This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fa	ilure to report can r	esult in all interim	FORM APPROVED
	since the beginning of the cost reporting period being			OMB NO. 0938-0050 EXPLRES 03-31-2022
HOSPITAL AND H	Worksheet S Parts I-III Date/Time Prepared: 11/17/2020 3:20 pm			
PART I - COST	REPORT STATUS			·
Provi der	1. [X] Electronically prepared cost report		Date: 11/17/2	020 Time: 3:20 pm
use only	2. [] Manually prepared cost report			
	3. [0]If this is an amended report enter the number 4. [F]Medicare Utilization. Enter "F" for full or " $$		r resubmitted this o	cost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	1 or this Provider CCN1	O.NPR Date: 1.Contractor's Vendo 2.[O]Ifline 5, co number of tim	or Code: 4 Dlumn 1 is 4: Enter nes 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 OAKLAWN PSYCHIATRIC CENTER, INC. (15-4031) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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.

> JOE BARKMAN (Si gned) Officer or Administrator of Provider(s) CF₀ Title

> > (Dated when report is electronically signed.) Date

	<u> </u>		Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 029	18, 545	0	218, 609	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1, 029	18, 545	0	218, 609	200.00

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

Health Financial Systems OAKLAWN PSYCHIATRIC CENTER, INC. In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4031 Peri od: Worksheet S-2 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/17/2020 3:20 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 330 LAKEVIEW DRIVE P0 Box: 809 1.00 1.00 Zip Code: 46527-0809 County: ELKHART 2.00 City: GOSHEN State: IN 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 OAKLAWN PSYCHLATRIC 154031 21140 4 08/20/1987 N 0 3.00 CENTER, INC. Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 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 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 07/01/2019 06/30/2020 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 O 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days el i gi bl e unpai d paid days days unpai d 1.00 5. 00 2.00 3.00 4.00 6.00 24.00 | If this provider is an IPPS hospital, enter the 0 24.00 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.

Health Financial Systems OAKLAWN PS	YCHLATRIC (CENTER, INC.			In Lie	u of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provi der CC	CN: 15-4031	Period: From 07/0	01/2019	Worksh Part I	eet S-2	
					30/2020	Date/T	ime Pre 2020 3:	
	In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medica HMO da	aid C	ther di cai d	
	pai d days	eligible	Medi cai d	Medi cai d	TIMO GE		days	
		unpai d days	paid days	el i gi bl e unpai d				
25.00 If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5. 00	0	5. 00	25.00
Medicaid paid days in column 1, the in-state		,		U		U .		25.00
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.								
pinio para ana ang ara ara anpara ang ara	'	'	'			Date of		
26.00 Enter your standard geographic classification (not w		s at the be	ginning of		00 1	2.	00	26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not w		s at the en	d of the co	st	1			27. 00
reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassif	or "2" for	rural. If a						
35.00 If this is a sole community hospital (SCH), enter th			CH status i	n	0)		35. 00
effect in the cost reporting period.				Begi n		Endi		
36.00 Enter applicable beginning and ending dates of SCH s	status. Sub	script line	: 36 for num		00	2.	00	36.00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), enter	tes.	·			0			37.00
is in effect in the cost reporting period.				us	U			
37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)								37. 01
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of								38. 00
enter subsequent dates.				Y,	/N	Y,	′N	
39.00 Does this facility qualify for the inpatient hospita	al navment	adiustmant	for low vol		00 V	2.		39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), o	r (iii)? En	iter in colu		•	'	•	37.00
1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	ii)? Enter	e requireme in column	ents in 2 "Y" for y	es				
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction	on adjustme	nt? Enter "	Y" for yes	or I	V	1	J	40. 00
"N" for no in column 1, for discharges prior to Octono in column 2, for discharges on or after October 1			yes or "N"	for				
		,			V 1. 00	XVIII 0 2.00	XI X 3. 00	
Prospective Payment System (PPS)-Capital	E!! -							45.00
45.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)						N	N	45. 00
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS					N	N	N	47.00
48.00 Is the facility electing full federal capital paymer Teaching Hospitals 56.00 Is this a hospital involved in training residents in					or N	N	N	48. 00 56. 00
"N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for	impacted by	y CR 11642						
57.00 If line 56 is yes, is this the first cost reporting	period dur	ing which r						57. 00
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor	nth of this	cost repor	ting period	? Enter "	Y"			
for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I			et E-4. If c	olumn 2 is				
58.00 If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	nbursement	for physici	ans' servic	es as	N			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes			1	a= w	N_			59.00
			NAHE 413.8 Y/N		neet A ie #		hrough cation	
						Cri te	eri on de	
60.00 Are you claiming pursing and allied health education	(NAUE) a-	ctc for	1. 00 N	2.	00	3.		60.00
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413	8.85? (see		IN IN					60.00
instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent	CR) NAHE M							
adjustement? Enter "Y" for yes or "N" for no in col	umn 2.		l	I				

Health Financial Systems OAKLAWALDC	VCIII ATDI	C CENTED IN	0	In lie	u of Form CMS	05E2 10
Health Financial Systems OAKLAWN PSY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		C CENTER, IN Provi der (CCN: 15-4031	Peri od: From 07/01/2019 To 06/30/2020	w of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 11/17/2020 3:	pared:
	Y/N	I ME	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
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
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
	Pro	ogram Name	Program Code	IME FTE Count	Unweighted Direct GME FTE Count	
(1 10 Of the FTEs in Line (1 OF specify each new program		1. 00	2. 00	3. 00	4.00	(1 10
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

	the direct GME FIE unweighted count.					
					1. 00	
	ACA Provisions Affecting the Health Resources and Se	ervices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting per	iod for which	0. 00	62.00
	your hospital received HRSA PCRE funding (see instru					
	Enter the number of FTE residents that rotated from		ter (THC) into	vour hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC pro			3		
	Teaching Hospitals that Claim Residents in Nonprovid		,			İ
63.00	Has your facility trained residents in nonprovider s	J	ost reporting	period? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, compl					
	, , , , , , , , , , , , , , , , , , , ,	3	Unwei ghted	Unweighted	Ratio (col.	
			FTEs	FTEs in	1/ (col. 1 +	
			Nonprovi der	Hospi tal	col. 2))	
			Si te		,,	
			1. 00	2, 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in N	Jonnrovider Settings				
	period that begins on or after July 1, 2009 and before		iiii 5 base year	13 your cost	reportring	
	Enter in column 1, if line 63 is yes, or your facili		0.00	0.00	0. 000000	64 00
01.00	in the base year period, the number of unweighted no		0.00	0.00	0.00000	01.00
	resident FTEs attributable to rotations occurring in					
	settings. Enter in column 2 the number of unweighte					
	resident FTEs that trained in your hospital. Enter i					
	of (column 1 divided by (column 1 + column 2)). (see					
	pr (corumn r drvrded by (corumn r + corumn 2)). (see	: I IISTI ucti olis)				I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4031 Peri od: Worksheet S-2 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/17/2020 3:20 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 Υ Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N"

Health Financial Systems	OAKLAWN PSYCHLATRIC	CENTER, INC.	In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH	CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-4031	Peri od:	Worksheet S-2	2
			From 07/01/2019 To 06/30/2020		nared.
			10 00/30/2020	11/17/2020 3:	
76.00 If line 75 is ves: Col	lump 1. Did the facility have an approxy	od CME taaabi na program i n	1.00	0 2.00 3.00	76.00
recent cost reporting no. Column 2: Did this CFR 412.424 (d)(1)(iii	umn 1: Did the facility have an approve period ending on or before November 15, s facility train residents in a new tead ()(D)? Enter "Y" for yes or "N" for no. m year began during this cost reporting	. 2004? Enter "Y" for yes ching program in accordanc Column 3: If column 2 is	or "N" for e with 42 Y,		76.00
				1. 00	1
Long Term Care Hospita	al PPS			1.00	
	are hospital (LTCH)? Enter "Y" for yes	and "N" for no.		N	80.00
	ated within another hospital for part or		g period? Enter	N	81.00
"Y" for yes and "N" for	or no.				
TEFRA Provi ders	da. 42 CED Casti as C412 40(f) (1) (i)	TEEDAO FILLIA IIVII 6	"N" <i></i>	N.	05.00
	under 42 CFR Section §413.40(f)(1)(i) ablish a new Other subprovider (excluded			N	85. 00 86. 00
	nter "Y" for yes and "N" for no.	d dili t) dilder 42 ci k Secti	OH		00.00
	xtended neoplastic disease care hospital	classified under section		N	87.00
1886(d)(1)(B)(vi)? Ent	ter "Y" for yes or "N" for no.		1		
			V	XIX	_
Title V and XIX Service	COS		1. 00	2. 00	
	ve title V and/or XIX inpatient hospital	services? Enter "Y" for	N	Υ	90.00
yes or "N" for no in t					
	oursed for title V and/or XIX through th		N	Υ	91.00
	r "Y" for yes or "N" for no in the appli ents occupying title XVIII SNF beds (dua			N	92.00
	Y" for yes or "N" for no in the applicat			IN	92.00
	erate an ICF/IID facility for purposes of		N	N	93.00
	r no in the applicable column.				
	educe capital cost? Enter "Y" for yes, a	and "N" for no in the	N	N	94.00
applicable column. 95.00 If line 94 is "Y", ent	ter the reduction percentage in the appl	i cable column	0.00	0.00	95.00
	educe operating cost? Enter "Y" for yes		0.00 N	0.00 N	96.00
applicable column.	adde operating east. Enter 1 101 year	or we receive the time	.,		70.00
97.00 If line 96 is "Y", ent	ter the reduction percentage in the appl	icable column.	0.00	0.00	97.00
	ollow Medicare (title XVIII) for the int		Y	Y	98.00
	on Wkst. B, Pt. I, col. 25? Enter "Y" fo	or yes or "N" for no in			
	and in column 2 for title XIX. ollow Medicare (title XVIII) for the rep	norting of charges on Wkst	. Y	Y	98. 01
98 ()1 lloes title V or XIX fo					70.01
	or ves or "N" for no in column 1 for tit	rie v. and in corullin 2 for			
	or yes or "N" for no in column 1 for tit	tre v, and in corumn 2 for			
C, Pt. I? Enter "Y" for title XIX. 98.02 Does title V or XIX for	ollow Medicare (title XVIII) for the cal	culation of observation	Y	Y	98. 02
C, Pt. I? Enter "Y" for title XIX. 98.02 Does title V or XIX for bed costs on Wkst. D-	ollow Medicare (title XVIII) for the cal 1, Pt. IV, line 89? Enter "Y" for yes or	culation of observation		Y	98. 02
C, Pt. I? Enter "Y" for title XIX. 98.02 Does title V or XIX for bed costs on Wkst. D-for title V, and in co	ollow Medicare (title XVIII) for the cal 1, Pt. IV, line 89? Enter "Y" for yes or olumn 2 for title XIX.	culation of observation r "N" for no in column 1	Y	·	
C, Pt. I? Enter "Y" for title XIX. 98.02 Does title V or XIX for bed costs on Wkst. D-for title V, and in comparison of the costs of Does title V or XIX for title V.	ollow Medicare (title XVIII) for the cal 1, Pt. IV, line 89? Enter "Y" for yes or olumn 2 for title XIX. ollow Medicare (title XVIII) for a criti	culation of observation "N" for no in column 1 cal access hospital (CAH)	Y	Y N	98. 02 98. 03
C, Pt. I? Enter "Y" for title XIX. 98.02 Does title V or XIX for bed costs on Wkst. D-for title V, and in composition of the composition of the composition of the composition of the composition of title V, and in composition of the composit	ollow Medicare (title XVIII) for the cal 1, Pt. IV, line 89? Enter "Y" for yes or olumn 2 for title XIX. ollow Medicare (title XVIII) for a criti oatient services cost? Enter "Y" for yes olumn 2 for title XIX.	culation of observation "N" for no in column 1 cal access hospital (CAH) s or "N" for no in column	Y	·	98. 03
C, Pt. I? Enter "Y" for title XIX. 98.02 Does title V or XIX for bed costs on Wkst. D-for title V, and in compared 101% of input for title V, and in compared 101% of input for title V, and in compared 101% of the V or XIX for permitted V, and in compared 101% of the V or XIX for title V or XIX fo	ollow Medicare (title XVIII) for the cal 1, Pt. IV, line 89? Enter "Y" for yes or olumn 2 for title XIX. ollow Medicare (title XVIII) for a criti oatient services cost? Enter "Y" for yes olumn 2 for title XIX. ollow Medicare (title XVIII) for a CAH r	culation of observation "N" for no in column 1 cal access hospital (CAH) s or "N" for no in column reimbursed 101% of	Y N N N	·	
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ealth Financial Systems OAKLAWN PSYCHIATRI IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 15-4031	Period: From 07/01/2019 To 06/30/2020		S-2 Prepared:
	Physi cal 1. 00	Occupati ona 2.00	Speech 3.00	Respirator 4.00	ТУ
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N	N N	N N	109.0
				1.00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worlapplicable.	Y" for yes o	r "N" for no.	If yes,	N	110. 0
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared in the second of the FCHIP demonstration for the second integration prong of the FCHIP demonstration which this CAH is participated in the second of the FCHIP demonstration of the second o	ost reporting Dlumn 1 is Y, Tticipating i	period? Ente enter the n column 2.	1.00 N	2.00	111.0
		1.00	2.00	3.00	
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	peri od? s "Y", enter ne	N			112.0
15.00 is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes	N			0115.0
16.00 s this facility classified as a referral center? Enter "Y"	for yes or	N			116.0
"N" for no. 17.00 s this facility legally-required to carry malpractice insur	ance? Enter	Y			117. 0
"Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence polif the policy is claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1		1		118. C
1. the portey to ordin made. Enter E 1. the portey to cood		Premi ums	Losses	Insurance	
		1.00	2. 00	3. 00	
18.01 List amounts of malpractice premiums and paid losses:		761, 3	34	0	0 118. 0
			1.00	2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 DO NOT USE THIS LINE			N		118.0
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.	n column 1, "' ualifies for	Y" for yes or the Outpatien		N	120. (
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devic	es charged to	N		121. (
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N	" for no. If	N		125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, er	nter the cert	ification data	e		126. (
in column 1 and termination date, if applicable, in column 2	2.				
·	2.				127. (
27.00 f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2		fication date			128. (
27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent					1
27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, ente	2.	ication date	i n		129.
27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent	2. er the certif		in		130. (
27.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.	2. er the certif enter the ce umn 2.	rti fi cati on			

132.00 If this is a Medicare certified islet transplant center, enter the in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the OPO and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, a are claimed, enter in column 2 the home office chain number. (see 1.00 2.00 2.00 If this facility is part of a chain organization, enter on lines 1 office and enter the home office contractor name and contractor number. (See 2.00 2.00 2.00 2.00 2.00 141.00 Name:	in CMS Pub. and home office instructions) 41 through 1- mber. Co Zi Ti Ti Ti Ti Ti Ti Ti Ti Ti	on date I umn 1 15-1, ce costs) 43 the national contractor of the code: I umn 1 is ring ort? 4020) If	ame and r's Numb	00 00 3.00 address	2.00	132. 00 133. 00 134. 00 140. 00 141. 00 142. 00 143. 00 145. 00 146. 00
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148.00 Was there a change in the order of allocation? Enter "Y" for yes on 149.00 Was there a change to the simplified cost finding method? Enter "Y" Par	r "N" for no.				N	148.00
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158. OO SUBPROVI DER 159. OO SNF NOOR HEALTH AGENCY NOOR NOOR HEALTH AGENCY		N N	1	N N	N N	156. 00 157. 00
159.00 SNF No No No No No No No No	•	IN		IN	IN IN	158. 00
	1	N		N	N	159.00
	1	N	1	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 mo Enter "Y" for yes or "N" for no.	re campuses i	in differ	rent CBS	SAs?	N	165.00
Name Count 0 1.00			Code . 00	CBSA 4. 00	FTE/Campus 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)	2.1	00 3.	. 00	4.00		00 166. 00
Weel the Left growth on To Leave (WT)			± A - I		1.00	
Health Information Technology (HIT) incentive in the American Reco 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user	yes or "N" fo	or no.		the	N	167. 00 168. 00
reasonable cost incurred for the HIT assets (see instructions) [168.01] This provider is a CAH and is not a meaningful user, does this	·	,				168. 00
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no 169.00 f this provider is a meaningful user (line 167 is "Y") and is not	(see instru	uctions)			0	00169.00

Health Financial Systems	OAKLAWN PSYCHLATRIC	CENTER, INC.	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-4031 Period: Worksheet				
			From 07/01/2019		
			To 06/30/2020	Date/Time Pre	pared:
				11/17/2020 3:	20 pm_
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170. 00
			1.00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in				0	171.00
section 1876 Medicare cost plans reporte	ed 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, e	nter the number of section	on		
1876 Medicare days in column 2. (see ins	structions)				

OSPI T	Financial Systems OAKLAWN PSYCHIATRI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-4031	Peri od: From 07/01/2019	Worksheet S- Part II	2
				To 06/30/2020		epared : 20 pm
		<u> </u>		Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO r	esponses. En	1.00 ter all dates in	2.00 the	
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in c	column 2. (see	rnstruction Y/N	S) Date	V/I	
			1.00	2. 00	3. 00	
.00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid	offices, drug Her or its	Y			3.
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and othe relationships? (see instructions)					
			Y/N 1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports			2.00	3.00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	for Compiled,	Y	A		4.
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		Y			5.
	•		•	Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider	is N		6.
00 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d during the	N N		7. 8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		n N		9.
0. 00 1. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N N		10.
	Teaching Program on Worksheet A? If yes, see instructions.					1
					Y/N 1.00	+
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12.
1. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	f yes, see i	nstructi ons.	N	14.
5. 00	Did total beds available change from the prior cost reporti				N	15.
		Y/N	t A Date	Par Y/N	rt B Date	
		1. 00	2.00	3. 00	4. 00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	09/14/2020) Y	09/14/2020	16.
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17.
. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.
9. 00	III TINE TO ULTITIS YES, WELL AUTUSTINETITS MAUE TO FORK					

Heal th	Financial Systems OAKLAWN PSYCHIATE	RIC CENTER, INC	3.	In Lie	u of Form CMS-	2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-4031	Peri od: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Pre 11/17/2020 3:	epared:	
			iption	Y/N	Y/N		
00.71	1011 44 47 1		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 (EXC	EPT CHILDRENS	HOSPI TALS)		1.00		
	Capital Related Cost		,			1	
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions	3		N	22. 00	
23.00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ring the cost	N	23.00	
	reporting period? If yes, see instructions.						
24. 00	Were new leases and/or amendments to existing leases enter	ed into during	, this cost r	eporting period?	Υ	24.00	
05.00	If yes, see instructions		05.05				
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	orting period	r гт yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost ropert	ing period?	If was soo	N	26.00	
20.00	instructions.	IN	20.00				
27. 00	Has the provider's capitalization policy changed during th	e cost reporti	na period? I	f ves. submit	N	27.00	
	copy.	'	3 1				
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or Letters of credit e	N	28. 00				
	period? If yes, see instructions.						
29. 00	Did the provider have a funded depreciation account and/or	N	29. 00				
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	N	30.00				
30.00	instructions.	IN	30.00				
31.00							
	instructions.						
	Purchased Services						
32.00	Have changes or new agreements occurred in patient care se		ned through c	ontractual	N	32.00	
00.00	arrangements with suppliers of services? If yes, see instr					00.00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	piled pertaini	ng to compet	itive blading? It		33.00	
	no, see instructions. Provider-Based Physicians					+	
34.00		rrangement wit	h provider-b	ased physicians?	Υ	34.00	
0 11 00	If yes, see instructions.	angomone in t	p. ov. do. D	acca prigor or ano.		011.00	
35.00	If line 34 is yes, were there new agreements or amended ex	isting agreeme	ents with the	provi der-based	Υ	35.00	
	physicians during the cost reporting period? If yes, see i	nstructions.					
				Y/N	Date		
	lu 0CC 0 . I			1.00	2. 00		
26.00	Home Office Costs Were home office costs claimed on the cost report?			NI		24 00	
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	renared by the	homo office	N		36. 00 37. 00	
37.00	If yes, see instructions.	repared by the	: Home Office	•		37.00	
38. 00	If line 36 is yes , was the fiscal year end of the home of	fice different	from that o	f		38.00	
55. 55	the provider? If yes, enter in column 2 the fiscal year en					55.55	
39.00				s,		39.00	
	see instructions.	•	,				
40.00	If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00	
	i nstructi ons.						
		1	. 00	2	00		
	Cost Report Preparer Contact Information	1.	. 00	Ζ.	00		
41.00	Enter the first name, last name and the title/position	MI CHAEL		ALESSANDRI NI		41.00	
00	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
42.00	Enter the employer/company name of the cost report	BLUE & CO., LI	LC			42.00	
	preparer.						
43. 00	<u>'</u>	317. 713. 7959		MALESSANDRI NI @	BLUEANDCO. COM	43.00	
	report preparer in columns 1 and 2, respectively.	1		I		II	

Health Financial Systems OAKLAWN PSYC	ATRIC CENTER, INC. In Lieu of Form CMS-255	52-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	Provider CCN: 15-4031 Period: Worksheet S-2	
	From 07/01/2019 Part II To 06/30/2020 Date/Time Prepai 11/17/2020 3:20	red: _pm
	3. 00	
Cost Report Preparer Contact Information		
41.00 Enter the first name, last name and the title/position	=:::==:::::::::::::::::::::::::::::::::	1.00
held by the cost report preparer in columns 1, 2, and	ı	
respecti vel y.		
42.00 Enter the employer/company name of the cost report	4	2.00
preparer.		
43.00 Enter the telephone number and email address of the c	t 4	3.00
report preparer in columns 1 and 2, respectively.		

Heal th Financial SystemsOAKLAWN PSYCHIATRIC CENTER, INC.HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider CCI Provi der CCN: 15-4031

						То	06/30/2020	Date/Time Pre 11/17/2020 3:		
	·							1/P Days /	Ť	рш
								0/P Vi si ts /		
								Trips		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V		
		Line Number			Avai I abl e					
		1. 00		2. 00	3. 00		4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		16	5, 85	6	0. 00	0	1	1. 00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days) (see instructions for col. 2									
2 00	for the portion of LDP room available beds)									2. 00
2. 00 3. 00	HMO and other (see instructions) 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			16	5, 85		0. 00	0		7. 00
7.00	beds) (see instructions)			10	3,00	,0	0.00	0		7.00
8. 00	INTENSIVE CARE UNIT									8. 00
9. 00	CORONARY CARE UNIT									9. 00
10.00	BURN INTENSIVE CARE UNIT									0.00
11. 00	SURGICAL INTENSIVE CARE UNIT		İ						1	1.00
12.00	OTHER SPECIAL CARE (SPECIFY)								1	2.00
13.00	NURSERY								1	3.00
14.00	Total (see instructions)			16	5, 85	6	0. 00	0	1	4.00
15.00	CAH visits							0	1	5.00
16.00	SUBPROVI DER - I PF								1	6.00
17. 00	SUBPROVI DER - I RF								1	7.00
18. 00	SUBPROVI DER									8.00
19. 00	SKILLED NURSING FACILITY									9.00
20. 00	NURSING FACILITY									20.00
21. 00	OTHER LONG TERM CARE									21. 00
22. 00										22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)									23. 00
24.00										24.00
24. 10	HOSPICE (non-distinct part)	30. 00								24. 10
25. 00	CMHC - CMHC									25.00
26. 00	RURAL HEALTH CLINIC	00.00						0		26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		16				0		26. 25 27. 00
27. 00 28. 00	Total (sum of lines 14-26)			10				0		27.00
29. 00	Observation Bed Days Ambulance Trips							U		29. 00
30.00	Employee discount days (see instruction)									30.00
31. 00	Employee discount days (see Histi detroit)									31. 00
32. 00	Labor & delivery days (see instructions)			0		0				32. 00
32. 00	Total ancillary labor & delivery room			O		٦				32. 01
02.01	outpatient days (see instructions)								١	
33.00	LTCH non-covered days								3	33.00
	LTCH site neutral days and discharges								3	33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-4031

Peri od: Worksheet S-3 From 07/01/2019 Part I To 06/30/2020 Date/Time Prepared:

11/17/2020 3:20 pm I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Total All Component Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 4, 476 Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 1,088 675 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 458 2.00 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 0 4.00 4 00 0 5.00 Hospital Adults & Peds. Swing Bed SNF 0 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 1,088 675 4, 476 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8 00 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) 1,088 675 4, 476 0.00 816.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 0 24.10 25.00 CMHC - CMHC 25.00 RURAL HEALTH CLINIC 26.00 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26. 25 0 0 0 0.00 26.25 Total (sum of lines 14-26) 0.00 816.00 27 00 27 00 Observation Bed Days 0 28.00 0 28.00 29.00 Ambul ance Trips 29.00 Employee discount days (see instruction) 30.00 30.00 Employee discount days - IRF 0 31 00 31.00 Labor & delivery days (see instructions) 0 32.00 0 0 32.00 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

 Heal th Financial
 Systems
 OAKLAWN PSYCHIATRIC
 CENTER, INC.

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCI
 In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 07/01/2019 | Part I | To 06/30/2020 | Date/Time Prepared: Provider CCN: 15-4031

				10	06/30/2020	11/17/2020 3:	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	40.00	11.00	Pati ents	
1 00	Hamital Adulta & Dada (asluma E. (7 and	11. 00	12. 00	13.00	14.00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	89	72	542	1.00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			o	64		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						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	89	72	542	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18. 00 19. 00
19. 00 20. 00	SKILLED NURSING FACILITY 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	HOSPI CE						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	Ambul ance Tri ps						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						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01

Health Financial Systems	TAWAL DOVOULATEL	CENTED INC		la li o	u of Form CMC	DEE2 10
Health Financial Systems OAK RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	<u>(LAWN_PSYCHLATRI)</u> OF EXPENSES	Provi der CO	CN: 15-4031	Peri od:	u of Form CMS-2 Worksheet A	2552-10
				From 07/01/2019 To 06/30/2020	Date/Time Pre	
					11/17/2020 3:	20 pm
Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
			+ col. 2)	i ons (See	Tri al Bal ance	
				A-6)	(col. 3 +-	
	1.00	2.00	3. 00	4. 00	<u>col. 4)</u> 5. 00	
GENERAL SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT		1		1, 448, 044	1, 448, 045	1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	521, 592	345, 232	866, 82		866, 824	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	4, 209, 440	6, 817, 803			10, 530, 850	
7. 00 00700 OPERATION OF PLANT	666, 895	1, 790, 876			1, 934, 817	7.00
10. 00 01000 DI ETARY	123, 808	163, 356			282, 857	10.00
11. 00 01100 CAFETERI A	120,000	0		0 4, 307	4, 307	11.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	491, 326	161, 272			652, 598	
INPATIENT ROUTINE SERVICE COST CENTERS	,	,	332,33	-1		1
30. 00 03000 ADULTS & PEDIATRICS	1, 866, 269	685, 836	2, 552, 10	5 0	2, 552, 105	30.00
ANCILLARY SERVICE COST CENTERS		· ·				
60. 00 06000 LABORATORY	10, 826	89, 110	99, 93	6 0	99, 936	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2	269, 541	269, 54	3 0	269, 543	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	13, 758, 921	3, 863, 020	17, 621, 94	1 -6, 114, 481	11, 507, 460	90.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	21, 649, 079	14, 186, 047	35, 835, 12	6 -5, 685, 784	30, 149, 342	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 00
192.01 19201 CHILD & ADOLESCENT RESIDENTIAL	10, 858, 921	5, 779, 627				
192. 02 19202 ADULT RESIDENTIAL	2, 712, 611	1, 424, 498		· ·	4, 075, 732	
192. 03 19203 CONTRACTED SERVI CES	432, 751	144, 399			577, 150	
192. 04 19204 THI RD PARTY OCCUPI ED SPACE	0	0		0 0		192.04
192. 05 19205 MR0	451 010	104 710		0 6, 114, 481		
192. 06 19206 TRANSITION SERVICES	451, 812	134, 713			586, 525	
200.00 TOTAL (SUM OF LINES 118 through 199)	36, 105, 174	21, 669, 284	57, 774, 45	8 0	57, 774, 458	J200.00

Health FinancialSystemsOAKLAWN PSYCHIRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-4031

Peri od: Worksheet A From 07/01/2019

Date/Time Prepared:

			То	Date/Time Prepared: 11/17/2020 3:20 pm
Cost Center Description	Adjustments	Net Expenses		117 177 2020 0. 20 piii
	(See A-8)	For		
	,	Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT	-266, 464	1, 181, 581		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	866, 824		4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-1, 390, 308			5. 00
7.00 00700 OPERATION OF PLANT	-146, 816			7.00
10. 00 01000 DI ETARY	-1, 860			10.00
11. 00 01100 CAFETERI A	-2, 592			11.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-507	652, 091		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	-385, 446	2, 166, 659		30.00
ANCILLARY SERVICE COST CENTERS	_			
60. 00 06000 LABORATORY	0	99, 936		60.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	269, 543		73.00
OUTPATIENT SERVICE COST CENTERS	0.070.70/	7 (00 (7)		
90. 00 09000 CLINIC	-3, 873, 786	7, 633, 674		90.00
SPECIAL PURPOSE COST CENTERS	/ 0/7 770	04 004 540		110.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	-6, 067, 779	24, 081, 563		118. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		192.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 192. 01 19201 CHILD & ADOLESCENT RESIDENTIAL	0	0		192.00
192. 02 19201 CHILD & ADOLESCENT RESTDENTIAL 192. 02 19202 ADULT RESTDENTIAL	0	16, 271, 228 4, 075, 732		192. 01
192. 03 19203 CONTRACTED SERVICES	0	577, 150		192. 02
192. 04 19204 THI RD PARTY OCCUPIED SPACE	0	377, 130		192.03
192. 05 19205 MRO		6, 114, 481		192.04
192. 06 19206 TRANSITION SERVICES	0	586, 525		192.06
200. 00 TOTAL (SUM OF LINES 118 through 199)	-6, 067, 779			200. 00
200.00 TOTAL (30m of Lines 110 till dugit 177)	0,007,777	31,700,079		₁ 200.00

Health Financial Systems	OAKLAWN PSYCHIATRIC CENTER, INC.	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN:	15-4031 Peri od: Worksheet A-6
		To 06/30/2020 Date/Time Prepared:
	Increases	11/17/2020 3: 20 pm

						11/17/2020 3	: 20 pm
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3. 00	4. 00	5. 00			
	A - CAFETERIA EXPENSES						
1.00	CAFETERI A	11. 00	1, 857	2, 450			1.00
	0		1, 857	2, 450			
	B - MRO EXPENSE						
1.00	MRO	192. 05	4, 774, 086	1, 340, 395			1.00
	0		4, 774, 086	1, 340, 395			
	C - CAPITAL RECLASS						
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	1, 448, 044			1.00
	FI XT						
2.00		0.00	0	0			2.00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4.00
	0		0	1, 448, 044			
500.00	Grand Total: Increases		4, 775, 943	2, 790, 889			500.00

Heal th Financial Systems OAKLAWN PSYCHIATRIC CENTER, INC. In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-4031 Period: From 07/01/2019

Decreases	ared: !O pm_
6. 00 7. 00 8. 00 9. 00 10. 00 A - CAFETERIA EXPENSES 1. 00 DI ETARY 10. 00 1, 857 2, 450 0 B - MRO EXPENSE	
A - CAFETERIA EXPENSES 1. 00 DI ETARY 10. 00 1, 857 2, 450 0 B - MRO EXPENSE	
1. 00 DI ETARY 0 10. 00 1, 857 2, 450 0 0 0 0 1, 857 2, 450 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
0 1,857 2,450 B - MRO EXPENSE	
B - MRO EXPENSE	1.00
1 OD TOLINIC	
1.00 [CLINIC	1.00
0 4, 774, 086 1, 340, 395	
C - CAPITAL RECLASS	
1.00 ADMINISTRATIVE & GENERAL 5.00 0 496,393 9	1.00
2. 00 OPERATION OF PLANT 7. 00 0 522, 954 0	2.00
3. 00 CHILD & ADOLESCENT 192. 01 0 367, 320 0	3.00
RESI DENTI AL	
4. 00 ADULT RESIDENTIAL 192. 02 192. 02 0 61, 377 0	4.00
0 0 1, 448, 044	
500.00 Grand Total: Decreases 4,775,943 2,790,889 50	500.00

8.00

9.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-4031 Peri od: Worksheet A-7 From 07/01/2019 Part I Date/Time Prepared: 06/30/2020 11/17/2020 3:20 pm Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 855, 638 1.00 Land 0 0 1, 409, 100 2.00 Land Improvements 51, 653 51, 653 Ω 2.00 3.00 6, 499 6, 499 3.00 Buildings and Fixtures 12, 110, 160 0 0 4.00 Building Improvements 6, 128, 469 101, 686 101, 686 0 4.00 Fi xed Equi pment 4, 600, 817 0 5.00 53, 283 53, 283 0 5.00 0 6.00 Movable Equipment 7, 463, 097 192, 368 6.00 0 0 7.00 HIT designated Assets 0 0 7.00 8.00 Subtotal (sum of lines 1-7) 32, 567, 281 213, 121 0 213, 121 192, 368 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 32, 567, 281 192, <u>368</u> 213, 121 213, 121 10.00 0 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 855, 638 0 1.00 2.00 0 2.00 Land Improvements 1, 460, 753 12, 116, 659 3.00 Buildings and Fixtures 0 3.00 6, 230, 155 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 4, 654, 100 0 5.00 Movable Equipment 0 6.00 7, 270, 729 6.00 HIT designated Assets 0 7.00 7.00

32, 588, 034

32, 588, 034

0

0

0

Heal th	Financial Systems OAM	KLAWN PSYCHLATR	IC CENTER, INC	•	In Lieu of Form CMS-2552			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-4031	Peri od: From 07/01/2019 To 06/30/2020		pared:	
			Sl	JMMARY OF CAP	I TAL			
	Cost Center Description	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	NEW CAP REL COSTS-BLDG & FLXT	1	0		0	0	1.00	
3.00	Total (sum of lines 1-2)	1	0		0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1		-		1.00	
3.00	Total (sum of lines 1-2)	0	1				3.00	
		•	•	•			•	

Heal th	Financial Systems OAF	KLAWN PSYCHLATR	IC CENTER, INC		In Lie	u of Form CMS-2	2552-10	
RECONCI	LIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 07/01/2019	Worksheet A-7		
					To 06/30/2020		nared.	
						11/17/2020 3:		
		COME	PUTATION OF RAT	ALLOCATION OF	OTHER CAPITAL			
					5 11 6			
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
			Leases	for Ratio	instructions)			
				(col . 1 -				
		1. 00	2.00	col. 2) 3.00	4. 00	5. 00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS								
	NEW CAP REL COSTS-BLDG & FLXT	32, 588, 034	0	32, 588, 03	1. 000000	0	1.00	
	Total (sum of lines 1-2)	32, 588, 034	l .				3. 00	
0.00	(TION OF OTHER (F CAPITAL	0.00	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
			Capi tal -Rel at	cols. 5				
			ed Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C		i					
	NEW CAP REL COSTS-BLDG & FLXT	0	1		1, 448, 045		1. 00	
3. 00	Total (sum of lines 1-2)	0	ľ	(1, 448, 045	0	3. 00	
			St	JMMARY OF CAPI	IAL			
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)		
	cost center bescription	Titterest	(see		Capi tal -Rel at			
			instructions)	Instructions)	ed Costs (see			
			This tructrons)		instructions)	7 till ough 14)		
		11. 00	12. 00	13.00	14. 00	15. 00		
F	PART III - RECONCILIATION OF CAPITAL COSTS C							
	NEW CAP REL COSTS-BLDG & FLXT	-266, 464	0		0	1, 181, 581	1.00	
3. 00	Total (sum of lines 1-2)	-266, 464	0		0	1, 181, 581	3.00	
		•	•		,			

ADJUST	MENTS TO EXPENSES				Peri od: From 07/01/2019	Worksheet A-8	
					To 06/30/2020	Date/Time Pre 11/17/2020 3:	pared:
				Expense Classification o			20 piii
			T	o/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	oost conter bescription	(2)				Ref.	
1. 00	Investment income - NEW CAP	1. 00	2. 00	3.00 EW CAP REL COSTS-BLDG &	4. 00	5. 00 0	1.00
1.00	REL COSTS-BLDG & FLXT (chapter			IXT	1.00		1.00
2. 00	2) Investment income - CAP REL		0 *	** Cost Center Deleted ***	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
3. 00	Investment income - other (chapter 2)		O		0.00	0	3. 00
4. 00	Trade, quantity, and time	В	OAI	DMINISTRATIVE & GENERAL	5. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		О		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)						
7. 00	Tel ephone servi ces (pay stati ons excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	
10. 00	Provi der-based physician adjustment	A-8-2	-3, 709, 031			0	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	О			0	12.00
12 00	transactions (chapter 10) Laundry and Linen service				0.00	0	13. 00
13. 00 14. 00	Cafeteria-employees and guests	В	-2, 592 C	AFETERI A	11. 00		14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		О		0.00	0	16.00
	supplies to other than patients						
17. 00	Sale of drugs to other than		О		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	- 507 M	EDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts						40.00
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines	В	-1, 860 D	LETADV	10. 00	0	20.00
21. 00	Income from imposition of	Ь	- 1, 800 D	ILIANI	0.00		21.00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0 *	** Cost Center Deleted ***	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0 *	** Cost Center Deleted ***	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0 *	** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT			EW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	Depreciation - CAP REL		l'	** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0 *	** Cost Center Deleted ***	19. 00		28. 00
29.00	Physicians' assistant	A-8-3	0	** Cost Center Deleted ***	0.00		29. 00 30. 00
30. 00	therapy costs in excess of	H-0-3		cost center beleted ~~~	67. 00		30.00
30 00	limitation (chapter 14) Hospice (non-distinct) (see		0 41	DULTS & PEDIATRICS	30.00		30. 99
50. 77	instructions)			DOLIO & LEDIMINIOS	30.00		30. 77

Heal th	Financial Systems	OAKLAWN PSYCHIATRIC CENTER, INC.			In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 07/01/2019 o 06/30/2020	Date/Time Pre	paradi	
					0 00/30/2020	11/17/2020 3:		
				Expense Classification on	Worksheet A	,		
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
	·	(2)				Ref.		
		1. 00	2. 00	3. 00	4. 00	5. 00		
31.00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31.00	
	pathology costs in excess of							
	limitation (chapter 14)				0.00			
32. 00	CAH HIT Adjustment for		0		0. 00	0	32.00	
22 00	Depreciation and Interest MISCELLANEOUS REVENUE	В	1 150	ADMINISTRATIVE & GENERAL	5. 00	0	33.00	
	MI SCELLANEOUS REVENUE	В		OPERATION OF PLANT	7. 00	0	36.00	
	MI SCELLANEOUS REVENUE	В	-94, 982	l e e e e e e e e e e e e e e e e e e e	90.00	0	38.00	
38. 01	RENTAL INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	38. 01	
	RENTAL I NCOME	В		OPERATION OF PLANT	7. 00	0	39.00	
40. 01	CONTRACT REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	40. 01	
41.00	CONTRACT REV	В	-452, 071	CLINIC	90.00	0	41.00	
42.00	INTEREST INCOME	В	-266, 464	NEW CAP REL COSTS-BLDG &	1. 00	11	42.00	
				FLXT				
43.00	COMMUNITY HOMES EXPENSE	A	-5, 040	CLINIC	90. 00	0	43.00	

-6, 067, 779

-1, 250, 745 ADMINISTRATIVE & GENERAL

-2, 381 ADMINISTRATIVE & GENERAL

-100, 866 ADMINISTRATIVE & GENERAL

5.00

5.00

5.00

44.00

45.00

46.00

50.00

Α

Α

Α

COMMUNITY HOMES EXPENSE HOSPITAL ASSESSMENT FEE OFFSET

TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,

LOBBYING RELATED DUES

FUND RAISING EXPENSE

column 6, line 200.)

44.00

45.00

46.00

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.

| Period: | Worksheet A-8-2 | From 07/01/2019 | To 06/30/2020 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-4031

					1	To 06/30/2020	Date/Time Pro 11/17/2020 3:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	3, 200	0	3, 200	181, 300	15	1.00
2.00	30.00	ADULTS & PEDIATRICS	489, 083	328, 551	160, 532	181, 300	1, 189	2.00
3.00	90. 00	CLINIC	5, 194, 313	2, 353, 844	2, 840, 469	181, 300	21, 484	3.00
4.00	0. 00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	1
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	
200.00	0.00		5, 686, 596	2, 682, 395	3, 004, 201	Ĭ	22, 688	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
			2	Li mi t	Continuing	Share of col.	Insurance	
				2	Education	12	11104141100	
	1. 00	2.00	8. 00	9, 00	12. 00	13. 00	14. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	1, 308	65	0	0	0	1.00
2.00	30. 00	ADULTS & PEDIATRICS	103, 637		0	0	0	2.00
3.00	90. 00	CLINIC	1, 872, 620	93, 631	0	0	0	3.00
4.00	0. 00		0	0	0	0	0	4.00
5.00	0. 00		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	1
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			1, 977, 565	98, 878	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0	,	·			1.00
2.00		ADULTS & PEDIATRICS	0					2.00
3.00		CLINIC	0	1, 872, 620	967, 849	3, 321, 693		3. 00
4.00	0. 00		0	0	0	0		4.00
5. 00	0. 00		0	0	0	0		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	1, 977, 565	1, 026, 636	3, 709, 031		200.00

COST ALLOCATION - GENERAL SERVICE COSTS	Heal th	Financial Systems OAk	KLAWN PSYCHLATR	IC CENTER, INC		In Lie	u of Form CMS-2	2552-10
CAPITAL RELATED COSTS NEW BLDG & FIXT SUBSTITUTIVE & GENERAL SERVICE COST CENTERS NEW BLDG & FIXT BENEFITS DEPARTMENT E & GENERAL SERVICE COST CENTERS SUBSTITUTIVE & SERVICE SUBSTITUTIVE & SERVICE COST CENTERS SUBSTITUTIVE & SERVICE SUBSTITUTIVE & SERVICE SUBSTITUTIVE & SERVICE SUBSTITUTIVE & SERVICE SUBSTITUTIVE & SERVICE SUBSTITUTIVE & SERVICE SUBSTITUTIVE	COST AI	LLOCATION - GENERAL SERVICE COSTS		Provi der CO				
CAPITAL RELATED COSTS NEW BLDG & FLAT FLAT E. & GENERAL FLAT COSTS FLAT COSTS NEW BLDG & BENEFITS DEPARTMENT E. & GENERAL E. & GEN								
CAPITAL RELATED COSTS Net Expenses For Cost All location (From West A col . 7) Cost Center Description Net Expenses For Cost New BLDG & FIXT BENEFITS DEPARTMENT E & GENERAL E & GENER						To 06/30/2020		
Cost Center Description				CADLTAL			11/1//2020 3:	20 pm
Cost Center Description								
GENERAL SERVICE COST CENTERS CONTON COST CENTERS CONTON COST CENTERS		Cook Cooker Doored at lon	Not Formand		EMDLOVEE	C	ADMINI CTDATIV	
Al location (From Wkst A col - 7)		Cost Center Description				Subtotal		
CFrom Wkst A Col. 77 Tol. 100 Col. 75				FIXI			E & GENERAL	
COL 7 O					DEPARTMENT			
Control Cont			•					
Control Cont				1 00	4.00	4.0	F 00	_
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1, 181, 581 1, 181, 581 0 866, 824 0 864, 824 0 8		CENEDAL SEDVICE COST CENTEDS	0	1.00	4.00	4A	3.00	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 866, 824 0 866, 824 9, 528, 322 9, 528, 322 5. 00 00500 ADMI NI STRATI VE & GENERAL 9, 140, 542 285, 238 102, 542 9, 528, 322 9, 528, 322 5. 00 00700 OPERATI ON OF PLANT 1, 788, 801 210, 163 16, 246 2, 014, 410 455, 065 7. 00 10, 00 00 DI ETARY 280, 997 42, 183 2, 971 326, 151 73, 679 10. 00 10 00 00 00 00 00			1 101 501	1 101 501				1 00
5.00 00500 ADMINISTRATIVE & GENERAL 9, 140, 542 285, 238 102, 542 9, 528, 322 9, 528, 322 7.00 7.00 00700 OPERATION OF PLANT 1, 788, 001 210, 163 16, 246 2, 014, 410 455, 065 7.00 10.00 01000 DIETARY 280, 997 42, 183 2, 971 326, 151 73, 679 10.00 10.00 01000 CAFETERIA 1, 715 642 45 2, 402 543 11.00 11.00 01100 CAFETERIA 1, 715 642 45 2, 402 543 11.00 11.00 01600 MEDI CAL RECORDS & LIBRARY 652, 091 15, 497 11, 969 679, 557 153, 515 16.00 INPATI ENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRICS 2, 166, 659 61, 826 45, 462 2, 273, 947 513, 696 40.00					044 02	4		
7. 00 00700 OPERATION OF PLANT 1,788,001 210,163 16,246 2,014,410 455,065 7. 00 10.00 10 10 10 10 10	1						0 520 222	
10.00 01000 DI ETARY 280,997 42,183 2,971 326,151 73,679 10.00 11.00 CAFETERI A 1,715 642 45 2,402 543 11.00 10.00 10.00 MEDI CAL RECORDS & LI BRARY 652,091 15,497 11,969 679,557 153,515 16.00 10.00 MEDI CAL RECORDS & LI BRARY 652,091 15,497 11,969 679,557 153,515 16.00 10.00 1								1
11. 00								
16. 00 01600 MEDI CAL RECORDS & LI BRARY 652, 091 15, 497 11, 969 679, 557 153, 515 16. 00 1NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 2, 166, 659 61, 826 45, 462 2, 273, 947 513, 696 30. 00 ANCI LLARY SERVI CE COST CENTERS 60. 00 06000 LABORATORY 99, 936 143 264 100, 343 22, 668 60. 00 07300 DRUGS CHARGED TO PATI ENTS 269, 543 1, 721 0 271, 264 61, 280 73. 00 00 000 CLI NI C SPECI AL PURPOSE COST CENTERS 90. 00 09000 CLI NI C 97, 633, 674 296, 641 218, 871 8, 149, 186 1, 840, 942 90. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 24, 081, 563 914, 054 398, 370 23, 345, 582 3, 121, 388 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 032 0 1, 032 233 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 264, 530 16, 535, 758 3, 735, 531 192. 01 19201 CHI LD & ADOLESCENT RESI DENTI AL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 02 19202 ADULT RESI DENTI AL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 02 192. 03 19203 CONTRACTED SERVI CES 577, 150 37, 945 10, 542 625, 637 141, 335 192. 03 192. 04 19204 THIR RD PARTY OCCUPI ED SPACE 0 0 0 0 0 0 0 192. 04 19204 THIR RD PARTY OCCUPI ED SPACE 0 0 0 0 0 0 0 192. 05 192. 05 19205 MRO 6, 114, 481 221, 582 116, 297 6, 452, 360 1, 457, 620 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06						· ·		
INPATI ENT ROUTI NE SERVI CE COST CENTERS 2, 166, 659 61, 826 45, 462 2, 273, 947 513, 696 30. 00 300 300 ADULTS & PEDI ATRI CS 2, 166, 659 61, 826 45, 462 2, 273, 947 513, 696 30. 00 300						· ·		
30. 00 03000 ADULTS & PEDI ATRI CS 2, 166, 659 61, 826 45, 462 2, 273, 947 513, 696 30. 00 ANCI LLARY SERVI CE COST CENTERS 99, 936 143 264 100, 343 22, 668 60. 00 07300 DRUGS CHARGED TO PATI ENTS 269, 543 1, 721 0 271, 264 61, 280 73. 00 000 DRUGS CHARGED TO PATI ENTS 269, 543 1, 721 0 271, 264 61, 280 73. 00 000 DRUGS CHARGED TO PATI ENTS 269, 543 1, 721 0 271, 264 61, 280 73. 00 271, 264 61, 280 73. 00 271, 264 61, 280 73. 00 271, 264 271, 271, 271, 271, 271, 271, 271, 271,	1		032, 041	15, 477	11, 70	7 077, 337	155, 515	10.00
ANCI LLARY SERVI CE COST CENTERS 60. 00			2 166 659	61 826	45.46	2 273 947	513 696	30.00
60. 00 06000 LABORATORY 99, 936 143 264 100, 343 22, 668 60. 00 07300 DRUGS CHARGED TO PATIENTS 269, 543 1, 721 0 271, 264 61, 280 73. 00 00 00 00 00 00 00 00			2, 100, 037	01,020	+5, +0.	2,213,741	313, 070	30.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 269, 543 1, 721 0 271, 264 61, 280 73. 00 00TPATI ENT SERVI CE COST CENTERS 90. 00 9000 CLI NI C 7, 633, 674 296, 641 218, 871 8, 149, 186 1, 840, 942 90. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 24, 081, 563 914, 054 398, 370 23, 345, 582 3, 121, 388 118. 00 NONREI MBURSABLE COST CENTERS 0 1, 032 0 1, 032 233 192. 00 192. 01 19201 CHI LD & ADOLESCENT RESI DENTI AL 16, 271, 228 0 264, 530 16, 535, 758 3, 735, 531 192. 01 192. 02 19202 ADULT RESI DENTI AL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 02 192. 03 19203 CONTRACTED SERVI CES 577, 150 37, 945 10, 542 625, 637 141, 335 192. 03 192. 04 19204 THI RD PARTY OCCUPI ED SPACE 0 0 0 0 0 192. 04 19205 MRO 6, 114, 481 221, 582 116, 297 6, 452, 360 1, 457, 620 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06 10. 00 0 0 0. 00 0 0. 00 0.			99 936	143	26	1 100 343	22 668	60.00
OUTPATI ENT SERVI CE COST CENTERS O O9000 CLI NI C SPECI AL PURPOSE COST CENTERS								
90. 00			2077010	.,,2.		27.17201	0.7200	1
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 24, 081, 563 914, 054 398, 370 23, 345, 582 3, 121, 388 118. 00 NONREI MBURSABLE COST CENTERS 0 1, 032 0 1, 032 233 192. 00 192. 01 19201 CHI LD & ADOLESCENT RESI DENTI AL 16, 271, 228 0 264, 530 16, 535, 758 3, 735, 531 192. 01 192. 02 19202 ADULT RESI DENTI AL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 02 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 03 192. 04 19204 THI RD PARTY OCCUPI ED SPACE 0 0 0 0 0 0 192. 04 192. 05 192. 05 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06 192. 06 10			7, 633, 674	296, 641	218. 87	8, 149, 186	1, 840, 942	90.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 24, 081, 563 914, 054 398, 370 23, 345, 582 3, 121, 388 118. 00 NONREI MBURSABLE COST CENTERS 0 1, 032 0 1, 032 233 192. 00 192. 01 19201 CHI LD & ADOLESCENT RESI DENTI AL 16, 271, 228 0 264, 530 16, 535, 758 3, 735, 531 192. 01 192. 02 19202 ADULT RESI DENTI AL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 02 192. 03 192.03 192.03 192.03 CONTRACTED SERVI CES 577, 150 37, 945 10, 542 625, 637 141, 335 192. 03 192. 04 192.04 192.04 192.04 192.04 192.05 192.05 192.05 192.05 192.05 192.05 180.05 192.05 192.06 192.06 17, 000 17, 000 192.06 17, 000 192.06 17, 000 192.06 17, 000 192.06 17, 000 192.06 17, 000 192.06 192.06 17, 000 192.06 192.			.,			., .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
NONRE MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 032 0 1, 032 233 192. 00 192. 01 19201 CHI LD & ADDLESCENT RESI DENTI AL 16, 271, 228 0 264, 530 16, 535, 758 3, 735, 531 192. 01 192. 02 19202 ADULT RESI DENTI AL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 03 192. 03 19203 CONTRACTED SERVI CES 577, 150 37, 455 10, 542 625, 637 141, 335 192. 04 192. 04 19204 THI RD PARTY OCCUPI ED SPACE 0 0 0 0 0 0 192. 04 192. 05 19205 MRO 6, 114, 481 221, 582 116, 297 6, 452, 360 1, 457, 620 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06			24, 081, 563	914, 054	398, 370	23, 345, 582	3, 121, 388	118.00
192. 01 19201 CHI LD & ADOLESCENT RESI DENTI AL 16, 271, 228 0 264, 530 16, 535, 758 3, 735, 531 192. 01 192. 02 19202 ADULT RESI DENTI AL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 02 192. 03 192. 03 19203 CONTRACTED SERVI CES 577, 150 37, 945 10, 542 625, 637 141, 335 192. 03 192. 04 192. 04 192. 05 19205 MRO 0 0 0 0 192. 04 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06								1
192. 01 19201 CHI LD & ADOLESCENT RESI DENTI AL 16, 271, 228 0 264, 530 16, 535, 758 3, 735, 531 192. 01 192. 02 19202 ADULT RESI DENTI AL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 02 192. 03 192. 03 19203 CONTRACTED SERVI CES 577, 150 37, 945 10, 542 625, 637 141, 335 192. 03 192. 04 192. 04 192. 05 19205 MRO 0 0 0 0 192. 04 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06	192. 00	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 032	(1, 032	233	192.00
192. 02 19202 ADULT RESIDENTIAL 4, 075, 732 6, 968 66, 079 4, 148, 779 937, 230 192. 02 192. 03 19203 CONTRACTED SERVICES 577, 150 37, 945 10, 542 625, 637 141, 335 192. 03 192. 04 19204 THI RD PARTY OCCUPIED SPACE 0 0 0 0 0 192. 04 192. 05 19205 MRO 6, 114, 481 221, 582 116, 297 6, 452, 360 1, 457, 620 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06	192. 01	19201 CHILD & ADOLESCENT RESIDENTIAL	16, 271, 228		264, 530			192. 01
192. 03 19203 CONTRACTED SERVI CES 577, 150 37, 945 10, 542 625, 637 141, 335 192. 03 192. 04 192. 04 19204 THI RD PARTY OCCUPI ED SPACE 0 0 0 0 0 192. 04 192. 05 19205 MRO 6, 114, 481 221, 582 116, 297 6, 452, 360 1, 457, 620 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06	192. 02	19202 ADULT RESIDENTIAL			66, 079			
192. 05 19205 MRO 6, 114, 481 221, 582 116, 297 6, 452, 360 1, 457, 620 192. 05 192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06	192. 03	19203 CONTRACTED SERVICES	577, 150					
192. 06 19206 TRANSI TI ON SERVI CES 586, 525 0 11, 006 597, 531 134, 985 192. 06	192. 04	19204 THIRD PARTY OCCUPIED SPACE	0	0		0	0	192. 04
	192. 05	19205 MRO	6, 114, 481	221, 582	116, 29 ⁻	6, 452, 360	1, 457, 620	192. 05
	192. 06	19206 TRANSITION SERVICES						
					,			
201.00 Negative Cost Centers 0 0 0 201.00	201.00	Negative Cost Centers		0		0	0	201.00
202.00 TOTAL (sum lines 118 through 201) 51,706,679 1,181,581 866,824 51,706,679 9,528,322 202.00	202. 00	TOTAL (sum lines 118 through 201)	51, 706, 679	1, 181, 581	866, 82	51, 706, 679	9, 528, 322	202.00

Health Financial Systems	OAKLAWN PSYCHIATRIC CENTER, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-4031	Period: Worksheet B

From 07/01/2019 Part I 06/30/2020 Date/Time Prepared: 11/17/2020 3:20 pm Cost Center Description OPERATION OF DI ETARY CAFETERI A MEDI CAL Subtotal PLANT RECORDS & LI BRARY 7. 00 10.00 11.00 24.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 2, 469, 475 7.00 10.00 01000 DI ETARY 151, 811 551, 641 10.00 2, 312 11.00 01100 CAFETERI A 5, 257 11.00 01600 MEDICAL RECORDS & LIBRARY 55, <u>7</u>71 888, 967 16.00 124 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 222, 505 551, 641 247 268, 206 3, 830, 242 30.00 ANCILLARY SERVICE COST CENTERS 60 00 60 00 06000 LABORATORY 516 0 7, 747 131, 274 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 192 0 0 45, 632 384, 368 73.00 OUTPATIENT SERVICE COST CENTERS 1, 589, 590 567, 382 12, 148, 235 90.00 09000 CLI NI C 0 90.00 1, 135 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 028, 697 551, 641 1, 506 888, 967 16, 494, 119 118. 00 NONREI MBURSABLE COST CENTERS

192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 096 192. 00 3, 715 116 192. 01 19201 CHILD & ADOLESCENT RESIDENTIAL 2, 145 20, 273, 434 192. 01 192. 02 19202 ADULT RESIDENTIAL 25, 078 0 5, 111, 651 192. 02 0 564 903, 607 192. 03 192. 03 19203 CONTRACTED SERVICES 0 136, 558 0 77 192. 04 19204 THIRD PARTY OCCUPIED SPACE 0 Ω 0 0 192.04 192. 05 19205 MRO 275, 427 0 849 0 8, 186, 256 192. 05 192.06 19206 TRANSITION SERVICES 732, 516 192. 06 0 0 0 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 2, 469, 475 551, 641 5, 257 888, 967 51, 706, 679 202. 00

Health Financial Systems	OAKLAWN PSYCHIATRIC CENTER, INC.	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-4031	Period: Worksheet B From 07/01/2019 Part I

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-4031	Worksheet B Part I Date/Time Prepar 11/17/2020 3:20	ed:
Cost Center Description	Intern &	Total			
	Resi dents				
	Cost & Post				
	Stepdown				
	Adjustments				
	25. 00	26. 00			
GENERAL SERVICE COST CENTERS					
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT					1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7. 00
10. 00 01000 DI ETARY					0. 00
11. 00 01100 CAFETERI A					1. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY				16	6. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	0	3, 830, 242		30	0. 00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	0	131, 274			0. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	384, 368		73	3.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	12, 148, 235		90	0. 00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	16, 494, 119		118	8. 00
NONREI MBURSABLE COST CENTERS					
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	5, 096			2. 00
192. 01 19201 CHILD & ADOLESCENT RESIDENTIAL	0	20, 273, 434			2. 01
192. 02 19202 ADULT RESIDENTI AL	0	5, 111, 651			2. 02
192. 03 19203 CONTRACTED SERVICES	0	903, 607			2. 03
192.04 19204 THIRD PARTY OCCUPIED SPACE	0	0			2. 04
192. 05 19205 MRO	0	8, 186, 256			2. 05
192. 06 19206 TRANSITION SERVICES	0	732, 516			2. 06
200.00 Cross Foot Adjustments	0	0			0. 00
201.00 Negative Cost Centers	0	0			1. 00
202.00 TOTAL (sum lines 118 through 201)	0	51, 706, 679		202	2. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-4031 Peri od: Worksheet B From 07/01/2019 Part II 06/30/2020 Date/Time Prepared: 11/17/2020 3:20 pm CAPI TAL RELATED COSTS **EMPLOYEE** ADMI NI STRATI V Cost Center Description Di rectly NEW BLDG & Subtotal FLXT E & GENERAL Assigned New BENEFLTS DEPARTMENT Capi tal Related Costs 1.00 2A 4.00 5.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 1, 010 00400 EMPLOYEE BENEFITS DEPARTMENT 1,010 1,010 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5, 663 285, 238 290, 901 118 291, 019 5.00 00700 OPERATION OF PLANT 134, 395 344, 558 19 13, 899 7.00 7.00 210, 163 01000 DI ETARY 2, 250 10.00 0 42, 183 42, 183 3 10.00 11.00 01100 CAFETERI A 0 642 642 0 17 11.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 15, 497 15, 497 4, 689 16.00 14 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 100 61,826 63, 926 52 15, 690 30.00 ANCILLARY SERVICE COST CENTERS 60.00 06000 LABORATORY 0 143 143 0 60.00 692 07300 DRUGS CHARGED TO PATIENTS 73.00 0 1, 721 1, 721 0 1, 872 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 63 296, 641 296, 704 252 56, 229 90.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 143, 231 914, 054 1, 057, 285 458 95, 338 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 1,032 1,032 7 192.00 192. 01 19201 CHILD & ADOLESCENT RESIDENTIAL 23, 918 23, 918 114, 086 192. 01 317 192. 02 19202 ADULT RESIDENTIAL 28, 627 192. 02 1, 312 6,968 8, 280 76 192. 03 19203 CONTRACTED SERVICES 6, 756 37, 945 44, 701 12 4, 317 192. 03 192. 04 19204 THIRD PARTY OCCUPIED SPACE 0 0 0 0 192.04 44, 521 192. 05 192. 05 19205 MRO 0 221, 582 221, 582 134 192.06 19206 TRANSITION SERVICES 0 0 13 4, 123 192. 06 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201.00 0

175, 217

1, 181, 581

1, 356, 798

1,010

291, 019 202. 00

202.00

TOTAL (sum lines 118 through 201)

ALLOCATI	ION OF CAPITAL RELATED COSTS		Provi der CC		Peri od: From 07/01/2019 To 06/30/2020	11/17/2020 3:	
	Cost Center Description	OPERATION OF PLANT	DI ETARY	CAFETERI A	MEDI CAL RECORDS & LI BRARY	Subtotal	
		7. 00	10. 00	11. 00	16.00	24. 00	
	ENERAL SERVICE COST CENTERS						
	0100 NEW CAP REL COSTS-BLDG & FIXT					1	1.00
	0400 EMPLOYEE BENEFITS DEPARTMENT					i	4. 00
	0500 ADMINISTRATIVE & GENERAL					1	5. 00
	0700 OPERATION OF PLANT	358, 476				i	7. 00
	1000 DI ETARY	22, 037	66, 473			1	10.00
	1100 CAFETERI A	336	0	99		1	11.00
	1600 MEDI CAL RECORDS & LI BRARY	8, 096	0		28, 319		16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	00.000				107.000	
	3000 ADULTS & PEDIATRICS	32, 299	66, 473		8, 543	187, 030	30.00
	NCILLARY SERVICE COST CENTERS	7.5	ما		0 247	1 157	/
	6000 LABORATORY	75	0		0 247 0 1 453	1, 157	1
	17300 DRUGS CHARGED TO PATIENTS UTPATIENT SERVICE COST CENTERS	899	U		0 1, 453	5, 945	73. 00
	19000 CLINIC	230, 750	ol	21	5 18, 076	402.224	90.00
	PECIAL PURPOSE COST CENTERS	230, 750	U _I		5 18,076	602, 226	90.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	294, 492	66, 473	28	28, 319	796, 358	110 00
_	ONREIMBURSABLE COST CENTERS	294, 492	00, 473		20, 319	190, 336	1110.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	539	0		22 0	1 600	192. 00
	9201 CHILD & ADOLESCENT RESIDENTIAL	0	0	40		138, 726	
	9202 ADULT RESIDENTIAL	3, 640	0	10			192. 02
	9203 CONTRACTED SERVICES	19, 823	0		5 0		192. 03
	9204 THIRD PARTY OCCUPIED SPACE	17, 020	0		0 0		192.04
	9205 MRO	39, 982	0	16		306, 380	
	9206 TRANSITION SERVICES	0,7,752	0		0 0		192.06
200.00	Cross Foot Adjustments		Ĭ				200.00
201. 00	Negative Cost Centers	l	o		ol ol		201.00
202.00	TOTAL (sum lines 118 through 201)	358, 476	66, 473	99	28, 319		
		•			•		•

ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	N: 15-4031	Peri od: From 07/01/2019 To 06/30/2020	Worksheet B Part II Date/Time Prepared: 11/17/2020 3:20 pm
Cost Center Description	Intern &	Total			
	Residents				
	Cost & Post				
	Stepdown				
	Adjustments 25.00	26. 00			
GENERAL SERVICE COST CENTERS	25.00	20.00			
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMINISTRATIVE & GENERAL					5. 00
7.00 00700 OPERATION OF PLANT					7.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	0	187, 030			30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	0	1, 157			60.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	5, 945			73. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	602, 226			90.00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	796, 358			118. 00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		1, 600			192.00
192. 00 19200 PHTSICIANS PRIVATE OFFICES 192. 01 19201 CHILD & ADOLESCENT RESIDENTIAL	0	138, 726			192.00
192. 02 19202 ADULT RESIDENTIAL		40, 730			192.02
192. 03 19203 CONTRACTED SERVICES		68, 868			192.03
192. 04 19204 THI RD PARTY OCCUPI ED SPACE		00, 000			192.04
192. 05 19205 MRO		306, 380			192.05
192. 06 19206 TRANSITION SERVICES		4, 136			192.06
200.00 Cross Foot Adjustments	ام	., 100			200.00
201.00 Negative Cost Centers	ام	o			201. 00
202.00 TOTAL (sum lines 118 through 201)	o	1, 356, 798			202.00

Health Financial Systems	OAKLAWN PSYCHIATRIC CENTER, INC.	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-4031	Peri od:	Worksheet B-1

		CLAWN FSICIIIAIKI				u or rorm cws-2	
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C	CN: 15-4031 P	eri od:	Worksheet B-1	
					rom 07/01/2019 o 06/30/2020	Date/Time Pre	paradi
				1	0 00/30/2020	11/17/2020 3:	
		CAPI TAL				1171772020 3.	20 piii
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Peconciliatio	ADMI NI STRATI V	OPERATION OF	
	cost center bescription	FLXT	BENEFITS	n	E & GENERAL	PLANT	
		(NO	DEPARTMENT	!!	(ACCUM. COST)	(SQUARE FEET)	
		STATISTICS)			(ACCOM. COST)	(SQUARE LELT)	
		STATISTICS)	(GROSS				
		1.00	SALARI ES)	ГА	F 00	7.00	
CENE	DAL CEDVICE COCT CENTERS	1. 00	4. 00	5A	5. 00	7. 00	
	RAL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT	204 020		ı			1 00
		206, 020	25 502 502				1.00
	EMPLOYEE BENEFITS DEPARTMENT	0	35, 583, 582				4.00
	ADMINISTRATIVE & GENERAL	49, 734	4, 209, 440				5.00
	OPERATION OF PLANT	36, 644	666, 895	•		· ·	
	DI ETARY	7, 355	121, 951			7, 355	
11.00 01100	CAFETERI A	112	1, 857	0	2, 402	112	11. 00
16.00 01600	MEDICAL RECORDS & LIBRARY	2, 702	491, 326	0	679, 557	2, 702	16.00
I NPAT	TIENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	10, 780	1, 866, 269	0	2, 273, 947	10, 780	30.00
	LLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	25	10, 826	0	100, 343	25	60.00
	DRUGS CHARGED TO PATIENTS	300	2	0	271, 264	300	73.00
OUTPA	ATIENT SERVICE COST CENTERS						
90.00 09000		51, 722	8, 984, 835	0	8, 149, 186	77, 013	90.00
SPECI	AL PURPOSE COST CENTERS]
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	159, 374	16, 353, 401	-9, 528, 322	13, 817, 260	98, 287	118.00
NONRE	IMBURSABLE COST CENTERS						
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	180	0	0	1, 032	180	192.00
192. 01 1920°	CHILD & ADOLESCENT RESIDENTIAL	o	10, 858, 921	0	16, 535, 758	0	192. 01
192, 02 19202	ADULT RESIDENTIAL	1, 215	2, 712, 611	l o	4, 148, 779	1, 215	192. 02
	CONTRACTED SERVICES	6, 616	432, 751				192. 03
	THIRD PARTY OCCUPIED SPACE	0	0				192.04
192. 05 19205		38, 635	4, 774, 086	-	-		192.05
	TRANSITION SERVICES	00,000	451, 812	•	597, 531		192.06
200. 00	Cross Foot Adjustments		101,012	Ĭ	077,001		200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	1, 181, 581	866, 824		9, 528, 322	2, 469, 475	
202.00	Part I)	1, 101, 581	000, 824		9, 020, 322	2, 409, 4/5	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	5. 735273	0. 024360		0. 225905	20. 640536	203 00
203.00	Cost to be allocated (per Wkst. B,	0.730273	1, 010	•	291, 019		
204.00	Part II)		1,010		291,019	358, 4/6	204.00
205 00			0. 000028		0.004.000	2. 996239	205 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000028		0. 006900	2. 990239	∠U5. UU
204 00	NAUE adjustment amount to be allegated						204 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207 00	(per Wkst. B-2)						207 20
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	l l		l	l		I

Provi der CCN: 15-4031

					To 06/30/2020	Date/Time Prepared: 11/17/2020 3:20 pm
	Cost Center Description	DI ETARY	CAFETERI A	MEDI CAL		117 177 2020 3. 20 piii
		(MEALS	(FTE	RECORDS &		
		SERVED)	EMPLOYEES)	LI BRARY		
				(GROSS		
				CHARGES)		
		10. 00	11. 00	16.00		
	RAL SERVICE COST CENTERS				_	
	NEW CAP REL COSTS-BLDG & FLXT					1.00
	EMPLOYEE BENEFITS DEPARTMENT					4. 00
	D ADMINISTRATIVE & GENERAL					5.00
	OPERATION OF PLANT					7.00
	DIETARY	5, 120				10.00
	CAFETERI A	0	681			11.00
	MEDICAL RECORDS & LIBRARY	0	16	17, 077, 50	2	16.00
	TIENT ROUTINE SERVICE COST CENTERS	1			_1	
	ADULTS & PEDIATRICS	5, 120	32	5, 152, 36	3	30.00
	LARY SERVICE COST CENTERS				. 1	
	LABORATORY	0	0			60.00
	D DRUGS CHARGED TO PATIENTS	0	0	876, 618	8	73. 00
	ATIENT SERVICE COST CENTERS	٥	117	10 000 70	-	00.00
90.00 09000	AL PURPOSE COST CENTERS	0	147	10, 899, 70	0	90.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 120	195	17, 077, 50	2	118.00
	IMBURSABLE COST CENTERS	3, 120	193	17,077,30.	<u> </u>	118.00
	PHYSICIANS' PRIVATE OFFICES	0	15	(O	192. 00
	CHILD & ADOLESCENT RESIDENTIAL	0	278		o o	192.01
	ADULT RESIDENTIAL	0	73		o o	192.02
	CONTRACTED SERVICES	ő	10		ก	192.03
	THIRD PARTY OCCUPIED SPACE	ő	0		Ď	192.04
192. 05 1920!		0	110		Ď	192.05
	TRANSITION SERVICES	0			2	192.06
200.00	Cross Foot Adjustments	1	_			200.00
201. 00	Negative Cost Centers					201.00
202. 00	Cost to be allocated (per Wkst. B,	551, 641	5, 257	888, 96 ⁻	7	202.00
	Part I)	, , , , ,				
203. 00	Unit cost multiplier (Wkst. B, Part I)	107. 742383	7. 719530	0. 05205	5	203. 00
204.00	Cost to be allocated (per Wkst. B,	66, 473	995	28, 319	9	204.00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	12. 983008	1. 461087	0. 001658	8	205. 00
	11)					
206. 00	NAHE adjustment amount to be allocated					206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,					207. 00
	Parts III and IV)	ļ				

Health Financial Systems	OAKLAWN PSYCHLATRI	IC CENTER, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 07/01/2019 To 06/30/2020		pared: 20 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 830, 242		3, 830, 24	2 56, 895	3, 887, 137	30.00
ANCILLARY SERVICE COST CENTERS				_		
60. 00 06000 LABORATORY	131, 274		131, 27	4 0	131, 274	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	384, 368		384, 36	8 0	384, 368	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	12, 148, 235		12, 148, 23	5 967, 849	13, 116, 084	90.00
200.00 Subtotal (see instructions)	16, 494, 119	0	16, 494, 11	9 1, 024, 744	17, 518, 863	200.00
201.00 Less Observation Beds	0			0	0	201.00
202.00 Total (see instructions)	16, 494, 119	0	16, 494, 11	9 1, 024, 744	17, 518, 863	202. 00

Heal th Finan	cial Systems 0.	AKLAWN PSYCHLATRI	C CENTER, INC		In Lie	u of Form CMS-	2552-10
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provi der CO		Period: From 07/01/2019 Fo 06/30/2020		pared:
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	ENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5, 152, 363		5, 152, 36	3		30.00
ANCI LI	LARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	148, 816	0	148, 81	0. 882123	0.000000	60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	864, 051	12, 567	876, 61	0. 438467	0. 000000	73.00
OUTPA ⁻	TIENT SERVICE COST CENTERS						
90.00 09000	CLI NI C	0	10, 899, 705	10, 899, 70	1. 114547	0. 000000	90.00
200. 00	Subtotal (see instructions)	6, 165, 230	10, 912, 272	17, 077, 50	2		200. 00
201. 00	Less Observation Beds						201.00
202. 00	Total (see instructions)	6, 165, 230	10, 912, 272	17, 077, 50	2		202. 00

Health Financial Systems	OAKLAWN PSYCHLATRIC	CENTER, INC.	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4031	Peri od: From 07/01/2019 To 06/30/2020		epared: 20 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY	0. 882123				60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 438467				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	1. 203343				90.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial	I Systems 0	AKLAWN PSYCHLATR	IC CENTER, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF I	RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 07/01/2019 To 06/30/2020		
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
Cos	t Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2.00	3.00	4. 00	5. 00	
I NPATI ENT	ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADU	ILTS & PEDIATRICS	3, 830, 242		3, 830, 24	2 56, 895	3, 887, 137	30.00
ANCI LLARY	/ SERVICE COST CENTERS						
60. 00 06000 LAB	SORATORY	131, 274		131, 27	4 0	131, 274	60.00
73. 00 07300 DRU	IGS CHARGED TO PATIENTS	384, 368		384, 36	8 0	384, 368	73.00
OUTPATI EN	NT SERVICE COST CENTERS						
90. 00 09000 CLI	NI C	12, 148, 235		12, 148, 23	5 967, 849	13, 116, 084	90.00
200. 00 Sub	ototal (see instructions)	16, 494, 119	0	16, 494, 11	9 1, 024, 744	17, 518, 863	200. 00
201. 00 Les	s Observation Beds	0			0	0	201.00
202. 00 Tota	al (see instructions)	16, 494, 119	0	16, 494, 11	9 1, 024, 744	17, 518, 863	202. 00

Health Finan	ncial Systems 0.	OAKLAWN PSYCHIATRIC CENTER, INC. In Lieu of Form CMS-2			2552-10		
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provi der CO		Period: From 07/01/2019 Fo 06/30/2020		pared: 20 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	IENT ROUTINE SERVICE COST CENTERS						
30. 00 03000	ADULTS & PEDIATRICS	5, 152, 363		5, 152, 363	3		30.00
ANCI L	LARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	148, 816	0	148, 816	0. 882123	0.000000	60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	864, 051	12, 567	876, 618	0. 438467	0. 000000	73.00
OUTPA	TIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	10, 899, 705	10, 899, 70	1. 114547	0.000000	90.00
200. 00	Subtotal (see instructions)	6, 165, 230	10, 912, 272	17, 077, 502	2		200.00
201. 00	Less Observation Beds						201.00
202. 00	Total (see instructions)	6, 165, 230	10, 912, 272	17, 077, 502	2		202. 00

Health Fir	nancial Systems	OAKLAWN PSYCHLATRIC	CENTER, INC.	In Lieu	of Form CMS-	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-4031	Peri od: From 07/01/2019 To 06/30/2020		pared: 20 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
INF	ATIENT ROUTINE SERVICE COST CENTERS					
30.00 030	000 ADULTS & PEDIATRICS					30.00
ANC	ILLARY SERVICE COST CENTERS					
60.00 060	000 LABORATORY	0. 000000				60.00
73.00 073	OO DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUT	PATIENT SERVICE COST CENTERS					1
90.00 090	000 CLI NI C	0. 000000				90.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202. 00	Total (see instructions)					202.00

Health Financial Systems 0.	AKLAWN PSYCHLATR	IC CENTER, INC		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS	Provider C		Period: From 07/01/2019 To 06/30/2020		epared: 20 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst.	Swing Bed Adjustment	Reduced Capi tal Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	B, Part II,		(col . 1 - col . 2)		COI . 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	187, 030	0	187, 03	0 4, 476	41. 79	30.00
200.00 Total (lines 30 through 199)	187, 030		187, 03	0 4, 476		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	1, 088 1, 088		1			30. 00 200. 00

Health Financial Systems OAk	CLAWN PSYCHLATR	WN PSYCHIATRIC CENTER, INC. In Lieu of Form CMS-2				2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider CO		Period: From 07/01/2019 To 06/30/2020		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	1, 157	148, 816	0. 00777	5 29, 027	226	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 945	876, 618	0. 00678	2 267, 945	1, 817	73.00
OUTPATIENT SERVICE COST CENTERS				<u>.</u>		
90. 00 09000 CLI NI C	602, 226	10, 899, 705	0. 05525	2 0	0	90.00
200.00 Total (lines 50 through 199)	609, 328	11, 925, 139		296, 972	2, 043	200. 00

Health Fina	ncial Systems OA	KLAWN PSYCHLATR	RIC CENTER, INC	;.	In Lie	u of Form CMS-	2552-10
	NT OF INPATIENT ROUTINE SERVICE OTHER P.			CN: 15-4031 F	Period: From 07/01/2019		
					o 06/30/2020	11/17/2020 3:	eparea: 20 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
		School	School	Post-Stepdown	Cost	Medi cal	
		Post-Stepdown		Adjustments		Educati on	
		Adjustments				Cost	
		1A	1. 00	2A	2. 00	3. 00	
	TENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	0	0	(0	0	1 00.00
200. 00	Total (lines 30 through 199)	0	0	(0		200.00
	Cost Center Description	Swi ng-Bed	Total Costs	Total Patient		I npati ent	
		Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
		Amount (see	1 through 3,		col. 6)		
			minus col. 4)				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	TIENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	0	0			1, 088	
200. 00	Total (lines 30 through 199)		0	4, 476		1, 088	200.00
	Cost Center Description	I npati ent					
		Program					
		Pass-Through					
		Cost (col. 7					
		x col. 8) 9.00					
LNDAT	TIENT ROUTINE SERVICE COST CENTERS	9.00					
	ADULTS & PEDIATRICS	0					30.00
200. 00	Total (lines 30 through 199)	0	1				200.00
200.00	Total (Tilles 30 till ough 177)	1	I				₁ 200.00

Health Financial Systems OAK	LAWN PSYCHLATR	IC CENTER, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider Co		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019 To 06/30/2020		nared·
				10 00/00/2020	11/17/2020 3:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0		0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0	0	90.00
200.00 Total (lines 50 through 199)	0	0		0	0	200. 00

Health Financial Systems OA	KLAWN PSYCHLATR	IC CENTER, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider Co		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019 Fo 06/30/2020		narod:
				10 00/30/2020	11/17/2020 3:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7.00	8. 00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0	0	(148, 816	0.000000	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(876, 618	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLINIC	0	0	(10, 899, 705	0.000000	90.00
200.00 Total (lines 50 through 199)	0	0	(11, 925, 139		200. 00

Health Financial Systems OA	KLAWN PSYCHLATRI	C CENTER, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUGH COSTS				From 07/01/2019		
				To 06/30/2020	Date/Time Pre 11/17/2020 3:	
		Title	XVIII	Hospi tal	PPS	20 p
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0. 000000	29, 027		0	0	60.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000	267, 945		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 1, 129, 667	0	90.00
200.00 Total (lines 50 through 199)		296, 972		0 1, 129, 667	0	200. 00

Health Financial Systems OAKLAWN PSYCHIATRIC CENTER, INC. In Lieu of Form CMS-25				2552-10		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der Co		Period: From 07/01/2019 To 06/30/2020	Date/Time Pre 11/17/2020 3:	
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins	. Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
60. 00 06000 LABORATORY	0. 882123	0		0 0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 438467	0	1	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1. 114547	1, 129, 667		0 0	1, 259, 067	90.00
200.00 Subtotal (see instructions)		1, 129, 667		0 0	1, 259, 067	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		1, 129, 667		0 0	1, 259, 067	202. 00

Health Finar	ncial Systems OA	OAKLAWN PSYCHIATRIC CENTER, INC. In Lieu of Form CMS			u of Form CMS-	2552-10	
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der Co		Peri od: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Pre 11/17/2020 3:	
				XVIII	Hospi tal	PPS	
		Cos	ts				
	Cost Center Description	Cost Reimbursed	Cost Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	LARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0				60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPA	TIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0				90.00
200. 00	Subtotal (see instructions)	0	0				200.00
201. 00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202. 00

Heal th	n Financial Systems OAKLAWN PSYCHI	ATRIC CENTER, INC.	In Lie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST	Provider CCN: 15-4031	Peri od:	Worksheet D-1	
			From 07/01/2019 To 06/30/2020	Date/Time Pre 11/17/2020 3:	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-be	ed days, excluding newborn)		4, 476	1.00
2.00	Inpatient days (including private room days, excluding s	swing-bed and newborn days)		4, 476	2.00
3. 00	Private room days (excluding swing-bed and observation I do not complete this line.	bed days). If you have only p	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observa-	tion bed days)		4, 476	4.00
5. 00	Total swing-bed SNF type inpatient days (including prival reporting period		er 31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including prival reporting period (if calendar year, enter 0 on this line		31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including prival reporting period	te room days) through Decembe	r 31 of the cost	0	7. 00
0 00	Total swing had NE type inpatient days (including prive	to room days) after December	21 of the cost	0	0 00

COMPUT	Financial Systems OAK ATION OF INPATIENT OPERATING COST	LAWN PSYCHLATR	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 07/01/2019 To 06/30/2020	Date/Time Pre	
			Title	XVIII	Hospi tal	11/17/2020 3: PPS	20 piii
	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)						42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
44. 00			•				44.00
45. 00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.0
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					143, 090	48. 0
49. 00	5 1 ,	41 through 48)	(see instructi	ons)		1, 087, 953	49.00
EO 00	PASS THROUGH COST ADJUSTMENTS	ationt routing	convices (free	m Wks+ D su	m of Dorte L and	1E 140	F0 0
50. 00	Pass through costs applicable to Program inpa	atrent routine	services (110	II WKSt. D, Su	m or Parts r and	45, 468	50.0
51. 00	Pass through costs applicable to Program inpa	atient ancilla	ry services (f	rom Wkst. D,	sum of Parts II	2, 043	51.0
	and IV)						
52.00	Total Program excludable cost (sum of lines!					47, 511	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		erated, non-pn	ysician anest	netist, and	1, 040, 442	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54.00	Program di scharges					0	54.0
55.00	Target amount per discharge						55.0
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and to	arget amount (lino E4 minus	lino E2)	0	1
58.00	Bonus payment (see instructions)	ing cost and ta	arget amount (illie so illillus	11 ne 53)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the		
	market basket		o .	•			
60.00	Lesser of lines 53/54 or 55 from prior year						60.0
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than					0	61.0
	amount (line 56), otherwise enter zero (see		ts (TITIES 54 X	00), 01 1% 0	i the target		
62. 00	Relief payment (see instructions)	,				0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instr	uctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Doc	ombor 21 of th	o cost roport	ing pariod (Saa	0	64.00
04.00	instructions)(title XVIII only)	ts through beco	elliber 31 of th	e cost report	ing perrou (see	U	04.0
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reportin	g period (See	0	65.0
	instructions)(title XVIII only)			.=>		_	
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	h December 31	of the cost r	eportina period	0	67.00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after l	December 31 of	the cost rep	orting period	0	68.00
60 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs	(lino 67 : lin	n 60)		0	69.00
09.00	PART III - SKILLED NURSING FACILITY, OTHER NU					0	1 09.00
70.00	Skilled nursing facility/other nursing facili)		70.00
71. 00	Adjusted general inpatient routine service co		line 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line		m (line 14 v l	ino 25)			72.0
73. 00 74. 00	Medically necessary private room cost application of the cost application of t	•		,			73.00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75.0
	26, line 45)		`	•			
76.00	Per diem capital-related costs (line 75 ÷ lin						76.0
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 0 78. 0
79. 00	Aggregate charges to beneficiaries for excess		provi der recor	ds)			79.0
80.00	00 0	, ,		*.	nus line 79)		80.0
81.00	Inpatient routine service cost per diem limi		4.				81.0
82.00	Inpatient routine service cost limitation (li		* .				82.0
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		113)				83.0
85. 00	Utilization review - physician compensation		ons)				85. 0
86.00	Total Program inpatient operating costs (sum	•					86.0
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
		`				-] ~ -
87. 00 88. 00	Total observation bed days (see instructions)		: line 2)			0	87. 00 88. 00

Health Financial Systems OAK	LAWN PSYCHLATR	IC CENTER, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od: From 07/01/2019	Worksheet D-1	
				To 06/30/2020		pared: 20 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	187, 030	3, 887, 137	0. 04811	5 0	0	90.00
91.00 Nursing School cost	0	3, 887, 137	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 887, 137	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 887, 137	0. 00000	0 0	0	93.00

Heal th	Financial Systems	OAKLAWN PSYCHLATRIC	CENTER, INC.	In Lie	u of Form CMS-2	552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provider CCN: 15-4031	Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020	Date/Time Prep 11/17/2020 3:2	
			Title XIX	Hospi tal	Cost	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1.00	Inpatient days (including private room	days and swing-bed day	s, excluding newborn)		4, 476	1.00
2.00	Inpatient days (including private room of	days, excluding swing-	bed and newborn days)		4, 476	2.00
3. 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 b	ed days)		4, 476	4.00
	l =				_	

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 476	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 476	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)	4, 476	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5.00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	٥	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	675	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
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)	0	13.00
.0.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	١	
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) SWING BED ADJUSTMENT	0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
19.00	reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	3, 830, 242 0	21. 00 22. 00
22.00	5 x line 17)	٥	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 830, 242	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		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	3, 830, 242	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	855. 73	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 9 x)	577, 618	
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)	577, 618	41.00

Total saing-bed SNF type inpatient days (including private room days) after December 31 of the cost rotal swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if cal endar year, enter 0 on this line)		reporting period		
7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost propring period (if calendar year, enter 0 on this line) 10.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost propring period (if calendar year, enter 0 on this line) 10.00 Total Inpatient days including private room days applicable to the Program (excluding private room days) 10.00 Total Inpatient days including private room days applicable to title XVIII only (including private room days) 10.00 Through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 12.00 Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 12.00 Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to the Program (excluding Swing-bed days) 12.00 Total nursery days (title V or XIX only) 12.00 Total calendar year, enter 0 on this line) 12.00 Nursery days (title V or XIX only) 12.00 Total Reporting period 12.00 Total Reporting period 12.00 Total Reporting period 12.00 Total Reporting period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Reporting Period 12.00 Total Report Period Reporting Period 12.00 Total Report Period Report Period Report Period Report Period Report Period Report Period Report Period	6.00		0	6.00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. 00 Swing-bed SNF type inpatient days applicable to 11 if 8 XVIII enly (including private room days) 11. 00 December 31 of the cost reporting period (see instructions) 12. 00 Swing-bed SNF type inpatient days applicable to 11 if 8 XVIII enly (including private room days) after become 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to 11 if 8 Vor XIX only (including private room days) after through becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to 11 if 8 Vor XIX only (including private room days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17. 00 Medically necessary private room days applicable to services through becember 31 of the cost reporting period (including private room days) 18. 00 Medically necessary private room days applicable to services through becember 31 of the cost reporting period (including private room days) 18. 00 Medically necessary private room days applicable to services through becember 31 of the cost reporting period (including private room days) 18. 00 Medically necessary private room days applicable to services after becember 31 of the cost reporting period (including private room days) 18. 00 Medically necessary private room days applicable to services after becember 31 of the cost reporting period (including private room days) 18. 00 Medically necessary private room days applicable to services after becember 31 of the cost reporting period (including necessary period period (including ne				
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)	7. 00		0	7. 00
reporting period (if calendar year, énter 0 on this line) 10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) after through December 31 of the cost reporting period (see instructions) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost cost in the cost reporting period (see instructions) 18.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost cost in the cost reporting period (see instructions) 19.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost cost cost in the cost reporting period (line of the cost period in the cost cost	0.00		0	0.00
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 0 10.00	8.00		0	8.00
newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 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) 12.00 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) 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) 14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Swing-bed NF type inpatient days applicable to the Program (excluding saing-bed days) 0 14.00 swing-bed NF services applicable to the Program (excluding saing-bed days) 0 15.00 swing-bed NF services applicable to services through December 31 of the cost reporting period (if ne reporting period on Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 17.00 reporting period (if ne reporting period bed NF services applicable to services after December 31 of the cost 0.00 17.00 reporting period on Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 17.00 reporting period (if ne 10.00 17.00 reporting pe	0.00		475	0.00
10.00 Swing-bed SMF type Inpatient days applicable to title XVIII only (Including private room days) 0 10.00	9.00		075	9.00
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11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Mursery days (title V or XIX only) 17.00 Mursery days (title V or XIX only) 18.00 Mursery days (title V or XIX only) 18.00 Mursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period or swing-bed SNF services applicable to services after December 31 of the cost reporting period or swing-bed SNF services applicable to services after December 31 of the cost reporting period or swing-bed NF services applicable to services after December 31 of the cost or reporting period or swing-bed NF services applicable to services after December 31 of the cost or reporting period or swing-bed NF services applicable to services after December 31 of the cost or reporting period or reporting period or swing-bed NF services after December 31 of the cost reporting period (line or size of swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line or x ine 19) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line or x ine 19) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line or x ine 19) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line or x ine 19) 25.00 Swing-bed cost (see instructions) 26.00 Swing-bed cost (see instructions) 27.00 Central	10.00		J	10.00
December 31 of the cost reporting period (if callendar year, enter 0 on this line)	11. 00		0	11.00
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through December 31 of the cost reporting period 13.00 May bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Newsery days (title V or XIX only) 17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (16.00 Newsery days) 18.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (17.00 reporting period) 18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost (17.00 reporting period) 19.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost (17.00 reporting period) 20.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost (17.00 reporting period) 20.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost (17.00 reporting period) 20.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost (17.00 reporting period) 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (11 ne (17.00 newser)) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne (17.00 newser)) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne (17.00 newser)) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne (17.00 newser)) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne (17.00 newser)) 20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (11 ne (17.00 newser)) 20.00 Swing-bed cost applicable to NF type services	12.00		0	12.00
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35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 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 3, 830, 242 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) 855.73 38.00 Program general inpatient routine service cost (line 9 x line 38) 577,618 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
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27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 855.73 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
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) 855.73 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		3, 030, 242	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 855.73 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 855.73 38.00 97.00 Program general inpatient routine service cost (line 9 x line 38) 98.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 98.00 September 1 inpatient routine service cost per diem (see instructions) 98.00 September 2 inpatient routine service cost per diem (see instructions) 98.00 September 3 inpatient routine service cost per diem (see instructions) 98.00 September 3 inpatient routine service cost per diem (see instructions) 98.00 September 3 inpatient routine service cost per diem (see instructions) 98.00 September 3 inpatient routine service cost per diem (see instructions) 98.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38) 99.00 September 3 inpatient routine service cost (line 9 x line 38)				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 577,618 39.00 40.00	38. 00		855 73	38.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
	41.00		577, 618	41.00
		·		

СОМРИТ	Financial Systems FATION OF INPATIENT OPERATING COST	OAKLAWN PSYCHLATR			Period:	u of Form CMS-2 Worksheet D-1	
					From 07/01/2019 To 06/30/2020		
						11/17/2020 3:	20 pm
	Cost Center Description	Total	Ti t Total	le XIX Average Per	Hospital Program Days	Program Cost	
	cost center bescriptron	Inpatient	I npati ent	Di em (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	NUDCEDY (+; +1 c V 0 VIV colv)	1.00	2. 00	3. 00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital	Uni ts					42.0
43. 00	INTENSIVE CARE UNIT						43.00
44.00							44.0
45.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 0 46. 0
	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description			•			
48. 00	Program inpatient ancillary service co	st (Wkst D.2 col 1	2 Line 200)			1. 00 95, 099	48.0
	Total Program inpatient costs (sum of			ons)		672, 717	
	PASS THROUGH COST ADJUSTMENTS					,	
50. 00	Pass through costs applicable to Progr	am inpatient routine	services (fro	om Wkst. D, sui	m of Parts I and	0	50.0
51. 00		am inpatient ancillar	rv services (from Wkst D	sum of Parts II	0	51.0
00	and IV)	pat. one anortha	, 55. 1, 555 (O .	"
52.00	Total Program excludable cost (sum of					0	
53. 00	Total Program inpatient operating cost medical education costs (line 49 minus		erated, non-pl	nysician anesti	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	1111e 32)					
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 0 56. 0
	Difference between adjusted inpatient	operating cost and ta	arget amount	(line 56 minus	line 53)	0	1
58. 00	Bonus payment (see instructions)	J	3		,	0	58.0
59. 00		ost reporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.0
60. 00	market basket Lesser of lines 53/54 or 55 from prior	vear cost renort ur	ndated by the	market hasket		0. 00	60.0
	If line 53/54 is less than the lower of				the amount by	0.00	1
	which operating costs (line 53) are le		ts (lines 54 :	x 60), or 1% o	f the target		
62. 00	amount (line 56), otherwise enter zero Relief payment (see instructions)	(see instructions)				0	62. 0
	Allowable Inpatient cost plus incentiv	e payment (see instru	uctions)				63.0
	PROGRAM INPATIENT ROUTINE SWING BED CO	ST					
64. 00	Medicare swing-bed SNF inpatient routi instructions)(title XVIII only)	ne costs through Dece	ember 31 of tl	ne cost report	ing period (See	0	64.0
65. 00	Medicare swing-bed SNF inpatient routi	ne costs after Decemb	oer 31 of the	cost reportin	g period (See	0	65.0
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient CAH (see instructions)	routine costs (line	64 plus line	65)(title XVI	II only). For	0	66.0
67. 00	1 '	routine costs through	December 31	of the cost re	eportina period	0	67.0
	(line 12 x line 19)				3 1 3		
68. 00	Title V or XIX swing-bed NF inpatient	routine costs after [December 31 o	f the cost rep	orting period	0	68.0
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpa	tient routine costs ((line 67 + li	ne 68)		0	69.0
	PART III - SKILLED NURSING FACILITY, O	THER NURSING FACILITY	, AND ICF/III	ONLY			
70.00	Skilled nursing facility/other nursing Adjusted general inpatient routine ser)		70.0
71. 00 72. 00	Program routine service cost (line 9 x		ine 70 ÷ iine	2)			71.0
73. 00	Medically necessary private room cost	,	n (line 14 x	ine 35)			73.0
74. 00	Total Program general inpatient routin	,		,			74.0
75. 00	Capital-related cost allocated to inpa 26, line 45)	tient routine service	e costs (from	Worksheet B,	Part II, column		75.0
76. 00	Per diem capital-related costs (line 7	5 ÷ line 2)					76.0
77. 00	Program capital-related costs (line 9						77.0
78. 00 79. 00	Inpatient routine service cost (line 7 Aggregate charges to beneficiaries for		orovider rocci	rde)			78. 0 79. 0
30.00	Total Program routine service costs for	, ,		,	nus line 79)		80.0
31. 00	Inpatient routine service cost per die	m limitation		,	Í		81.0
32.00	Inpatient routine service cost limitat	* .	* .				82.0
33. 00 34. 00	Reasonable inpatient routine service of Program inpatient ancillary services (15)				83. 0 84. 0
85.00	Utilization review - physician compens		ons)				85. 0
86. 00	Total Program inpatient operating cost		nrough 85)				86.0
87. 00	PART IV - COMPUTATION OF OBSERVATION B Total observation bed days (see instru					0	87. 0
	, ,	•	: line 2)				88.00
88. 00							

Health Financial Systems OAk	CLAWN PSYCHLATR	IC CENTER, INC		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2019 To 06/30/2020	Date/Time Pre 11/17/2020 3:	pared: 20 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	187, 030	3, 830, 242	0. 04883	0 0	0	90.00
91.00 Nursing School cost	0	3, 830, 242	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 830, 242	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 830, 242	0. 00000	0 0	0	93. 00

Health Financial Systems	OAKLAWN PSYCHIATRIC CENTER, I	NC.	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-4031	Peri od:	Worksheet D-3	
			From 07/01/2019 To 06/30/2020		pared: 20 pm
	Ti t	le XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 251, 740		30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY		0. 88212	29, 027	25, 605	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 43846	267, 945	117, 485	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		1. 20334	13 0	0	90.00
200.00 Total (sum of lines 50 through 94 a	and 96 through 98)		296, 972	143, 090	200.00
201.00 Less PBP Clinic Laboratory Services	s-Program only charges (line 61)	0		201.00
202.00 Net charges (line 200 minus line 20	01)		296, 972		202.00

Health Financial Systems	OAKLAWN PSYCHIATRIC CENTER, IN	C.	In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (CCN: 15-4031	Peri od:	Worksheet D-3	
			From 07/01/2019 To 06/30/2020		pared: 20 pm
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	1 1 1 1 1 1 1	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			776, 250		30.00
ANCILLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY		0. 88212	27, 446	24, 211	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 43846	7 161, 673	70, 888	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		1. 11454	17 0	0	90.00
200.00 Total (sum of lines 50 through 94 a	and 96 through 98)		189, 119	95, 099	200.00
201.00 Less PBP Clinic Laboratory Services	s-Program only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 20	01)		189, 119		202.00

Health Financial Systems	OAKLAWN PSYCHIATRIC CENTER, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-40	From 07/01/2019	Worksheet E Part B Date/Time Prepared: 11/17/2020 3:20 pm

			10 00/30/2020	11/17/2020 3:	
		Title XVIII	Hospi tal	PPS	
			'		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	i ons)		1, 259, 067	2.00
3. 00	OPPS payments	,		1, 219, 059	
4. 00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)			0	
5. 00	1	tions)			
	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	
6. 00	Line 2 times line 5			0	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	
8. 00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	
10. 00	Organ acqui si ti ons			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13.00
	Total reasonable charges (sum of lines 12 and 13)	ŕ		0	14.00
	Customary charges				1
15. 00	Aggregate amount actually collected from patients liable for p	avment for services on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for	3	~	0	
. 5. 55	had such payment been made in accordance with 42 CFR §413.13(e		a. gobasi 3	١	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	17.00
	Total customary charges (see instructions)			0.000000	
	Excess of customary charges over reasonable cost (complete only	v if line 19 exceeds li	no 11) (coo	0	
17.00	instructions)	y II IIIle 10 exceeds II	116 11) (366	, U	19.00
20. 00	Excess of reasonable cost over customary charges (complete onl	v if line 11 evenede li	no 10) (coo	0	20.00
20.00		y II IIIle II exceeds II	ne 10) (See	, U	20.00
21 00	instructions)				21 00
	Lesser of cost or charges (see instructions)			0	
	Interns and residents (see instructions)	. 11		0	
	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			1, 219, 059	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		310, 704	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line	24 (for CAH, see instr	uctions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	and 23] (see	908, 355	27.00
	instructions)				
28.00	Direct graduate medical education payments (from Wkst. E-4, Ii	ne 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
	Subtotal (sum of lines 27 through 29)			908, 355	30.00
	Primary payer payments			0	1
	Subtotal (line 30 minus line 31)			908, 355	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)		,	1
33 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			25, 962	
	Adjusted reimbursable bad debts (see instructions)			16, 875	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		25, 962	
	,	uctions)		925, 230	
	Subtotal (see instructions)				1
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			925, 230	1
40. 01	Sequestration adjustment (see instructions)			15, 451	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments			891, 234	41.00
41.01	Interim payments-PARHM			ļ	41.01
	Tentative settlement (for contractors use only)			0	
42. 01	Tentative settlement-PARHM (for contractor use only)			·	42. 01
43. 00	Balance due provider/program (see instructions)			18, 545	
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2	chanter 1	0	1
-4. 00	\$115. 2	SS WITH SWISTUD. 19-2,	onaptor I,	0	-4.00
	TO BE COMPLETED BY CONTRACTOR				1
00.00				0	90.00
	Original outlier amount (see instructions)			_	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			01	94.00

Health Financial Systems OAKLAWN PSYCHIATRIC CENTER, INC. In Lieu of Form CMS-2552-10 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-4031 Peri od: Worksheet E-1 From 07/01/2019 Part I 06/30/2020 Date/Time Prepared: 11/17/2020 3:20 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 576, 585 891, 234 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 3.01 0 3.02 0 3.02 0 3 03 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 0 0 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 576, 585 891, 234 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 5.50 0 5.51 0 0 5. 51

0

0

Contractor Number

1.00

1,029

577, 614

0

0

18, 545

909, 779

NPR Date

(Mo/Day/Yr)

2.00

5.52

5.99

6.00

6.01

6.02

7.00

8.00

5.52

5.99

6.00

6.01

6.02

7.00

5. 50-5. 98)

8.00 Name of Contractor

the cost report. (1)

SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

Subtotal (sum of lines 5.01-5.49 minus sum of lines

Total Medicare program liability (see instructions)

Determined net settlement amount (balance due) based on

Health Financial Systems	OAKLAWN PSYCHLATRIC CE	ENTER, INC.	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	P		From 07/01/2019 To 06/30/2020	Worksheet E-3 Part II Date/Time Prepared: 11/17/2020 3:20 pm
		Title VVIII	Hospi tal	DDC

PART II - MEDICARE PART A SERVICES - IPF PPS		Title XVIII Hospital				20 piii
PART 11 - MEDICARE PART A SERVICES - IPF PPS						
1.00						
2.00						
Net IPF PPS ECT Payments			ical education payments))		
4.00 Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions) 4.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions) 6.00 November of the reaching program and usement. (see instructions) 7.00 Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 8.00 Lurent year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 8.00 Teaching Adjustment Factor {(f(1 + (line B/line 9)) raised to the power of .5150 -1}. 8.00 Teaching Adjustment (line 1 multiplied by line 10) 8.00 Adjusted Not IPF PPS Payments (sum of lines 1, 2, 3 and 11) 8.00 Augusted Not IPF PPS Payments (sum of lines 1, 2, 3 and 11) 8.00 Augusted Not IPF PPS Payments (sum of lines 1, 2, 3 and 11) 8.00 Augusted Not IPF PPS Payments (see instructions) 8.01 Organ acquisition (00 NOT USE THIS LINE) 8.02 Subtotal (see instructions) 8.03 Subtotal (see instructions) 8.04 Organ acquisition (00 NOT USE THIS LINE) 8.05 Subtotal (see instructions) 8.06 Subtotal (see instructions) 8.07 Augusted Notal (see instructions) 8.08 Subtotal (see instructions) 8.09 Deductibles 8.00 Subtotal (see instructions) 8.01 Augusted Notal (see instructions) 8.02 Augusted Notal (see instructions) 8.03 Augusted Notal (see instructions) 8.04 Augusted Pinhursable bad debts (see instructions) 8.05 Augusted Pinhursable bad debts (see instructions) 8.06 Augusted Pinhursable bad debts (see instructions) 8.07 Augusted Pinhursable bad debts (see instructions) 8.09 Demonstration payments adjustment see instructions) 9.00 Offer paps through costs (see instructions) 9.01 Offer paps throu		1			·	
15, 2004. (see instructions) 4, 01 4, 01 5, 02 priorcreases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412,424(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		,			-	
program or hospital closure that would not be counted without a temporary cap adjustment under 42 CTR \$412.424(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1) or (2) (see instructions) 5.00 New Teaching program adjustment. (see instructions) 1.00 Createnty agris unweighted ETE count of IAR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 1.00 Creaching program" (see instructions) 1.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 1.01 Teaching Adjustment Factor (((1 + (line 87line 9)) raised to the power of .5150 -1). 1.00 Adjusted Net IPF PPS payments (sum of lines 1), 2, 3 and 11) 1.00 Teaching Adjustment (line 1 multiplied by line 10). 1.01 Teaching Adjustment (line 1 multiplied by line 10). 1.02 Organ acquisition (00 NOT USE THIS LINE) 1.03 Organ acquisition (00 NOT USE THIS LINE) 1.04 Organ acquisition (00 NOT USE THIS LINE) 1.05 Subtotal (see instructions) 1.06 Subtotal (line 16 less line 17). 1.07 Open acquisition (10 NOT USE THIS LINE) 1.09 Objusted Not (see instructions) 1.00 Subtotal (line 16 less line 17). 1.00 Subtotal (line 16 less line 17). 1.00 Subtotal (line 20 minus line 2) 1.00 Subtotal (line 20 minus line 2) 1.00 Subtotal (line 20 minus line 2) 1.00 Olinaurance 1.01 Olinaurance 1.01 Olinaurance 1.02 Olinaurance 1.03 Olinaurance 1.04 Olinaurance 1.05 Olinaurance 1.06 Olinaurance 1.07 Olinaurance 1.08 Olinaurance 1.09 Olinaurance 1.00 Olinaurance 1.01 Olinaurance 1.01 Olinaurance 1.01 Olinaurance 1.02 Olinaurance 1.03 Olinaurance 1.04 Olinaurance 1.05 Olinaurance 1.06 Olinaurance 1.07 Olinaurance 1.08 Olinaurance 1.09 Olinaurance 1.00 Olinaurance 1.01 Olinaurance 1.01 Olinaurance 1.02 Olinaurance 1.03 Olinaurance 1.04 Olinaurance 1.05 Olinaurance 1.07 Olinaurance 1.08 Olinaurance 1.09 Olinaurance 1.00 Olinaurance 1.00 Olinaurance 1.00 Olinaurance 1.00 Olinaurance 1.00 Olinaurance 1.00 Olinaurance 1.00 Olinaurance 1.00 Olinaurance 1.00 Olinaurance 1.00 Olina	4.00		ost report filed on or i	perore November	0.00	4.00
5.00 New Teaching program adjustment. (see instructions) 0.00 6.00 current year's unweighted FTE count of 1&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 0.00 6.00 current year's unweighted 1&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 0.00 0.	4. 01	Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou			0. 00	4. 01
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35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 §115.2			2 22 and 22)		-	
§115. 2				chantor 1		
TO BE COMPLETED BY CONTRACTOR	33.00	§115. 2	nice with cws rub. 13-2,	спартег т,	0	35.00
		TO BE COMPLETED BY CONTRACTOR				
50.00 Original outlier amount from Worksheet E-3, Part II, line 2		1 9			·	
						51.00
						52. 00 53. 00
53.00 Time Value of Money (see instructions) 0 53.00	55.00	Time value of money (see Histiactions)		١	U	1 55.00

Health Financial Systems	OAKLAWN PSYCHIATRIC CENTER, INC.	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-4031	Peri od: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 11/17/2020 3:20 pm		

			Го 06/30/2020	Date/Time Pre 11/17/2020 3:	
		Title XIX	Hospi tal	Cost	20 piii
		THE STATE	Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	S FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		672, 717		1.00
2. 00	Medical and other services		,	0	2.00
3. 00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		672, 717	0	4.00
5. 00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		672, 717	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		, ,		
	Reasonable Charges				
8.00	Routi ne servi ce charges		776, 250		8. 00
9.00	Ancillary service charges		189, 119	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		965, 369	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for serv	vices on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for paym		0	0	14.00
	a charge basis had such payment been made in accordance with 42 CFF	R §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		965, 369	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	292, 652	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instruction	ons)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		672, 717	0	21. 00
00.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	eted for PPS provid			00.00
22. 00	Other than outlier payments		0	0	22.00
23. 00	Outlier payments		0	0	23.00
24. 00	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0	0	25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		(70.747	0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		672, 717	0	29. 00
30. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	30. 00
	Excess of reasonable cost (from line 18)		(72, 717	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		672, 717	0	
32.00	Deducti bl es			0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	Ü	34. 00 35. 00
35. 00 36. 00	Utilization review Subtatal (sum of Lines 21, 24 and 25 minus sum of Lines 22 and 22)		472 717	0	36.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		672, 717	0	36.00
38. 00	Subtotal (line 36 ± line 37)		672, 717	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0/2, /1/	U	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		672, 717	0	40.00
41. 00	Interim payments		454, 108	0	40.00
41.00	Balance due provider/program (line 40 minus line 41)		218, 609	0	41.00
43. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Dub 15_2	210, 009	0	43.00
43.00	chapter 1, §115.2	tii GWO FUD 10-Z,	١	U	43.00
	Onaptor 1, 3110.2		1		1

Health Financial Systems OAKLAWN PSYCHIA
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-4031

——————————————————————————————————————	<u> </u>				11/17/2020 3:	20 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1. 00	
1.00	Cash on hand in banks	10, 560, 305	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	
3.00	Notes receivable	0	0	0	0	
4. 00	Accounts receivable	2, 816, 983	1	0	0	1
5. 00 6. 00	Other receivable	4, 721, 390	0	0	0	
7. 00	Allowances for uncollectible notes and accounts receivable Inventory			0	0	
8. 00	Prepai d expenses	905, 098	0	0	0	
9. 00	Other current assets	0	Ö	0	0	
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	19, 003, 776	0	0	0	11.00
40.00	FI XED ASSETS	055 (00		0		10.00
12.00	Land	855, 638	1	0	0	
13. 00 14. 00	Land improvements Accumulated depreciation	1, 460, 753 -1, 229, 042		0	0	
15. 00	Buildings	18, 312, 932	1	0	0	1
16. 00	Accumulated depreciation	-10, 219, 568	1	0	0	
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumulated depreciation	0	0	0	0	
19. 00	Fi xed equipment	4, 654, 100	1	0	0	
20.00	Accumulated depreciation	-4, 609, 517	1	0	0	
21. 00 22. 00	Automobiles and trucks	764, 626	1	0	0	
23. 00	Accumulated depreciation Major movable equipment	-623, 826 6, 539, 986	1	0	0	
24. 00	Accumulated depreciation	-5, 118, 244	1	0	0	
25. 00	Minor equipment depreciable	0,110,211	Ö	0	0	
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	10, 787, 838	0	0	0	30.00
31. 00	Investments	14, 631, 026	0	0	0	31.00
32. 00	Deposits on leases	0	Ö	0	0	
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	1
35.00	Total other assets (sum of lines 31-34)	14, 631, 026	1	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	44, 422, 640	0	0	0	36.00
37. 00	Accounts payable	1, 518, 419	0	0	0	37.00
38. 00	Salaries, wages, and fees payable	3, 023, 992	1	0	0	
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	601, 190	0	0	0	1
41. 00	Deferred income	0	0	0	0	
42. 00	Accel erated payments	0		0		42.00
43. 00 44. 00	Due to other funds Other current liabilities	1, 390, 519	0	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 534, 120	1	0		1
10.00	LONG TERM LIABILITIES	0,001,120	<u> </u>	<u> </u>	0	10.00
46.00	Mortgage payable	7, 264, 517	0	0	0	46.00
47.00	Notes payable	0	0	0	0	
48. 00	Unsecured Loans	0	0	0	0	
49. 00	Other long term liabilities	1, 680, 663		0	0	
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	8, 945, 180 15, 479, 300	1	0	0	
31.00	CAPITAL ACCOUNTS	15, 479, 300	0	U	0	31.00
52. 00	General fund balance	28, 943, 340				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	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					58.00
59. 00	Total fund balances (sum of lines 52 thru 58)	28, 943, 340	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	44, 422, 640	i i	Ö	Ö	
	59)					

Fund balance at end of period per balance

sheet (line 11 minus line 18)

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 15-4031 Peri od: Worksheet G-1 From 07/01/2019 06/30/2020 Date/Time Prepared: 11/17/2020 3:20 pm General Fund Special Purpose Fund Endowment Fund 1. 00 3. 00 4.00 5.00 2.00 1.00 Fund balances at beginning of period 28, 396, 193 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 547, 147 2.00 2.00 3.00 Total (sum of line 1 and line 2) 28, 943, 340 ol 3.00 4.00 Additions (credit adjustments) (specify) 4.00 0 5.00 0000 0 5.00 0 6.00 0 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 Subtotal (line 3 plus line 10) 28, 943, 340 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 0 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 28, 943, 340 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 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 0 3.00 3.00 Total (sum of line 1 and line 2) 0 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 7.00 8.00 0 8.00 9.00 0 9.00 Total additions (sum of line 4-9) 0 10.00 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 0 18.00

0

0

| Peri od: | Worksheet G-2 | From 07/01/2019 | Parts | & II | To 06/30/2020 | Date/Time Prepared:
 Heal th Financial
 Systems
 OAKLA

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 Provider CCN: 15-4031

To 06/30/2020 Date/Time Prep						
	Cost Center Description	I npati ent		Outpati ent	Total	•
		1.00		2. 00	3. 00	
PART I - PATIENT REVENUES						
4 00	General Inpatient Routine Services	5 450 0			5 450 0/0	4 00
1.00	Hospi tal	5, 152, 3	63		5, 152, 363	1.00
2.00	SUBPROVIDER - IPF SUBPROVIDER - IRF					2.00
3. 00 4. 00	SUBPROVI DER - 1 RF					3. 00 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		Ĭ		ĭ	7. 00
8. 00	NURSI NG FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5, 152, 3	63		5, 152, 363	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT					11.00
12. 00	CORONARY CARE UNIT					12.00
13.00	BURN I NTENSI VE CARE UNI T					13.00
14.00	SURGI CAL 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)		0		0	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5, 152, 3	63		5, 152, 363	17. 00
18. 00	Ancillary services	1, 012, 8		12, 567	1, 025, 434	18. 00
19. 00	Outpatient services	1,012,0	0	10, 899, 705	10, 899, 705	19. 00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	ō	o	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	HOSPI CE					26.00
27. 00	CHILD & ADOLESCENT RESIDENTIAL		0	15, 693, 618	15, 693, 618	27.00
27. 01	ADULT RESIDENTIAL		0	3, 968, 625	3, 968, 625	
27. 02	CONTRACTED SERVICES		0	39, 550	39, 550	
27. 03	MRO	077.0	0	8, 141, 697	8, 141, 697	
27. 04	PROFESSIONAL FEES	377, 8		6, 005, 734	6, 383, 547	
27. 05 27. 06	OTHER TRANSITION SERVICES	2, 5		725 024	2, 592	27. 05 27. 06
27. 00	PHYSI CLAN SERVICES		0	725, 024	725, 024 0	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	t. 6, 545, 6	-	45, 486, 520	52, 032, 155	
20.00	G-3, line 1)	0, 343, 0	55	43, 400, 320	32, 032, 133	20.00
	PART II - OPERATING EXPENSES			·		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			57, 774, 458		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 36. 00	Total additions (sum of lines 30-35)		0			35. 00 36. 00
37. 00	DEDUCT (SPECIFY)		0	٩		37.00
38.00	DEDUCT (SPECITY)		0			38. 00
39. 00			0			39. 00
40. 00			0			40.00
41. 00			0		ļ	41.00
42. 00	Total deductions (sum of lines 37-41)			o	ļ	42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	sfer		57, 774, 458		43.00
	to Wkst. G-3, line 4)			l	l	

Heal th	Financial Systems OAKLAWN PSYCHIATRIC	CENTER, INC.	_	u of Form CMS-2	2552-10	
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-4031 Period:					
			From 07/01/2019	Date/Time Pre	narod:	
	To 06/30/2020					
				11/17/2020 3:		
				1. 00		
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin	ne 28)		52, 032, 155	1.00	
2.00	Less contractual allowances and discounts on patients' accounts	nts		12, 813, 641	2.00	
3.00	Net patient revenues (line 1 minus line 2)			39, 218, 514	3.00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		57, 774, 458	4.00	
5.00	Net income from service to patients (line 3 minus line 4)			-18, 555, 944	5.00	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00						
8.00	8.00 Revenues from telephone and other miscellaneous communication services					
9.00	Revenue from television and radio service			0	9.00	
10.00	Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses			0	11.00	
12.00	Parking Lot receipts			0	12.00	
13.00	Revenue from Laundry and Linen service			0	13.00	
14.00	Revenue from meals sold to employees and guests			0	14.00	
15.00	Revenue from rental of living quarters			0	15.00	
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00	
17.00	Revenue from sale of drugs to other than patients			0	17.00	
18.00	Revenue from sale of medical records and abstracts			0	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21.00	Rental of vending machines			0	21.00	
22.00	Rental of hospital space			0	22.00	
23.00	Governmental appropriations			0	23.00	
24.00	PUBLI C SUPPORT			16, 642, 125	24.00	
24.01	NON OPERATING REVENUE			650, 044	24. 01	
24.02	OPERATI NG REVENUE			816, 548	24. 02	
24 50	COVID 10 DIE Funding			004 274	1 24 50	

994, 376 19, 103, 093 547, 149

24. 50 25. 00 26. 00 27. 00

2 28.00 547, 147 29.00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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

27. 00 OTHER