000000	50.00
51.00	05100	RECOVERY ROOM	415,566	1,227,696	1,643,262	0.686563	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,805	77,286	255,091	1.995159	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	309,287	1,595,115	1,904,402	0.050944	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,231,401	28,187,545	29,418,946	0.163880	0.000000	54.00
60.00	06000	LABORATORY	2,818,943	21,687,413	24,506,356	0.150938	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,026,471	6,292,793	8,319,264	0.257853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	415,821	2,099,868	2,515,689	0.592480	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,001	931,460	1,098,461	0.386793	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,691	434,500	457,191	0.320831	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,416,081	542,641	1,958,722	0.477555	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,349,867	21,291,542	24,641,409	0.239405	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	223,621	6,091,531	6,315,152	0.560397	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	421,764	2,709,808	3,131,572	0.494184	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,772,777	1,772,777	2.179175	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	500	2,016,575	2,017,075	1.064557	0.000000	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,074,025	107,264,585	129,338,610			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,074,025	107,264,585	129,338,610			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000		93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000		93.01
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/13/2020 4:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,750,804		5,750,804	0	5,750,804	30.00
31.00	03100	INTENSIVE CARE UNIT	1,261,552		1,261,552	0	1,261,552	31.00
43.00	04300	NURSERY	298,586		298,586	0	298,586	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,440,132		3,440,132	0	3,440,132	50.00
51.00	05100	RECOVERY ROOM	1,128,203		1,128,203	0	1,128,203	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	508,947		508,947	0	508,947	52.00
53.00	05300	ANESTHESIOLOGY	97,018		97,018	0	97,018	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,821,166		4,821,166	0	4,821,166	54.00
60.00	06000	LABORATORY	3,698,933		3,698,933	0	3,698,933	60.00
65.00	06500	RESPIRATORY THERAPY	2,145,144	0	2,145,144	0	2,145,144	65.00
66.00	06600	PHYSICAL THERAPY	1,490,496	0	1,490,496	0	1,490,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	424,877	0	424,877	0	424,877	67.00
68.00	06800	SPEECH PATHOLOGY	146,681	0	146,681	0	146,681	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	935,398		935,398	0	935,398	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,899,279		5,899,279	0	5,899,279	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,538,995		3,538,995	0	3,538,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,547,573		1,547,573		1,547,573	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	3,863,192		3,863,192	0	3,863,192	93.00
93.01	04951	SHAFER MEDICAL CENTER	2,147,292		2,147,292	0	2,147,292	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	43,144,268	0	43,144,268	0	43,144,268	200.00
201.00		Less Observation Beds	1,547,573		1,547,573		1,547,573	201.00
202.00		Total (see instructions)	41,596,695	0	41,596,695	0	41,596,695	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/13/2020 4:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,101,836		3,101,836			30.00
31.00	03100	INTENSIVE CARE UNIT	1,482,108		1,482,108			31.00
43.00	04300	NURSERY	234,591		234,591			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,258,671	10,306,035	14,564,706	0.236196	0.000000	50.00
51.00	05100	RECOVERY ROOM	415,566	1,227,696	1,643,262	0.686563	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	177,805	77,286	255,091	1.995159	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	309,287	1,595,115	1,904,402	0.050944	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,231,401	28,187,545	29,418,946	0.163880	0.000000	54.00
60.00	06000	LABORATORY	2,818,943	21,687,413	24,506,356	0.150938	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,026,471	6,292,793	8,319,264	0.257853	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	415,821	2,099,868	2,515,689	0.592480	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	167,001	931,460	1,098,461	0.386793	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	22,691	434,500	457,191	0.320831	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,416,081	542,641	1,958,722	0.477555	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,349,867	21,291,542	24,641,409	0.239405	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	223,621	6,091,531	6,315,152	0.560397	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	421,764	2,709,808	3,131,572	0.494184	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,772,777	1,772,777	2.179175	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	500	2,016,575	2,017,075	1.064557	0.000000	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,074,025	107,264,585	129,338,610			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,074,025	107,264,585	129,338,610			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet C Part I Date/Time Prepared: 5/13/2020 4:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000		93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000		93.01
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part II Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	221,071	14,564,706	0.015179	1,282,627	19,469	50.00
51.00	05100	RECOVERY ROOM	125,666	1,643,262	0.076474	112,937	8,637	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,226	255,091	0.165533	1,488	246	52.00
53.00	05300	ANESTHESIOLOGY	4,678	1,904,402	0.002456	85,522	210	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	322,899	29,418,946	0.010976	467,797	5,135	54.00
60.00	06000	LABORATORY	98,287	24,506,356	0.004011	1,035,971	4,155	60.00
65.00	06500	RESPIRATORY THERAPY	108,711	8,319,264	0.013067	890,893	11,641	65.00
66.00	06600	PHYSICAL THERAPY	90,128	2,515,689	0.035826	126,078	4,517	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,760	1,098,461	0.003423	43,293	148	67.00
68.00	06800	SPEECH PATHOLOGY	1,304	457,191	0.002852	10,843	31	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,854	1,958,722	0.002989	500,590	1,496	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	77,680	24,641,409	0.003152	1,079,045	3,401	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	181,528	6,315,152	0.028745	21,126	607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	124,646	3,131,572	0.039803	48,644	1,936	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	360,204	1,772,777	0.203186	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	73,350	2,017,075	0.036365	207	8	93.01
200.00		Total (lines 50 through 199)	1,841,992	124,520,075		5,707,061	61,637	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	0	93.01
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	14,564,706	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,643,262	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	255,091	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,904,402	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,418,946	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	24,506,356	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	8,319,264	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,515,689	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,098,461	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	457,191	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,958,722	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,641,409	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	6,315,152	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,131,572	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	1,772,777	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	2,017,075	0.000000	93.01
200.00		Total (lines 50 through 199)	0	0	0	124,520,075		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part IV | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	1,282,627	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	112,937	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	1,488	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	85,522	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	467,797	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,035,971	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	890,893	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	126,078	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	43,293	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	10,843	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	500,590	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,079,045	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	21,126	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	48,644	0	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0.000000	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0.000000	207	0	0	0	93.01
200.00		Total (lines 50 through 199)		5,707,061	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.236196	0	1,707,968	0	0	50.00
51.00	05100	RECOVERY ROOM	0.686563	0	189,097	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.995159	0	1,072	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050944	0	310,646	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163880	0	8,089,779	0	0	54.00
60.00	06000	LABORATORY	0.150938	0	5,641,277	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.257853	0	1,959,278	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.592480	0	625,906	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386793	0	255,267	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.320831	0	27,455	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.477555	0	91,177	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239405	0	6,741,974	19,746	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.560397	0	1,259,865	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494184	0	494,282	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2.179175	0	33,378	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.064557	0	182,182	3,119	0	93.01
200.00		Subtotal (see instructions)		0	27,610,603	22,865	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	27,610,603	22,865	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	403,415	0		50.00
51.00	05100	RECOVERY ROOM	129,827	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,139	0		52.00
53.00	05300	ANESTHESIOLOGY	15,826	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,325,753	0		54.00
60.00	06000	LABORATORY	851,483	0		60.00
65.00	06500	RESPIRATORY THERAPY	505,206	0		65.00
66.00	06600	PHYSICAL THERAPY	370,837	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	98,735	0		67.00
68.00	06800	SPEECH PATHOLOGY	8,808	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,542	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,614,062	4,727		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	706,025	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	244,266	0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	72,737	0		93.00
93.01	04951	SHAFER MEDICAL CENTER	193,943	3,320		93.01
200.00		Subtotal (see instructions)	6,586,604	8,047		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,586,604	8,047		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.236196	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.686563	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.995159	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050944	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163880	0	0	0	0	54.00
60.00	06000	LABORATORY	0.150938	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.257853	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.592480	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386793	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.320831	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.477555	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239405	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.560397	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494184	0	0	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2.179175	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.064557	0	0	0	0	93.01
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D Part V | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0		93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0		93.01
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,410	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,114	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,229	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	165	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	131	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	864	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	161	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,750,804	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	16,917	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	305,448	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,445,356	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,445,356	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,748.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,510,851	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,510,851	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,261,552	548	2,302.10	239	550,202	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,478,973	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,540,026	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	281,536	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	281,536	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	885	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,748.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,547,573	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	463,188	5,750,804	0.080543	1,547,573	124,646	90.00
91.00	Nursing School cost	0	5,750,804	0.000000	1,547,573	0	91.00
92.00	Allied health cost	0	5,750,804	0.000000	1,547,573	0	92.00
93.00	All other Medical Education	0	5,750,804	0.000000	1,547,573	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,410	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,114	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,229	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	131	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	90	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	326	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,750,804	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	16,917	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	16,917	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,733,887	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,733,887	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,841.33	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	165,720	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	165,720	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	298,586	326	915.91	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,261,552	548	2,302.10	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	80,429	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	246,149	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	885	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,841.33	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,629,577	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-1 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	463,188	5,750,804	0.080543	1,629,577	131,251	90.00
91.00	Nursing School cost	0	5,750,804	0.000000	1,629,577	0	91.00
92.00	Allied health cost	0	5,750,804	0.000000	1,629,577	0	92.00
93.00	All other Medical Education	0	5,750,804	0.000000	1,629,577	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,092,467		30.00
31.00	03100	INTENSIVE CARE UNIT		634,146		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236196	1,282,627	302,951	50.00
51.00	05100	RECOVERY ROOM	0.686563	112,937	77,538	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.995159	1,488	2,969	52.00
53.00	05300	ANESTHESIOLOGY	0.050944	85,522	4,357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163880	467,797	76,663	54.00
60.00	06000	LABORATORY	0.150938	1,035,971	156,367	60.00
65.00	06500	RESPIRATORY THERAPY	0.257853	890,893	229,719	65.00
66.00	06600	PHYSICAL THERAPY	0.592480	126,078	74,699	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386793	43,293	16,745	67.00
68.00	06800	SPEECH PATHOLOGY	0.320831	10,843	3,479	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.477555	500,590	239,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239405	1,079,045	258,329	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.560397	21,126	11,839	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494184	48,644	24,039	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2.179175	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.064557	207	220	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,707,061	1,478,973	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		5,707,061		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236196	1,739	411	50.00
51.00	05100	RECOVERY ROOM	0.686563	7	5	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.995159	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050944	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163880	8,353	1,369	54.00
60.00	06000	LABORATORY	0.150938	16,033	2,420	60.00
65.00	06500	RESPIRATORY THERAPY	0.257853	26,257	6,770	65.00
66.00	06600	PHYSICAL THERAPY	0.592480	60,336	35,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386793	29,886	11,560	67.00
68.00	06800	SPEECH PATHOLOGY	0.320831	747	240	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.477555	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239405	25,724	6,158	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.560397	7	4	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494184	209	103	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2.179175	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.064557	1	1	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		169,299	64,789	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		169,299		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet D-3 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		108,673		30.00
31.00	03100	INTENSIVE CARE UNIT		13,460		31.00
43.00	04300	NURSERY		2,044		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.236196	95,705	22,605	50.00
51.00	05100	RECOVERY ROOM	0.686563	12,123	8,323	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.995159	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.050944	7,877	401	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163880	18,223	2,986	54.00
60.00	06000	LABORATORY	0.150938	52,121	7,867	60.00
65.00	06500	RESPIRATORY THERAPY	0.257853	19,443	5,013	65.00
66.00	06600	PHYSICAL THERAPY	0.592480	3,449	2,043	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.386793	1,101	426	67.00
68.00	06800	SPEECH PATHOLOGY	0.320831	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.477555	17,221	8,224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.239405	64,685	15,486	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.560397	12,589	7,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.494184	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2.179175	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.064557	0	0	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		304,537	80,429	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		304,537		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 5/13/2020 4:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,594,651	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,594,651	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	6,660,598	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	84,520	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,377,314	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,198,764	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,198,764	30.00
31.00	Primary payer payments	3,691	31.00
32.00	Subtotal (line 30 minus line 31)	2,195,073	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	966,580	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	628,277	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	966,580	36.00
37.00	Subtotal (see instructions)	2,823,350	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,823,350	40.00
40.01	Sequestration adjustment (see instructions)	56,467	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,210,529	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-443,646	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,665,450		3,210,529	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	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)		2,665,450		3,210,529	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	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		532,224		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		443,646	6.02
7.00	Total Medicare program liability (see instructions)		3,197,674		2,766,883	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-1 Part I | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		292,961		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	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)		292,961		0	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	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		47,324		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		340,285		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1313	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Prepared: 5/13/2020 4:35 pm
	Title XVIII	Hospital	Cost

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
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 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet E-2 | Date/Time Prepared: 5/13/2020 4:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	284,351	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	65,437	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	161	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	349,788	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	349,788	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	349,788	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,558	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	347,230	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	347,230	0	19.00
19.01	Sequestration adjustment (see instructions)	6,945	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	292,961	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	47,324	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 5/13/2020 4:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,540,026	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,540,026	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,575,426	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,575,426	19.00
20.00	Deductibles (exclude professional component)	340,928	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,234,498	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,234,498	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	43,746	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	28,435	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	43,746	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,262,933	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,262,933	30.00
30.01	Sequestration adjustment (see instructions)	65,259	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	2,665,450	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	532,224	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 5/13/2020 4:35 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	246,149		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	246,149	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	246,149	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	124,177		8.00
9.00	Ancillary service charges	304,537	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	428,714	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	428,714	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	182,565	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	246,149	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	246,149	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	246,149	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	246,149	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	246,149	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	246,149	0	40.00
41.00	Interim payments	217,976	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	28,173	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G | Date/Time Prepared: 5/13/2020 4:35 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	7,573,158	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	20,780,674	0	0	0	4.00
5.00	Other receivable	1,211,675	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,629,140	0	0	0	6.00
7.00	Inventory	892,293	0	0	0	7.00
8.00	Prepaid expenses	182,965	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,011,625	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	596,216	0	0	0	12.00
13.00	Land improvements	510,775	0	0	0	13.00
14.00	Accumulated depreciation	-397,388	0	0	0	14.00
15.00	Buildings	27,302,119	0	0	0	15.00
16.00	Accumulated depreciation	-13,679,818	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,521,060	0	0	0	23.00
24.00	Accumulated depreciation	-8,110,788	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,742,176	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	5,291,234	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	617,210	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,908,444	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,662,245	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,288,443	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,615,412	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,302,549	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,206,404	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,154,894	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,154,894	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	16,361,298	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,300,947				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	23,300,947	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,662,245	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-1 | Date/Time Prepared: 5/13/2020 4:35 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,403,396		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		897,551				2.00
3.00	Total (sum of line 1 and line 2)		23,300,947		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,300,947		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,300,947		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/13/2020 4:35 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,101,836		3,101,836	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				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)	3,101,836		3,101,836	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,485,332		1,485,332	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	1,485,332		1,485,332	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,587,168		4,587,168	17.00
18.00	Ancillary services	16,609,605	94,673,894	111,283,499	18.00
19.00	Outpatient services	645,885	11,278,602	11,924,487	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				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	FCMC CLINIC	0	3,118,253	3,118,253	27.00
27.01	ARGOS CLINIC	0	2,924,706	2,924,706	27.01
27.02	AKRON CLINIC	0	828,972	828,972	27.02
27.03	PROFESSIONAL FEES	211,672	12,878,185	13,089,857	27.03
27.04	DIETARY	0	13,892	13,892	27.04
27.05	NURSERY	234,591	0	234,591	27.05
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,288,921	125,716,504	148,005,425	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		60,968,548		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		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		60,968,548		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2019 To 12/31/2019 | Worksheet G-3 | Date/Time Prepared: 5/13/2020 4:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	148,005,425	1.00
2.00	Less contractual allowances and discounts on patients' accounts	90,039,930	2.00
3.00	Net patient revenues (line 1 minus line 2)	57,965,495	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	60,968,548	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,003,053	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	180,061	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	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	153,946	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	37	21.00
22.00	Rental of hospital space	8,629	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	940,108	24.00
24.01	EQUITY REVENUE	2,621,263	24.01
24.02	GAIN/LOSS DISP ASSET-MISC	0	24.02
25.00	Total other income (sum of lines 6-24)	3,904,044	25.00
26.00	Total (line 5 plus line 25)	900,991	26.00
27.00	GAIN/LOSS DISP ASSET-MISC	3,440	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,440	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	897,551	29.00