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 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-1313	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 9:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2019 Time: 9:25 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 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
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	-106,279	-241,035	0	0	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	-7,962	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-114,241	-241,035	0	0	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 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:25 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)	01/01/2018	12/31/2018	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 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2019 9:25 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 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:25 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 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:25 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

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		1.00	2.00	3.00	
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

		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	N	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:25 pm

		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

		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:	312,080	52,948	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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:25 pm

		1.00	2.00	
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

	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)	0	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)	01/01/2018	12/31/2018	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1313	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Prepared: 5/29/2019 9:25 pm

		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 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2019 9:25 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	04/30/2019	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	04/16/2019	Y	04/16/2019	16.00
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		17.00
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		18.00
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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 9:25 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.	KERRY	BEJARANO	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000	KBEJARANO@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1313	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Prepared: 5/29/2019 9:25 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 MANAGING CONSULTANT		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 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 9:25 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	64,704.00	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	64,704.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	16,080.00	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	80,784.00	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 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 9:25 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)	1,081	62	2,696			1.00
2.00	HMO and other (see instructions)	676	71				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	178	0	212			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	19			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,259	62	2,927			7.00
8.00	INTENSIVE CARE UNIT	296	0	670			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		186	352			13.00
14.00	Total (see instructions)	1,555	248	3,949	0.00	359.52	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	359.52	27.00
28.00	Observation Bed Days		0	600			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	22	91			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 01/01/2018 To 12/31/2018 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2019 9:25 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	350	20	1,009	1.00
2.00	HMO and other (see instructions)			172	30		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	350	20	1,009	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 01/01/2018 To 12/31/2018 | Worksheet S-10 | Date/Time Prepared: 5/29/2019 9:25 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)	0.312401	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,559,927	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?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	790,339	5.00
6.00	Medicaid charges	18,388,744	6.00
7.00	Medicaid cost (line 1 times line 6)	5,744,662	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)	394,396	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)	394,396	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)	798,312	0	798,312	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	249,393	0	249,393	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)	249,393	0	249,393	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)	3,635,601	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	819,871	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,261,340	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,374,261	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,183,191	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,432,584	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,826,980	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 9:25 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		2,480,359	2,480,359	-133,980	2,346,379	1.00
1.02	00102	AKRON BUILDING		48,057	48,057	0	48,057	1.02
1.03	00103	ARGOS BUILDING		88,447	88,447	0	88,447	1.03
1.04	00101	CLAYS BUILDING		12,659	12,659	133,980	146,639	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,123,998	3,123,998	0	3,123,998	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,253,101	5,471,110	8,724,211	93,738	8,817,949	5.00
7.00	00700	OPERATION OF PLANT	357,144	1,157,263	1,514,407	0	1,514,407	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	14,335	130,904	145,239	0	145,239	8.00
9.00	00900	HOUSEKEEPING	375,951	178,581	554,532	0	554,532	9.00
10.00	01000	DIETARY	397,717	311,808	709,525	-528,241	181,284	10.00
11.00	01100	CAFETERIA	0	0	0	528,241	528,241	11.00
13.00	01300	NURSING ADMINISTRATION	112,573	63,703	176,276	0	176,276	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	392,326	4,878,028	5,270,354	0	5,270,354	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	648,721	334,594	983,315	0	983,315	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,163,470	911,562	3,075,032	-737,383	2,337,649	30.00
31.00	03100	INTENSIVE CARE UNIT	483,265	168,694	651,959	40,862	692,821	31.00
43.00	04300	NURSERY	0	0	0	375,640	375,640	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	804,020	1,497,456	2,301,476	58,156	2,359,632	50.00
51.00	05100	RECOVERY ROOM	398,236	160,460	558,696	0	558,696	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	227,663	227,663	52.00
53.00	05300	ANESTHESIOLOGY	0	913,994	913,994	0	913,994	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,735,282	1,336,791	3,072,073	0	3,072,073	54.00
60.00	06000	LABORATORY	870,130	1,675,309	2,545,439	0	2,545,439	60.00
65.00	06500	RESPIRATORY THERAPY	1,058,679	353,278	1,411,957	0	1,411,957	65.00
66.00	06600	PHYSICAL THERAPY	685,708	190,974	876,682	0	876,682	66.00
67.00	06700	OCCUPATIONAL THERAPY	197,181	41,071	238,252	0	238,252	67.00
68.00	06800	SPEECH PATHOLOGY	76,381	16,367	92,748	0	92,748	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	864,834	864,834	0	864,834	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,373,106	2,235,087	3,608,193	35,062	3,643,255	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	3,562,504	859,719	4,422,223	0	4,422,223	93.00
93.01	04951	SHAFER MEDICAL CENTER	3,271,420	1,102,981	4,374,401	0	4,374,401	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)	22,231,250	30,608,088	52,839,338	93,738	52,933,076	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FCMC	1,476,109	948,909	2,425,018	0	2,425,018	192.01
192.02	19202	ARGOS MEDICAL CENTER	1,591,996	503,317	2,095,313	0	2,095,313	192.02
192.03	19203	AKRON MEDICAL CENTER	582,644	194,815	777,459	0	777,459	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	74,648	236,122	310,770	-93,738	217,032	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	25,956,647	32,491,251	58,447,898	0	58,447,898	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A | Date/Time Prepared: 5/29/2019 9:25 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	-75,640	2,270,739		1.00
1.02	00102	AKRON BUILDING	0	48,057		1.02
1.03	00103	ARGOS BUILDING	0	88,447		1.03
1.04	00101	CLAYS BUILDING	0	146,639		1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-72,079	3,051,919		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,320,959	6,496,990		5.00
7.00	00700	OPERATION OF PLANT	0	1,514,407		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	145,239		8.00
9.00	00900	HOUSEKEEPING	0	554,532		9.00
10.00	01000	DIETARY	-8,547	172,737		10.00
11.00	01100	CAFETERIA	-145,480	382,761		11.00
13.00	01300	NURSING ADMINISTRATION	0	176,276		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	-297,873	4,972,481		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-29,827	953,488		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,337,649		30.00
31.00	03100	INTENSIVE CARE UNIT	0	692,821		31.00
43.00	04300	NURSERY	0	375,640		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,359,632		50.00
51.00	05100	RECOVERY ROOM	0	558,696		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	227,663		52.00
53.00	05300	ANESTHESIOLOGY	-840,863	73,131		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-252,488	2,819,585		54.00
60.00	06000	LABORATORY	0	2,545,439		60.00
65.00	06500	RESPIRATORY THERAPY	-3,276	1,408,681		65.00
66.00	06600	PHYSICAL THERAPY	-16,581	860,101		66.00
67.00	06700	OCCUPATIONAL THERAPY	-44,491	193,761		67.00
68.00	06800	SPEECH PATHOLOGY	-1,932	90,816		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	864,834		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,351,657	2,291,598		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	-2,869,081	1,553,142		93.00
93.01	04951	SHAFER MEDICAL CENTER	-2,800,210	1,574,191		93.01
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,130,984	41,802,092		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		192.00
192.01	19201	FCMC	0	2,425,018		192.01
192.02	19202	ARGOS MEDICAL CENTER	0	2,095,313		192.02
192.03	19203	AKRON MEDICAL CENTER	0	777,459		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	ADVERTISING	0	217,032		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,130,984	47,316,914		200.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 9:25 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA				
1.00	CAFETERIA	11.00	296,100	232,141	1.00
	0		296,100	232,141	
	B - ADVERTISING				
1.00	ADMINISTRATIVE & GENERAL	5.00	22,516	71,222	1.00
	0		22,516	71,222	
	C - DEPRECIATION				
1.00	CLAYS BUILDING	1.04	0	133,980	1.00
	0		0	133,980	
	D - NURSERY				
1.00	NURSERY	43.00	252,426	117,256	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	153,005	71,073	2.00
	0		405,431	188,329	
	E - NURSING SUPERVISOR				
1.00	INTENSIVE CARE UNIT	31.00	40,862	0	1.00
2.00	NURSERY	43.00	5,958	0	2.00
3.00	OPERATING ROOM	50.00	58,156	0	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	3,585	0	4.00
5.00	EMERGENCY	91.00	35,062	0	5.00
	TOTALS		143,623	0	
500.00	Grand Total: Increases		867,670	625,672	500.00

RECLASSIFICATIONS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-6 | Date/Time Prepared: 5/29/2019 9:25 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	296,100	232,141	0		1.00
	0		296,100	232,141			
	B - ADVERTISING						
1.00	ADVERTISING	194.00	22,516	71,222	0		1.00
	0		22,516	71,222			
	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	405,431	188,329	0		1.00
2.00		0.00	0	0	0		2.00
	0		405,431	188,329			
	E - NURSING SUPERVISOR						
1.00	ADULTS & PEDIATRICS	30.00	143,623	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		143,623	0			
500.00	Grand Total: Decreases		867,670	625,672			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2019 9:25 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	27,141,936	162,758	0	162,758	2,575	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	9,709,252	296,378	0	296,378	226,167	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,958,179	459,136	0	459,136	228,742	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,958,179	459,136	0	459,136	228,742	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	9,779,463	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,188,573	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	38,188,573	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2019 9:25 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	1,277,141	0	547,773	618,160	37,285	1.00
1.02	AKRON BUILDING	28,466	0	0	0	10,666	1.02
1.03	ARGOS BUILDING	51,792	0	0	0	14,604	1.03
1.04	CLAYS BUILDING	0	0	0	0	12,659	1.04
3.00	Total (sum of lines 1-2)	1,357,399	0	547,773	618,160	75,214	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	2,480,359	1.00
1.02	AKRON BUILDING	8,925	48,057	1.02
1.03	ARGOS BUILDING	22,051	88,447	1.03
1.04	CLAYS BUILDING	0	12,659	1.04
3.00	Total (sum of lines 1-2)	30,976	2,629,522	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2019 9:25 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	36,206,124	0	36,206,124	0.948088	0	1.00
1.02	AKRON BUILDING	697,932	0	697,932	0.018276	0	1.02
1.03	ARGOS BUILDING	1,284,517	0	1,284,517	0.033636	0	1.03
1.04	CLAYS BUILDING	0	0	0	0.000000	0	1.04
3.00	Total (sum of lines 1-2)	38,188,573	0	38,188,573	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,135,205	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	1,349,443	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	480,089	618,160	37,285	0	2,270,739	1.00
1.02	AKRON BUILDING	0	0	10,666	8,925	48,057	1.02
1.03	ARGOS BUILDING	0	0	14,604	22,051	88,447	1.03
1.04	CLAYS BUILDING	0	0	12,659	0	146,639	1.04
3.00	Total (sum of lines 1-2)	480,089	618,160	75,214	30,976	2,553,882	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 9:25 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	-67,684	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	-8,114,299			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	-133,065	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	-29,827	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	-14	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

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet A-8 | Date/Time Prepared: 5/29/2019 9:25 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	
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
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	-7,956	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	HOME MEAL PROGRAM	B	-12,401	CAFETERIA	11.00	0	33.00
34.00	DIETARY SPEC EVENTS	B	-8,547	DIETARY	10.00	0	34.00
35.00	SUPPLY SALES	B	-114	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PT - OTHER REVENUE	B	-1,581	PHYSICAL THERAPY	66.00	0	36.00
37.00	OCC THER OTH REV	B	-44,491	OCCUPATIONAL THERAPY	67.00	0	37.00
38.00	EDUCATION OTHER REVENUE	B	-2,401	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	RESPIRATORY OTHER REV	B	-3,276	RESPIRATORY THERAPY	65.00	0	39.00
40.00	ATHLETIC TRAINING -OTH REV	B	-15,000	PHYSICAL THERAPY	66.00	0	40.00
41.00	DRUG SALES	B	-297,873	PHARMACY	15.00	0	41.00
42.00	CHAPLAIN - OTHER REVENUE	B	-900	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	SPEECH THERAPY OTHER REVENUE	B	-1,932	SPEECH PATHOLOGY	68.00	0	43.00
44.00	PHYSICIAN RECRUITMENT-HR	A	-72,079	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	PHYS RECRUITMENT - OTH EXP	A	-12,837	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	HOSPITAL ASSESSMENT FEE	A	-2,076,790	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	IHA LOBBYING DUES	A	-1,241	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PART B BILLING OFFSET	A	-53,607	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	LTC EXPENSES	A	-100,425	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	INSURANCE RECEIPTS	B	-72,644	ADMINISTRATIVE & GENERAL	5.00	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,130,984				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 01/01/2018 To 12/31/2018 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2019 9:25 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	840,863	840,863	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	252,488	252,488	0	0	0	2.00
3.00	91.00	EMERGENCY	2,155,437	1,351,657	803,780	0	0	3.00
4.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	2,869,081	2,869,081	0	0	0	4.00
5.00	93.01	SHAFER MEDICAL CENTER	2,800,210	2,800,210	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			8,918,079	8,114,299	803,780		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	840,863		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	252,488		2.00
3.00	91.00	EMERGENCY	0	0	0	1,351,657		3.00
4.00	93.00	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	2,869,081		4.00
5.00	93.01	SHAFER MEDICAL CENTER	0	0	0	2,800,210		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	8,114,299		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 9:25 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	2,270,739	2,270,739				1.00
1.02	00102	AKRON BUILDING	48,057	0	48,057			1.02
1.03	00103	ARGOS BUILDING	88,447	0	0	88,447		1.03
1.04	00101	CLAYS BUILDING	146,639	0	0	0	146,639	1.04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,051,919	12,962	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,496,990	236,144	5,492	7,076	115	5.00
7.00	00700	OPERATION OF PLANT	1,514,407	215,513	3,295	8,066	33,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	145,239	9,311	0	0	0	8.00
9.00	00900	HOUSEKEEPING	554,532	24,383	0	0	309	9.00
10.00	01000	DIETARY	172,737	36,291	0	0	0	10.00
11.00	01100	CAFETERIA	382,761	71,182	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	176,276	54,710	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	4,972,481	28,663	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	953,488	33,268	0	0	30,522	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,337,649	325,441	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	692,821	44,080	0	0	0	31.00
43.00	04300	NURSERY	375,640	4,017	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,359,632	170,439	0	0	0	50.00
51.00	05100	RECOVERY ROOM	558,696	105,971	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	227,663	15,174	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	73,131	2,840	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,819,585	247,341	0	0	0	54.00
60.00	06000	LABORATORY	2,545,439	54,122	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,408,681	89,074	0	0	3,017	65.00
66.00	06600	PHYSICAL THERAPY	860,101	71,750	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	193,761	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	90,816	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	864,834	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	2,291,598	132,971	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1,553,142	279,899	0	0	34,437	93.00
93.01	04951	SHAFER MEDICAL CENTER	1,574,191	0	0	0	44,787	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,802,092	2,265,546	8,787	15,142	146,639	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	39,270	73,305	0	192.00
192.01	19201	FCMC	2,425,018	0	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	2,095,313	0	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	777,459	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	217,032	5,193	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)	47,316,914	2,270,739	48,057	88,447	146,639	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 9:25 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	3,064,881					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	490,762	7,236,579	7,236,579			5.00
7.00	00700	OPERATION OF PLANT	53,509	1,828,242	330,093	2,158,335		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,148	156,698	28,292	11,127	196,117	8.00
9.00	00900	HOUSEKEEPING	56,326	635,550	114,750	29,138	48,748	9.00
10.00	01000	DIETARY	15,225	224,253	40,489	43,368	3,381	10.00
11.00	01100	CAFETERIA	44,363	498,306	89,970	85,063	0	11.00
13.00	01300	NURSING ADMINISTRATION	16,866	247,852	44,750	65,379	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	58,780	5,059,924	913,572	34,253	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	97,194	1,114,472	201,220	39,756	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	241,878	2,904,968	524,498	388,904	32,968	30.00
31.00	03100	INTENSIVE CARE UNIT	78,527	815,428	147,227	52,677	7,749	31.00
43.00	04300	NURSERY	38,712	418,369	75,537	4,800	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	129,175	2,659,246	480,132	203,676	20,992	50.00
51.00	05100	RECOVERY ROOM	59,665	724,332	130,780	126,637	15,216	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,461	266,298	48,081	18,133	0	52.00
53.00	05300	ANESTHESIOLOGY	0	75,971	13,717	3,394	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	259,987	3,326,913	600,681	295,576	20,852	54.00
60.00	06000	LABORATORY	130,366	2,729,927	492,894	64,676	0	60.00
65.00	06500	RESPIRATORY THERAPY	158,616	1,659,388	299,606	106,444	16,061	65.00
66.00	06600	PHYSICAL THERAPY	102,736	1,034,587	186,797	85,742	4,790	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,542	223,303	40,318	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	11,444	102,260	18,463	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	864,834	156,148	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	164,877	2,589,446	467,530	158,903	25,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT		0				92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	115,063	1,982,541	357,952	334,483	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	130,878	1,749,856	315,940	0	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,510,100	41,129,543	6,119,437	2,152,129	196,117	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	112,575	20,326	0	0	192.00
192.01	19201	FCMC	221,157	2,646,175	477,772	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	238,519	2,333,832	421,378	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	87,294	864,753	156,133	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	7,811	230,036	41,533	6,206	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)	3,064,881	47,316,914	7,236,579	2,158,335	196,117	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 9:25 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	828,186					9.00
10.00	01000	DIETARY	2,685	314,176				10.00
11.00	01100	CAFETERIA	9,161	0	682,500			11.00
13.00	01300	NURSING ADMINISTRATION	1,974	0	8,942	368,897		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	8,135	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,923	0	53,252	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	193,179	255,656	88,620	187,835	0	30.00
31.00	03100	INTENSIVE CARE UNIT	48,255	58,520	28,886	61,210	0	31.00
43.00	04300	NURSERY	0	0	12,332	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	91,771	0	46,072	0	0	50.00
51.00	05100	RECOVERY ROOM	79,530	0	19,180	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	7,479	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,928	0	88,321	0	0	54.00
60.00	06000	LABORATORY	30,438	0	57,340	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	34,118	0	60,664	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17,533	0	34,504	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	5,186	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,925	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	16,554	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	87,112	0	56,543	119,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	42,016	0	92,409	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	86,243	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)	827,001	314,176	679,209	368,897	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	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	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	1,185	0	3,291	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)	828,186	314,176	682,500	368,897	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part I | Date/Time Prepared: 5/29/2019 9:25 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	6,015,884					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,414,623				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	68,087	4,644,715	0	4,644,715	30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,021	1,238,973	0	1,238,973	31.00
43.00	04300	NURSERY	0	2,660	513,698	0	513,698	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	184,986	3,686,875	0	3,686,875	50.00
51.00	05100	RECOVERY ROOM	0	21,439	1,117,114	0	1,117,114	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,907	342,898	0	342,898	52.00
53.00	05300	ANESTHESIOLOGY	0	23,181	116,263	0	116,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	312,427	4,733,698	0	4,733,698	54.00
60.00	06000	LABORATORY	0	251,332	3,626,607	0	3,626,607	60.00
65.00	06500	RESPIRATORY THERAPY	0	86,662	2,262,943	0	2,262,943	65.00
66.00	06600	PHYSICAL THERAPY	0	22,589	1,386,542	0	1,386,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,483	278,290	0	278,290	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,609	128,257	0	128,257	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,899	1,044,881	0	1,044,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,015,884	275,845	6,308,283	0	6,308,283	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	71,395	3,576,141	0	3,576,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	18,637	2,828,038	0	2,828,038	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	15,464	2,167,503	0	2,167,503	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,015,884	1,414,623	40,001,719	0	40,001,719	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	132,901	0	132,901	192.00
192.01	19201	FCMC	0	0	3,123,947	0	3,123,947	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	2,755,210	0	2,755,210	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	1,020,886	0	1,020,886	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	282,251	0	282,251	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)	6,015,884	1,414,623	47,316,914	0	47,316,914	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 9:25 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	12,962	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	236,144	5,492	7,076	115	5.00
7.00	00700	OPERATION OF PLANT	0	215,513	3,295	8,066	33,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,311	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	24,383	0	0	309	9.00
10.00	01000	DIETARY	0	36,291	0	0	0	10.00
11.00	01100	CAFETERIA	0	71,182	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	54,710	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	28,663	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,268	0	0	30,522	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	325,441	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	44,080	0	0	0	31.00
43.00	04300	NURSERY	0	4,017	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	170,439	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	105,971	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,174	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,840	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	247,341	0	0	0	54.00
60.00	06000	LABORATORY	0	54,122	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	89,074	0	0	3,017	65.00
66.00	06600	PHYSICAL THERAPY	0	71,750	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 PAT	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	132,971	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	279,899	0	0	34,437	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	0	44,787	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,265,546	8,787	15,142	146,639	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	39,270	73,305	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	0	5,193	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	2,270,739	48,057	88,447	146,639	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 9:25 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	12,962	12,962				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	248,827	2,071	250,898			5.00
7.00	00700	OPERATION OF PLANT	260,326	226	11,445	271,997		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,311	9	981	1,402	11,703	8.00
9.00	00900	HOUSEKEEPING	24,692	238	3,979	3,672	2,910	9.00
10.00	01000	DIETARY	36,291	64	1,404	5,465	202	10.00
11.00	01100	CAFETERIA	71,182	188	3,119	10,720	0	11.00
13.00	01300	NURSING ADMINISTRATION	54,710	71	1,552	8,239	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	28,663	249	31,668	4,317	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,790	411	6,977	5,010	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	325,441	1,024	18,185	49,011	1,967	30.00
31.00	03100	INTENSIVE CARE UNIT	44,080	332	5,105	6,638	462	31.00
43.00	04300	NURSERY	4,017	164	2,619	605	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,439	547	16,647	25,668	1,253	50.00
51.00	05100	RECOVERY ROOM	105,971	252	4,534	15,959	908	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,174	99	1,667	2,285	0	52.00
53.00	05300	ANESTHESIOLOGY	2,840	0	476	428	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	247,341	1,100	20,826	37,249	1,244	54.00
60.00	06000	LABORATORY	54,122	552	17,089	8,151	0	60.00
65.00	06500	RESPIRATORY THERAPY	92,091	671	10,388	13,414	958	65.00
66.00	06600	PHYSICAL THERAPY	71,750	435	6,477	10,805	286	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	125	1,398	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	48	640	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	5,414	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	132,971	698	16,210	20,025	1,513	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0					92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	314,336	487	12,411	42,152	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	44,787	554	10,954	0	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,436,114	10,615	212,165	271,215	11,703	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	112,575	0	705	0	0	192.00
192.01	19201	FCMC	0	936	16,565	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	1,009	14,610	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	369	5,413	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	5,193	33	1,440	782	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)	2,553,882	12,962	250,898	271,997	11,703	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 9:25 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	35,491					9.00
10.00	01000	DIETARY	115	43,541				10.00
11.00	01100	CAFETERIA	393	0	85,602			11.00
13.00	01300	NURSING ADMINISTRATION	85	0	1,122	65,779		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	349	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	254	0	6,679	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,277	35,431	11,115	33,494	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,068	8,110	3,623	10,914	0	31.00
43.00	04300	NURSERY	0	0	1,547	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,933	0	5,779	0	0	50.00
51.00	05100	RECOVERY ROOM	3,408	0	2,406	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	938	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,811	0	11,078	0	0	54.00
60.00	06000	LABORATORY	1,304	0	7,192	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,462	0	7,609	0	0	65.00
66.00	06600	PHYSICAL THERAPY	751	0	4,328	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	650	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	367	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	2,076	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,733	0	7,092	21,371	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1,801	0	11,588	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	3,696	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)	35,440	43,541	85,189	65,779	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	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	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	51	0	413	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)	35,491	43,541	85,602	65,779	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B Part II | Date/Time Prepared: 5/29/2019 9:25 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	65,246					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	83,121				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,000	487,945	0	487,945	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,117	82,449	0	82,449	31.00
43.00	04300	NURSERY	0	156	9,108	0	9,108	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,867	235,133	0	235,133	50.00
51.00	05100	RECOVERY ROOM	0	1,259	134,697	0	134,697	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	171	20,334	0	20,334	52.00
53.00	05300	ANESTHESIOLOGY	0	1,362	5,106	0	5,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,374	341,023	0	341,023	54.00
60.00	06000	LABORATORY	0	14,764	103,174	0	103,174	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,091	131,684	0	131,684	65.00
66.00	06600	PHYSICAL THERAPY	0	1,327	96,159	0	96,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	557	2,730	0	2,730	67.00
68.00	06800	SPEECH PATHOLOGY	0	271	1,326	0	1,326	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,404	6,818	0	6,818	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,246	16,204	83,526	0	83,526	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	4,194	207,807	0	207,807	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,095	383,870	0	383,870	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	908	60,899	0	60,899	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,246	83,121	2,393,788	0	2,393,788	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	113,280	0	113,280	192.00
192.01	19201	FCMC	0	0	17,501	0	17,501	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	15,619	0	15,619	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	5,782	0	5,782	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	0	7,912	0	7,912	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)	65,246	83,121	2,553,882	0	2,553,882	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:25 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 (ASSIGNED TIME)	
			1.00	1.02	1.03	1.04	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	111,939					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	639	0	0	0	20,456,556	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,641	400	600	16	3,275,617	5.00
7.00	00700	OPERATION OF PLANT	10,624	240	684	4,657	357,144	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	459	0	0	0	14,335	8.00
9.00	00900	HOUSEKEEPING	1,202	0	0	43	375,951	9.00
10.00	01000	DIETARY	1,789	0	0	0	101,617	10.00
11.00	01100	CAFETERIA	3,509	0	0	0	296,100	11.00
13.00	01300	NURSING ADMINISTRATION	2,697	0	0	0	112,573	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,413	0	0	0	392,326	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,640	0	0	4,249	648,721	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,043	0	0	0	1,614,416	30.00
31.00	03100	INTENSIVE CARE UNIT	2,173	0	0	0	524,127	31.00
43.00	04300	NURSERY	198	0	0	0	258,384	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,402	0	0	0	862,176	50.00
51.00	05100	RECOVERY ROOM	5,224	0	0	0	398,236	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	748	0	0	0	156,590	52.00
53.00	05300	ANESTHESIOLOGY	140	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,193	0	0	0	1,735,282	54.00
60.00	06000	LABORATORY	2,668	0	0	0	870,130	60.00
65.00	06500	RESPIRATORY THERAPY	4,391	0	0	420	1,058,679	65.00
66.00	06600	PHYSICAL THERAPY	3,537	0	0	0	685,708	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	197,181	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	76,381	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	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	6,555	0	0	0	1,100,473	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	13,798	0	0	4,794	767,986	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	6,235	873,542	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,683	640	1,284	20,414	16,753,675	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	2,860	6,216	0	0	192.00
192.01	19201	FCMC	0	0	0	0	1,476,109	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	0	1,591,996	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	582,644	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	256	0	0	0	52,132	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)	2,270,739	48,057	88,447	146,639	3,064,881	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.285504	13.730571	11.792933	7.183257	0.149824	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					12,962	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000634	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 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:25 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVIC)	
			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	-7,236,579	40,080,335				5.00
7.00	00700	OPERATION OF PLANT	0	1,828,242	89,035			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	156,698	459	1,392		8.00
9.00	00900	HOUSEKEEPING	0	635,550	1,202	346	52,432	9.00
10.00	01000	DIETARY	0	224,253	1,789	24	170	10.00
11.00	01100	CAFETERIA	0	498,306	3,509	0	580	11.00
13.00	01300	NURSING ADMINISTRATION	0	247,852	2,697	0	125	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	5,059,924	1,413	0	515	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,114,472	1,640	0	375	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,904,968	16,043	234	12,230	30.00
31.00	03100	INTENSIVE CARE UNIT	0	815,428	2,173	55	3,055	31.00
43.00	04300	NURSERY	0	418,369	198	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,659,246	8,402	149	5,810	50.00
51.00	05100	RECOVERY ROOM	0	724,332	5,224	108	5,035	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	266,298	748	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	75,971	140	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,326,913	12,193	148	5,630	54.00
60.00	06000	LABORATORY	0	2,729,927	2,668	0	1,927	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,659,388	4,391	114	2,160	65.00
66.00	06600	PHYSICAL THERAPY	0	1,034,587	3,537	34	1,110	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	223,303	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	102,260	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	864,834	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	2,589,446	6,555	180	5,515	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,982,541	13,798	0	2,660	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	1,749,856	0	0	5,460	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,236,579	33,892,964	88,779	1,392	52,357	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	112,575	0	0	0	192.00
192.01	19201	FCMC	0	2,646,175	0	0	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	2,333,832	0	0	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	864,753	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	230,036	256	0	75	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)		7,236,579	2,158,335	196,117	828,186	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.180552	24.241422	140.888649	15.795430	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		250,898	271,997	11,703	35,491	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.006260	3.054945	8.407328	0.676896	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 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:25 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	3,597					10.00
11.00	01100	CAFETERIA	0	20,532				11.00
13.00	01300	NURSING ADMINISTRATION	0	269	108,904			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	2,930,554		14.00
15.00	01500	PHARMACY	0	0	0	2,416	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,602	0	3,551	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,927	2,666	55,452	112,344	0	30.00
31.00	03100	INTENSIVE CARE UNIT	670	869	18,070	33,600	0	31.00
43.00	04300	NURSERY	0	371	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,386	0	1,000,809	0	50.00
51.00	05100	RECOVERY ROOM	0	577	0	62,905	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	225	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	22,536	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,657	0	119,901	0	54.00
60.00	06000	LABORATORY	0	1,725	0	3,989	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,825	0	72,385	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,038	0	7,787	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	156	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	88	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	864,834	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	498	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	1,701	35,382	79,139	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	2,780	0	98,230	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	131,104	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,597	20,433	108,904	2,615,530	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	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	175,906	0	192.01
192.02	19202	ARGOS MEDICAL CENTER	0	0	0	113,309	0	192.02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	25,404	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	ADVERTISING	0	99	0	405	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)	314,176	682,500	368,897	0	6,015,884	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	87.343898	33.240795	3.387360	0.000000	60,158.840000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,541	85,602	65,779	0	65,246	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	12.104810	4.169199	0.604009	0.000000	652.460000	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 01/01/2018 To 12/31/2018 | Worksheet B-1 | Date/Time Prepared: 5/29/2019 9:25 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	128,045,988		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,162,796		30.00
31.00	03100	INTENSIVE CARE UNIT	1,721,634		31.00
43.00	04300	NURSERY	240,730		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	16,743,836		50.00
51.00	05100	RECOVERY ROOM	1,940,492		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	263,105		52.00
53.00	05300	ANESTHESIOLOGY	2,098,188		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,281,835		54.00
60.00	06000	LABORATORY	22,749,126		60.00
65.00	06500	RESPIRATORY THERAPY	7,844,146		65.00
66.00	06600	PHYSICAL THERAPY	2,044,656		66.00
67.00	06700	OCCUPATIONAL THERAPY	858,342		67.00
68.00	06800	SPEECH PATHOLOGY	417,181		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,163,171		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,967,905		73.00
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	6,462,266		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1,686,871		93.00
93.01	04951	SHAFER MEDICAL CENTER	1,399,708		93.01
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,045,988		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	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)	1,414,623		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011048		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	83,121		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000649		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 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 9:25 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	4,644,715		4,644,715	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,238,973		1,238,973	0	0	31.00
43.00	04300	NURSERY	513,698		513,698	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,686,875		3,686,875	0	0	50.00
51.00	05100	RECOVERY ROOM	1,117,114		1,117,114	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	342,898		342,898	0	0	52.00
53.00	05300	ANESTHESIOLOGY	116,263		116,263	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,733,698		4,733,698	0	0	54.00
60.00	06000	LABORATORY	3,626,607		3,626,607	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,262,943	0	2,262,943	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,386,542	0	1,386,542	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	278,290	0	278,290	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	128,257	0	128,257	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,044,881		1,044,881	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,308,283		6,308,283	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,576,141		3,576,141	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	793,974		793,974		0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2,828,038		2,828,038	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	2,167,503		2,167,503	0	0	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,795,693	0	40,795,693	0	0	200.00
201.00		Less Observation Beds	793,974		793,974		0	201.00
202.00		Total (see instructions)	40,001,719	0	40,001,719	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 9:25 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,422,100		3,422,100			30.00
31.00	03100	INTENSIVE CARE UNIT	1,721,634		1,721,634			31.00
43.00	04300	NURSERY	240,730		240,730			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,707,597	12,036,239	16,743,836	0.220193	0.000000	50.00
51.00	05100	RECOVERY ROOM	446,583	1,493,909	1,940,492	0.575686	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	172,213	90,892	263,105	1.303274	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	332,556	1,765,632	2,098,188	0.055411	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,597,343	26,684,492	28,281,835	0.167376	0.000000	54.00
60.00	06000	LABORATORY	3,156,891	19,592,235	22,749,126	0.159417	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,550,657	5,293,489	7,844,146	0.288488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	375,371	1,669,285	2,044,656	0.678130	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,854	710,488	858,342	0.324218	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	21,122	396,059	417,181	0.307437	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,447,071	716,100	2,163,171	0.483032	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,944,745	21,023,160	24,967,905	0.252656	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	348,991	6,113,275	6,462,266	0.553388	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	185,377	2,555,319	2,740,696	0.289698	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,686,871	1,686,871	1.676499	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	1,399,708	1,399,708	1.548539	0.000000	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,818,835	103,227,153	128,045,988			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,818,835	103,227,153	128,045,988			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 9:25 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 PAT	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	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 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 9:25 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	4,644,715		4,644,715	0	4,644,715	30.00
31.00	03100	INTENSIVE CARE UNIT	1,238,973		1,238,973	0	1,238,973	31.00
43.00	04300	NURSERY	513,698		513,698	0	513,698	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,686,875		3,686,875	0	3,686,875	50.00
51.00	05100	RECOVERY ROOM	1,117,114		1,117,114	0	1,117,114	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	342,898		342,898	0	342,898	52.00
53.00	05300	ANESTHESIOLOGY	116,263		116,263	0	116,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,733,698		4,733,698	0	4,733,698	54.00
60.00	06000	LABORATORY	3,626,607		3,626,607	0	3,626,607	60.00
65.00	06500	RESPIRATORY THERAPY	2,262,943	0	2,262,943	0	2,262,943	65.00
66.00	06600	PHYSICAL THERAPY	1,386,542	0	1,386,542	0	1,386,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	278,290	0	278,290	0	278,290	67.00
68.00	06800	SPEECH PATHOLOGY	128,257	0	128,257	0	128,257	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,044,881		1,044,881	0	1,044,881	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,308,283		6,308,283	0	6,308,283	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,576,141		3,576,141	0	3,576,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	793,974		793,974		793,974	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	2,828,038		2,828,038	0	2,828,038	93.00
93.01	04951	SHAFER MEDICAL CENTER	2,167,503		2,167,503	0	2,167,503	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	40,795,693	0	40,795,693	0	40,795,693	200.00
201.00		Less Observation Beds	793,974		793,974		793,974	201.00
202.00		Total (see instructions)	40,001,719	0	40,001,719	0	40,001,719	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 9:25 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	3,422,100		3,422,100			30.00
31.00	03100	INTENSIVE CARE UNIT	1,721,634		1,721,634			31.00
43.00	04300	NURSERY	240,730		240,730			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,707,597	12,036,239	16,743,836	0.220193	0.000000	50.00
51.00	05100	RECOVERY ROOM	446,583	1,493,909	1,940,492	0.575686	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	172,213	90,892	263,105	1.303274	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	332,556	1,765,632	2,098,188	0.055411	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,597,343	26,684,492	28,281,835	0.167376	0.000000	54.00
60.00	06000	LABORATORY	3,156,891	19,592,235	22,749,126	0.159417	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,550,657	5,293,489	7,844,146	0.288488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	375,371	1,669,285	2,044,656	0.678130	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	147,854	710,488	858,342	0.324218	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	21,122	396,059	417,181	0.307437	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,447,071	716,100	2,163,171	0.483032	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,944,745	21,023,160	24,967,905	0.252656	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	348,991	6,113,275	6,462,266	0.553388	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	185,377	2,555,319	2,740,696	0.289698	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	1,686,871	1,686,871	1.676499	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	1,399,708	1,399,708	1.548539	0.000000	93.01
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,818,835	103,227,153	128,045,988			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,818,835	103,227,153	128,045,988			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet C Part I Date/Time Prepared: 5/29/2019 9:25 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 PAT	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	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 01/01/2018 To 12/31/2018 | Worksheet D Part II Date/Time Prepared: 5/29/2019 9:25 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	235,133	16,743,836	0.014043	1,413,716	19,853	50.00
51.00	05100	RECOVERY ROOM	134,697	1,940,492	0.069414	125,892	8,739	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,334	263,105	0.077285	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,106	2,098,188	0.002434	98,368	239	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	341,023	28,281,835	0.012058	629,254	7,588	54.00
60.00	06000	LABORATORY	103,174	22,749,126	0.004535	1,222,426	5,544	60.00
65.00	06500	RESPIRATORY THERAPY	131,684	7,844,146	0.016788	1,109,454	18,626	65.00
66.00	06600	PHYSICAL THERAPY	96,159	2,044,656	0.047029	143,235	6,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,730	858,342	0.003181	47,888	152	67.00
68.00	06800	SPEECH PATHOLOGY	1,326	417,181	0.003178	15,318	49	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,818	2,163,171	0.003152	549,718	1,733	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,526	24,967,905	0.003345	1,464,891	4,900	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	207,807	6,462,266	0.032157	15,250	490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	83,410	2,740,696	0.030434	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	383,870	1,686,871	0.227563	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	60,899	1,399,708	0.043508	0	0	93.01
200.00		Total (lines 50 through 199)	1,897,696	122,661,524		6,835,410	74,649	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 9:25 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 PAT	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	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 01/01/2018 To 12/31/2018 | Worksheet D Part IV | Date/Time Prepared: 5/29/2019 9:25 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	16,743,836	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,940,492	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	263,105	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,098,188	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	28,281,835	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	22,749,126	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,844,146	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,044,656	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	858,342	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	417,181	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,163,171	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,967,905	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	6,462,266	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,740,696	0.000000	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	0	0	0	1,686,871	0.000000	93.00
93.01	04951	SHAFER MEDICAL CENTER	0	0	0	1,399,708	0.000000	93.01
200.00		Total (lines 50 through 199)	0	0	0	122,661,524		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part IV Date/Time Prepared: 5/29/2019 9:25 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	1,413,716	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	125,892	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	98,368	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	629,254	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	1,222,426	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,109,454	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	143,235	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	47,888	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,318	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	549,718	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,464,891	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	15,250	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	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	0	0	0	0	93.01
200.00		Total (lines 50 through 199)		6,835,410	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 9:25 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	0.220193	0	2,287,401	0	0	50.00
51.00	05100	RECOVERY ROOM	0.575686	0	253,019	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.303274	0	258	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055411	0	369,938	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167376	0	7,450,437	0	0	54.00
60.00	06000	LABORATORY	0.159417	0	5,340,626	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.288488	0	1,636,738	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.678130	0	473,703	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324218	0	233,780	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.307437	0	46,271	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.483032	0	149,845	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252656	0	9,059,746	20,677	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.553388	0	1,369,581	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.289698	0	446,715	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1.676499	0	72,716	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.548539	0	264,826	2,394	0	93.01
200.00		Subtotal (see instructions)		0	29,455,600	23,071	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	29,455,600	23,071	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 9:25 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	503,670	0		50.00
51.00	05100	RECOVERY ROOM	145,659	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	336	0		52.00
53.00	05300	ANESTHESIOLOGY	20,499	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,247,024	0		54.00
60.00	06000	LABORATORY	851,387	0		60.00
65.00	06500	RESPIRATORY THERAPY	472,179	0		65.00
66.00	06600	PHYSICAL THERAPY	321,232	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	75,796	0		67.00
68.00	06800	SPEECH PATHOLOGY	14,225	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,380	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,288,999	5,224		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	757,910	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	129,412	0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	121,908	0		93.00
93.01	04951	SHAFER MEDICAL CENTER	410,093	3,707		93.01
200.00		Subtotal (see instructions)	7,432,709	8,931		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,432,709	8,931		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 9:25 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	0.220193	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.575686	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.303274	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055411	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167376	0	0	0	0	54.00
60.00	06000	LABORATORY	0.159417	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.288488	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.678130	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324218	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.307437	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.483032	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252656	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.553388	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.289698	0	0	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1.676499	0	0	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.548539	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 01/01/2018 To 12/31/2018 | Worksheet D Part V | Date/Time Prepared: 5/29/2019 9:25 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 PAT	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	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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 9:25 pm

Title XIX | 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	0.220193	0	1,085,679	0	0	50.00
51.00	05100	RECOVERY ROOM	0.575686	0	153,583	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.303274	0	28,129	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055411	0	141,004	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167376	0	2,498,514	0	0	54.00
60.00	06000	LABORATORY	0.159417	0	1,955,564	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.288488	0	454,847	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.678130	0	244,576	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324218	0	118,401	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.307437	0	168,947	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.483032	0	12,159	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252656	0	1,040,469	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.553388	0	1,079,485	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.289698	0	517,711	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1.676499	0	208,929	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.548539	0	73,364	0	0	93.01
200.00		Subtotal (see instructions)		0	9,781,361	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	9,781,361	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D Part V Date/Time Prepared: 5/29/2019 9:25 pm

Title XIX | 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	239,059	0		50.00
51.00	05100	RECOVERY ROOM	88,416	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,660	0		52.00
53.00	05300	ANESTHESIOLOGY	7,813	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	418,191	0		54.00
60.00	06000	LABORATORY	311,750	0		60.00
65.00	06500	RESPIRATORY THERAPY	131,218	0		65.00
66.00	06600	PHYSICAL THERAPY	165,854	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	38,388	0		67.00
68.00	06800	SPEECH PATHOLOGY	51,941	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,873	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	262,881	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	597,374	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	149,980	0		92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	350,269	0		93.00
93.01	04951	SHAFER MEDICAL CENTER	113,607	0		93.01
200.00		Subtotal (see instructions)	2,969,274	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,969,274	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:25 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)	3,527	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,296	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)	2,696	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	212	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	19	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)	1,081	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)	178	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	138.07	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,644,715	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)	2,623	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)	283,160	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,361,555	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)	4,361,555	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)	1,323.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,430,476	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)	1,430,476	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:25 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	1,238,973	670	1,849.21	296	547,366	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)	1,770,927	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,748,769	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)	235,546	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)	235,546	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)	600	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,323.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	793,974	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:25 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	487,945	4,644,715	0.105054	793,974	83,410	90.00
91.00	Nursing School cost	0	4,644,715	0.000000	793,974	0	91.00
92.00	Allied health cost	0	4,644,715	0.000000	793,974	0	92.00
93.00	All other Medical Education	0	4,644,715	0.000000	793,974	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:25 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)	3,527	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,296	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)	2,696	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	212	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	19	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)	62	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)	352	15.00
16.00	Nursery days (title V or XIX only)	186	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	138.07	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,644,715	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)	2,623	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)	283,160	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,361,555	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)	4,361,555	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)	1,323.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	82,044	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)	82,044	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:25 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)	513,698	352	1,459.37	186	271,443	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,238,973	670	1,849.21	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)	402,262	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	755,749	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)	600	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,323.29	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	793,974	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-1 | Date/Time Prepared: 5/29/2019 9:25 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	487,945	4,644,715	0.105054	793,974	83,410	90.00
91.00	Nursing School cost	0	4,644,715	0.000000	793,974	0	91.00
92.00	Allied health cost	0	4,644,715	0.000000	793,974	0	92.00
93.00	All other Medical Education	0	4,644,715	0.000000	793,974	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 9:25 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		1,310,772		30.00
31.00	03100	INTENSIVE CARE UNIT		752,842		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.220193	1,413,716	311,290	50.00
51.00	05100	RECOVERY ROOM	0.575686	125,892	72,474	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.303274	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055411	98,368	5,451	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167376	629,254	105,322	54.00
60.00	06000	LABORATORY	0.159417	1,222,426	194,875	60.00
65.00	06500	RESPIRATORY THERAPY	0.288488	1,109,454	320,064	65.00
66.00	06600	PHYSICAL THERAPY	0.678130	143,235	97,132	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324218	47,888	15,526	67.00
68.00	06800	SPEECH PATHOLOGY	0.307437	15,318	4,709	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.483032	549,718	265,531	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252656	1,464,891	370,114	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.553388	15,250	8,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.289698	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1.676499	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.548539	0	0	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,835,410	1,770,927	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)		6,835,410		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 15-1313 | Component CCN: 15-Z313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 9:25 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	0.220193	1,778	392	50.00
51.00	05100	RECOVERY ROOM	0.575686	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.303274	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.055411	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167376	6,178	1,034	54.00
60.00	06000	LABORATORY	0.159417	19,475	3,105	60.00
65.00	06500	RESPIRATORY THERAPY	0.288488	34,105	9,839	65.00
66.00	06600	PHYSICAL THERAPY	0.678130	59,544	40,379	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324218	27,927	9,054	67.00
68.00	06800	SPEECH PATHOLOGY	0.307437	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.483032	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252656	53,913	13,621	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.553388	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.289698	0	0	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1.676499	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.548539	0	0	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		202,920	77,424	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)		202,920		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet D-3 | Date/Time Prepared: 5/29/2019 9:25 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		282,164		30.00
31.00	03100	INTENSIVE CARE UNIT		104,493		31.00
43.00	04300	NURSERY		141,424		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.220193	351,159	77,323	50.00
51.00	05100	RECOVERY ROOM	0.575686	39,178	22,554	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.303274	37,026	48,255	52.00
53.00	05300	ANESTHESIOLOGY	0.055411	27,864	1,544	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.167376	73,074	12,231	54.00
60.00	06000	LABORATORY	0.159417	259,891	41,431	60.00
65.00	06500	RESPIRATORY THERAPY	0.288488	173,691	50,108	65.00
66.00	06600	PHYSICAL THERAPY	0.678130	7,562	5,128	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.324218	2,217	719	67.00
68.00	06800	SPEECH PATHOLOGY	0.307437	130	40	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.483032	44,518	21,504	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252656	270,217	68,272	73.00
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.553388	64,165	35,508	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.289698	60,907	17,645	92.00
93.00	04950	WOODLAWN MEDICAL PROFESSIONALS	1.676499	0	0	93.00
93.01	04951	SHAFER MEDICAL CENTER	1.548539	0	0	93.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,411,599	402,262	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)		1,411,599		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/29/2019 9:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,441,640	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)	7,441,640	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)	7,516,056	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)	92,986	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	4,804,632	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)	2,618,438	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)	2,618,438	30.00
31.00	Primary payer payments	574	31.00
32.00	Subtotal (line 30 minus line 31)	2,617,864	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)	1,209,794	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	786,366	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,023,745	36.00
37.00	Subtotal (see instructions)	3,404,230	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)	3,404,230	40.00
40.01	Sequestration adjustment (see instructions)	68,085	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,577,180	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-241,035	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 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2019 9:25 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		3,368,448		3,577,180	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	08/22/2018	96,500		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)		96,500		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)		3,464,948		3,577,180	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		106,279		241,035	6.02
7.00	Total Medicare program liability (see instructions)		3,358,669		3,336,145	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 01/01/2018 To 12/31/2018 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2019 9:25 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		312,158		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)		312,158		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		7,962		0	6.02
7.00	Total Medicare program liability (see instructions)		304,196		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 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Prepared: 5/29/2019 9:25 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 01/01/2018 To 12/31/2018 | Worksheet E-2 | Date/Time Prepared: 5/29/2019 9:25 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)	237,901	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)	78,198	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	178	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)	316,099	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	316,099	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)	316,099	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,695	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)	310,404	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)	310,404	0	19.00
19.01	Sequestration adjustment (see instructions)	6,208	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	312,158	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)	-7,962	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 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 9:25 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,748,769	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)	3,748,769	4.00
5.00	Primary payer payments	6,698	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,779,559	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)	3,779,559	19.00
20.00	Deductibles (exclude professional component)	385,851	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,393,708	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,393,708	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	51,546	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	33,505	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,868	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,427,213	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)	3,427,213	30.00
30.01	Sequestration adjustment (see instructions)	68,544	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
31.00	Interim payments	3,464,948	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)	-106,279	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

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 01/01/2018 To 12/31/2018 | Worksheet G | Date/Time Prepared: 5/29/2019 9:25 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	8,634,537	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	19,596,512	0	0	0	4.00
5.00	Other receivable	1,064,594	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-11,878,269	0	0	0	6.00
7.00	Inventory	1,087,776	0	0	0	7.00
8.00	Prepaid expenses	212,008	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)	18,717,158	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	-362,527	0	0	0	14.00
15.00	Buildings	27,302,119	0	0	0	15.00
16.00	Accumulated depreciation	-12,993,388	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	9,779,463	0	0	0	23.00
24.00	Accumulated depreciation	-7,770,080	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)	17,062,578	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,405,651	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	771,512	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,177,163	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,956,899	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,135,577	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,146,093	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	7,599,800	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,881,470	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	10,764,460	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)	10,764,460	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	21,645,930	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,310,969				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)	18,310,969	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,956,899	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-1 | Date/Time Prepared: 5/29/2019 9:25 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		16,642,693		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,668,276				2.00
3.00	Total (sum of line 1 and line 2)		18,310,969		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)		18,310,969		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)		18,310,969		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 01/01/2018 To 12/31/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2019 9:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	6,516,933		6,516,933	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)	6,516,933		6,516,933	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,293,044		2,293,044	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)	2,293,044		2,293,044	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	8,809,977		8,809,977	17.00
18.00	Ancillary services	18,374,308	91,161,343	109,535,651	18.00
19.00	Outpatient services	2,196,418	18,768,776	20,965,194	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	OTHER REVENUE	0	6,824,691	6,824,691	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	29,380,703	116,754,810	146,135,513	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		58,447,898		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)		58,447,898		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-1313 | Period: From 01/01/2018 To 12/31/2018 | Worksheet G-3 | Date/Time Prepared: 5/29/2019 9:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	146,135,513	1.00
2.00	Less contractual allowances and discounts on patients' accounts	90,741,376	2.00
3.00	Net patient revenues (line 1 minus line 2)	55,394,137	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	58,447,898	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,053,761	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	147,667	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	154,013	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	114	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	14	21.00
22.00	Rental of hospital space	14,874	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISC REVENUE	4,405,355	24.00
25.00	Total other income (sum of lines 6-24)	4,722,037	25.00
26.00	Total (line 5 plus line 25)	1,668,276	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,668,276	29.00