This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1313 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/29/2021 4:15 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 7/29/2021 4: 15 pm Manually prepared cost report use only ]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. Contractor ]Cost Report Status 10. NPR Date: (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [ N ] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9.

## PART II - CERTIFICATION

(4) Reopened(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WOODLAWN HOSPITAL (15-1313) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned) JOHN KRAFT
Officer or Administrator of Provider(s)

CF0 Title

(Dated when report is electronically signed.)

Date

|        |  |         | Title    | XVIII     |       |           |        |
|--------|--|---------|----------|-----------|-------|-----------|--------|
|        | Cost Center Description                  | Title V | Part A   | Part B    | HIT   | Title XIX |        |
|        |  | 1. 00   | 2.00     | 3. 00     | 4. 00 | 5. 00     |        |
|        | PART III - SETTLEMENT SUMMARY            |         |          |           |       |           |        |
| 1.00   | Hospi tal                                | 0       | 327, 042 | -364, 754 | 0     | -27, 599  | 1.00   |
| 2.00   | Subprovi der - IPF                       | 0       | 0        | 0         |       | 0         | 2.00   |
| 3.00   | Subprovider - IRF                        | 0       | 0        | 0         |       | 0         | 3.00   |
| 5.00   | Swing Bed - SNF                          | 0       | 24, 337  | 0         |       | 0         | 5. 00  |
| 6.00   | Swing Bed - NF                           | 0       |          |           |       | 0         | 6.00   |
| 10.00  | SHAFER MEDICAL CENTER I                  | 0       |          | 28, 211   |       | 0         | 10.00  |
| 10.01  | WOODLAWN MEDICAL PROFESSIONALS II        | 0       |          | 41, 791   |       | 0         | 10. 01 |
| 10.02  | FULTON COUNTY MEDICAL CENTER- 700 MA III | 0       |          | 93, 161   |       | 0         | 10. 02 |
| 10.03  | FULTON COUNTY MEDICAL CENTER - 100 E IV  | 0       |          | 37, 131   |       | 0         | 10. 03 |
| 10.04  | AKRON MEDICAL CLINIC V                   | 0       |          | 53, 980   |       | 0         | 10.04  |
| 10.05  | ARGOS MEDICAL CLINIC VI                  | 0       |          | 104, 573  |       | 0         | 10.05  |
| 200.00 | Total                                    | 0       | 351, 379 |           | 0     | -27, 599  | 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 WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1313 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/29/2021 4:15 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1400 EAST 9TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: ROCHESTER Zi p Code: 46975-County: FULTON 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 Hospi tal WOODLAWN HOSPITAL 151313 99915 01/01/1966 Ν 0 0 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF WOODLAWN HOSPITAL 15Z313 99915 10/23/2001 N 0 N 7.00 SWI NGBED 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital -Based Health Clinic - RHC SHAFER MEDICAL CENTER 158551 99915 15 00 04/13/2020 N Λ 0 15 00 Hospital -Based Health Clinic - RHC WOODLAWN MEDICAL 158552 99915 04/13/2020 15.01 0 15.01 PROFESSI ONALS Hospital -Based Health Clinic - RHC FULTON COUNTY MEDICAL 158550 99915 0 0 15.02 15.02 04/13/2020 N 1111 CENTER - MAIN FULTON COUNTY MEDICAL 15.03 Hospital -Based Health Clinic - RHC 158549 99915 04/13/2020 N 0 0 15.03 CENTER - DUNN ١V Hospital-Based Health Clinic - RHC VAKRON MEDICAL CLINIC 158547 99915 15.04 04/13/2020 Ν 0 0 15.04 Hospital -Based Health Clinic - RHC 15.05 ARGOS MEDICAL CLINIC 158548 99915 04/13/2020 Ν 0 15.05 0 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 8 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

22.02 Is this a newly merged hospital that requires final uncompensated care 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 October 1 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

Ν

N

58.00

59.00

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

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

| OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA  | ATA                            | Provi der C          | CN: 15-1313        | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet S-2<br>Part I<br>Date/Time Pre<br>7/29/2021 4:1 | pared: |
|---|--------------------------------|----------------------|--------------------|--|---|--------|
|   |                                |                      | NAHE 413. 8<br>Y/N | Worksheet A<br>Line #                        | Pass-Through<br>Qualification<br>Criterion<br>Code        |        |
|   |                                |                      | 1.00               | 2. 00  | 3. 00   |        |
| Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in colu   | .85? (s<br>Lumn 1.<br>CR) NAHE | ee<br>If column 1    | N                  |  |   | 60.00  |
| adjustemente. Enten i for yes of it for he in con-  | Y/N                            | I ME                 | Direct GME         | IME  | Direct GME  |        |
|   | 1.00                           | 2. 00                | 3.00               | 4. 00  | 5. 00   |        |
| 1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)  |                                |                      |                    | 0.00   |   | 61.00  |
| I.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)   |                                |                      |                    |  |   | 61.0   |
| 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)   |                                |                      |                    |  |   | 61. 0  |
| 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. 0  |
| 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).  |                                |                      |                    |  |   | 61.0   |
| 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)  |                                |                      |                    |  |   | 61.0   |
| 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  |                                |                      |                    |  |   | 61. 0  |
|   | Prog                           | gram Name            | Program Coo        | de Unweighted<br>IME FTE Count               | Unweighted Direct GME FTE Count                           |        |
|   |                                | 1. 00                | 2.00               | 3. 00  | 4. 00   |        |
| 1.10 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. 1  |
| 1. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,                           |                                |                      |                    | 0.00   | 0. 00   | 61. 2  |
| the direct GME FTE unweighted count.  |                                |                      |                    |  |   |        |
| ACA Dravicione Affecting the Health Decourses and Co  | mui oss A                      | dmi ni c+so+! -      | n (HDCA)           |  | 1.00  |        |
| ACA Provisions Affecting the Health Resources and Sei<br>2.00 Enter the number of FTE residents that your hospital<br>PROVIDED THE Funding (See 1987)   | trai ned                       |                      |                    | period for which                             | 0.00  | 62.00  |
| your hospital received HRSA PCRE funding (see instruction 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC production.   | a Teachi<br>gram. (s           | <u>ee instructio</u> | , ,                | nto your hospital                            | 0.00  | 62.0   |
| Teaching Hospitals that Claim Residents in Nonprovider sea.  3.00 Has your facility trained residents in nonprovider sea.  "Y" for yes or "N" for no in column 1. If yes, complete  | ettings                        | during this d        |                    |  | N   | 63. C  |

| Health Financial Systems  | WOO   | DLAWN HOSPITAL  |  | In Lieu                           | u of Form CMS-2                         | 2552-10      |  |  |
|---|---|---|--|-----------------------------------|---|--------------|--|--|
| HOSPITAL AND HOSPITAL HEALTH CARE COMP  |   |   |  | eriod:<br>rom 01/01/2020          | Worksheet S-2<br>Part I                 |              |  |  |
|   |   |   | Unwei ghted                                  | Unwei ghted                       | 7/29/2021 4:1                           |              |  |  |
|   |   |   | FTEs<br>Nonprovi der                         | FTEs in<br>Hospital               | 1/ (col . 1 + col . 2))                 |              |  |  |
|   |   |   | Si te<br>1. 00                               | 2. 00                             | 3. 00                                   |              |  |  |
| Section 5504 of the ACA Base Yea  |   |   |  |                                   |   |              |  |  |
| period that begins on or after July 1, 2009 and before June 30, 2010.  64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.000000 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)   |   |   |  |                                   |   |              |  |  |
| [2. (2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2. 2   | Program Name  | Program Code  | Unwei ghted                                  | Unwei ghted                       | Ratio (col.                             |              |  |  |
|   |   |   | FTEs<br>Nonprovi der<br>Si te                | FTEs in<br>Hospital               | 3/ (col. 3 + col. 4))                   |              |  |  |
| (5.00   5.11   1.01   1. | 1. 00   | 2. 00   | 3. 00  | 4. 00                             | 5. 00                                   | <b>45.00</b> |  |  |
| 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)  |   |   | 0.00   | 0.00                              | 0.000000<br>Ratio (col.                 | 65. 00       |  |  |
|   |   |   | FTEs   | FTEs in                           | 1/ (col. 1 +                            |              |  |  |
|   |   |   | Nonprovider<br>Site                          | Hospi tal                         | col. 2))                                |              |  |  |
|   |   |   | 1. 00  | 2. 00                             | 3. 00                                   |              |  |  |
| Section 5504 of the ACA Current   |   | n Nonprovider Setting                                   |  |                                   |   |              |  |  |
| beginning on or after July 1, 20<br>66.00 Enter in column 1 the number of   |   | rv care resident  | 0.00   | 0. 00                             | 0. 000000                               | 66 00        |  |  |
| FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +   | occurring in all nonpounce<br>unweighted non-priman<br>cal. Enter in column 3 | rovider settings.<br>ry care resident<br>3 the ratio of | 0.00   | 0.00                              | 0.00000                                 | 00.00        |  |  |
|   | Program Name  | Program Code  | Unwei ghted<br>FTEs<br>Nonprovi der<br>Si te | Unweighted<br>FTEs in<br>Hospital | Ratio (col.<br>3/ (col. 3 +<br>col. 4)) |              |  |  |
| (7.00   5.1   1.1   | 1. 00   | 2. 00   | 3.00   | 4. 00                             | 5. 00                                   | /= ==        |  |  |
| 67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)  |   |   | 0.00   | 0. 00                             | 0.000000                                | 67.00        |  |  |

|  | Period:<br>From 01/01/<br>To 12/31/ | 2020<br>2020 | Workshe<br>Part I<br>Date/Ti<br>7/29/20 | me Pre | pared          |
|--|-------------------------------------|--------------|---|--------|----------------|
|  |                                     | 1. 00        | 2.00                                    | 3.00   |                |
| Inpatient Psychiatric Facility PPS 0.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF su   | hnrovi der2                         | N            |   |        | 70. 0          |
| Enter "Y" for yes or "N" for no.   | ppi ovi dei ?                       | IN           |   |        | 70.0           |
| 1.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teat program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reporti    | no. (see<br>chi ng<br>no.           |              |   | 0      | 71. C          |
| (see instructions) Inpatient Rehabilitation Facility PPS   |                                     |              |   |        | -              |
| 5.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF  |                                     | N            |   |        | 75. C          |
| subprovider? Enter "Y" for yes and "N" for no.  6.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes no. Column 2: Did this facility train residents in a new teaching program in accordance.   | or "N" for                          |              |   | 0      | 76.0           |
| CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions   | Υ,                                  |              |   |        |                |
|  |                                     |              | 1. (                                    | 00     |                |
| Long Term Care Hospital PPS  |                                     |              |   |        |                |
| 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reportir "Y" for yes and "N" for no. TEFRA Providers   | g period? E                         | nter         | N<br>N                                  |        | 80. 0<br>81. 0 |
| 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes 6.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Secti §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  |                                     | no.          | N                                       | l      | 85. 0<br>86. 0 |
| 7.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.  |                                     |              | N                                       |        | 87.0           |
|  | 1. 00                               |              | 2. C                                    |        | 1              |
| Title V and XIX Services   |                                     |              |   |        |                |
| 0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in   | N<br>N                              |              | Y                                       |        | 90.0           |
| full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see  |                                     |              | N                                       |        | 92.            |
| instructions) Enter "Y" for yes or "N" for no in the applicable column.  3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.  | N                                   |              | N                                       |        | 93.            |
| 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.  | N                                   |              | N                                       |        | 94.            |
| 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column.<br>6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the   | 0. 00<br>N                          |              | O. 0<br>N                               |        | 95.<br>96.     |
| applicable column. 7.00   If line 96 is "Y", enter the reduction percentage in the applicable column. 8.00   Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.   | 0. 00<br>Y                          |              | 0. (<br>Y                               |        | 97.<br>98.     |
| 8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst<br>C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for  |                                     |              | Υ                                       |        | 98.            |
| title XIX.  8.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.   | Y                                   |              | Υ                                       |        | 98.            |
| 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column for title V, and in column 2 for title XIX.  | 1 N                                 |              | N                                       |        | 98.            |
| 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  | N                                   |              | N                                       |        | 98.            |
| 8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance or Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and i column 2 for title XIX.   |                                     |              | Υ                                       |        | 98.            |
| B.O6 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.  | Y                                   |              | Y                                       |        | 98.            |
| Rural Providers 05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of paymer  | t N                                 |              |   |        | 105.<br>106.   |
| for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or LRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions) | N                                   |              |   |        | 107. (         |

| Health Financial Systems WOODLAWN HO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA   |  | CN: 15-1313 Pe   | In Lieu<br>eriod:   | u of Form CMS-<br>Worksheet S-2 |   |
|--|--|--|---------------------|---------------------------------|---|
| HOSFITAL AND HOSFITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | FI OVI dei Ci  | Fr   | om 01/01/2020       | Part I                          |   |
|  |  | To   | 12/31/2020          | Date/Time Pro 7/29/2021 4:      |   |
|  |  |  | V                   | XI X                            |   |
| 108.00 s this a rural hospital qualifying for an exception to the  | CRNA fee sche  | edul e? See 42   | 1. 00<br>N          | 2. 00                           | 108.00  |
| CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  |  |  |                     |                                 |   |
|  | Physi cal<br>1. 00   | Occupati onal<br>2.00  | Speech<br>3.00      | Respiratory<br>4.00             | -   |
| 109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  | N  | N  | N                   | N                               | 109.00  |
|  |  |  | -                   | 1. 00                           | +   |
| 110. 00 Did this hospital participate in the Rural Community Hospital<br>Demonstration) for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Worksheet E.  | Y" for yes or  | r"N" for no. It  | f yes,              | N                               | 110. 00   |
|  |  |  | 1. 00               | 2. 00                           |   |
| 111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.  | st reporting<br>Jumn 1 is Y,<br>ticipating ir  | period? Enter<br>enter the<br>n column 2.  | N                   |                                 | 111. 00   |
|  |  | 1.00   | 2.00                | 3. 00                           | +   |
| 112.00 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.  | peri od?<br>: "Y", enter<br>:e   | N N  | 2.00                | 3.00                            | 112.00  |
| Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or  | "N" for no   | N  |                     |                                 | _ <br>0115.00   |
| in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.   | , or E only)<br>3" percent<br>includes   |  |                     |                                 | 0 110.00  |
| 116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.   | for yes or   | N  |                     |                                 | 116. 00   |
| 117.00 s this facility legally-required to carry malpractice insur   | ance? Enter  | Y  |                     |                                 | 117. 00   |
| "Y" for yes or "N" for no.  118.00 s the malpractice insurance a claims-made or occurrence pol   | icv? Enter 1   | 1  |                     |                                 | 118. 00   |
| if the policy is claim-made. Enter 2 if the policy is occurr   |  |  |                     | <u> </u>                        |   |
|  |  | Premi ums  | Losses              | Insurance                       |   |
| 440.04   |  | 1.00   | 2. 00               | 3. 00                           |   |
| 118.01 List amounts of malpractice premiums and paid losses:   |  |  |                     |                                 |   |
|  |  | 467, 908   | 39, 286             | 1                               | 0118.01   |
|  |  | 467, 908   | 1.00                | 2. 00                           |   |
| Administrative and General? If yes, submit supporting sched and amounts contained therein.   |  | 467, 908<br>than the   |                     |                                 | 118. 02   |
| Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments.  | lule listing of<br>Harmless pro<br>column 1, "\<br>Halifies for t  | than the cost centers  ovision in ACA Y" for yes or the Outpatient   | 1.00                |                                 | 118. 02   |
| Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impla   | ule listing of<br>Harmless pro<br>column 1, "\<br>alifies for t<br>ts? (see inst   | than the cost centers  Division in ACA Y" for yes or the Outpatient tructions)   | 1. 00<br>N          | 2. 00                           | 118. 02<br>119. 00<br>120. 00   |
| Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.   | Harmless pro<br>column 1, "\<br>alifies for t<br>ts? (see inst<br>intable device   | than the cost centers  ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the   | 1. 00<br>N          | 2. 00                           | 118. 02<br>119. 00<br>120. 00   |
| Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.  122.00 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. Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for  | Harmless pro<br>column 1, "Y<br>alifies for t<br>ts? (see inst<br>intable device<br>ined in §1903<br>is "Y", ente  | than the cost centers  ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2  | 1.00<br>N<br>N      | 2. 00                           | 118. 02<br>119. 00<br>120. 00<br>121. 00  |
| Administrative and General? If yes, submit supporting sched and amounts contained therein.  119. 00 DO NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.  122. 00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.  Transplant Center Information  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.   | Harmless pro<br>column 1, "Y<br>alifies for t<br>its? (see inst<br>intable device<br>ined in §1903<br>is "Y", ente   | than the cost centers  Division in ACA Y" for yes or the Outpatient tructions)  es charged to  3(w)(3) of the er in column 2   | 1.00<br>N<br>N<br>Y | 2. 00                           | 118. 02<br>119. 00<br>120. 00<br>121. 00<br>122. 00   |
| Administrative and General? If yes, submit supporting sched and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hold Harmless provision in ACA §3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 | Harmless proceed to column 1, "Yealifies for the series of | than the cost centers  Division in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2  ' for no. If   | 1.00<br>N<br>N<br>Y | 2. 00                           | 118. 02<br>119. 00<br>120. 00<br>121. 00<br>122. 00<br>125. 00<br>126. 00   |
| Administrative and General? If yes, submit supporting sched and amounts contained therein.  119. 00 D0 NOT USE THIS LINE  120. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendmententer in column 2, "Y" for yes or "N" for no.  121. 00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no.  122. 00 Does the cost report contain heal thcare related taxes as defective 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.  125. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2   | Harmless proceed to column 1, "Yealifies for the series and "N" ter the certific er the certific.  | than the cost centers  ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2  ' for no. If ification date fication date               | 1.00<br>N<br>N<br>Y | 2. 00                           | 118. 02<br>119. 00<br>120. 00<br>121. 00<br>122. 00<br>125. 00<br>126. 00<br>127. 00                                  |
| and amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implated patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain heal thcare related taxes as defective Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2   | Harmless produced in the control of the certification of the certificati | than the cost centers  ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2  ' for no. If ification date fication date fication date | 1.00<br>N<br>N<br>Y | 2. 00                           | 118. 01<br>118. 02<br>119. 00<br>120. 00<br>121. 00<br>122. 00<br>125. 00<br>126. 00<br>127. 00<br>128. 00<br>129. 00 |

| OSPITAL AND HOSPITAL HEALTH CARE COMPLE  | WOODLAWN X IDENTIFICATION DATA   | Provi der CO   | CN: 15-1313  | Peri od  |   | of Form CMS<br>Worksheet S  |   |
|--|--|--|--|--|---|---|---|
|  |  |  |  |  | 01/01/2020<br>2/31/2020   | Part I<br>Date/Time P<br>7/29/2021 4  | repared   |
|  |  |  |  |  | 1. 00   | 2. 00   |   |
| 30.00 If this is a Medicare certified pa   |  |  | ti fi cati on  |  |   |   | 130.0   |
| date in column 1 and termination of<br>31.00 If this is a Medicare certified in  |  |  | erti fi cati o   | n  |   |   | 131. (  |
| date in column 1 and termination o   | late, if applicable, in  | column 2.  |  |  |   |   |   |
| 32.00 If this is a Medicare certified is in column 1 and termination date,   |  |  | ication dat  | е  |   |   | 132.0   |
| 33.00 Removed and reserved   |  |  |  |  |   |   | 133. (  |
| 34.00   f this is an organ procurement or<br>and termination date, if applicabl<br>All Providers   |  | the OPO number   | in column 1  |  |   |   | 134. (  |
| 40.00 Are there any related organization   |  |  |  |  | N   |   | 140. (  |
| chapter 10? Enter "Y" for yes or "<br>are claimed, enter in column 2 the   |  |  |  | ts   |   |   |   |
| 1.00   | 2  | . 00   |  |  | 3. 00   |   |   |
| If this facility is part of a chai office and enter the home office of   |  |  | ough 143 the   | e name ai  | nd address  | of the home   | :   |
| 41. 00 Name:   | Contractor's Name:   | Tactor Humber.   | Contrac  | tor's Nu   | umber:  |   | 141. (  |
| 42.00 Street:  | PO Box:  |  | 7: - 0   | la.  |   |   | 142.0   |
| 43. 00 Ci ty:  | State:   |  | Zi p Coc   | ie:  |   |   | 143. (  |
| 44.00  | To the last to West above  |  |  |  |   | 1.00  |   |
| 14.00 Are provider based physicians' cos   | sts included in worksnee   | t A?   |  |  |   | Y   | 144.0   |
|  |  |  |  |  | 1. 00   | 2. 00   |   |
| 15.00 If costs for renal services are cl<br>inpatient services only? Enter "Y"   |  |  |  |  |   |   | 145.  |
| no, does the dialysis facility inc   | lude Medicare utilizati  |  |  |  |   |   |   |
| period? Enter "Y" for yes or "N"   |  | iously filed ses   | t roport?  |  | N   |   | 114   |
| 46.00 Has the cost allocation methodolog<br>Enter "Y" for yes or "N" for no ir<br>yes, enter the approval date (mm/o   | column 1. (See CMS Pub   |  |  | lf   | N   |   | 146. (  |
|  | id/yyyy/ iii coruiiii z.   |  |  |  |   |   |   |
|  | aryyyy) iii corumii 2.   |  |  |  | •   | 1 00  |   |
|  |  | r yes or "N" for   | no.  |  |   | 1. 00<br>N  | 147.  |
| 47.00 Was there a change in the statisti<br>48.00 Was there a change in the order of   | cal basis? Enter "Y" fo<br>allocation? Enter "Y"   | for yes or "N" f   | or no.   |  |   | N<br>N  | 148. (  |
| 47.00 Was there a change in the statisti<br>48.00 Was there a change in the order of   | cal basis? Enter "Y" fo<br>allocation? Enter "Y"   | for yes or "N" f   | or no.   |  | ritle V   | N   | 148.<br>149.  |
| 47.00Was there a change in the statisti<br>48.00Was there a change in the order of<br>49.00Was there a change to the simplifi  | cal basis? Enter "Y" fo<br>allocation? Enter "Y"<br>ed cost finding method?  | for yes or "N" for y Enter "Y" for y Part A 1.00   | for no.<br>yes or "N" f<br>Part B<br>2.00  | 7  | 3. 00   | N<br>N<br>N<br>Title XIX<br>4.00  | 148.<br>149.  |
| 47.00Was there a change in the statisti 48.00Was there a change in the order of 49.00Was there a change to the simplifi  Does this facility contain a provi  | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?   | for yes or "N" for yes or "N" for yes or "N" for yes or ye | or no.  yes or "N" f Part B 2.00  om the appli   | cation (   | 3.00<br>of the low  | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs   | 148.<br>149.  |
| 17.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change to the simplifi  Does this facility contain a provi or charges? Enter "Y" for yes or "  | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?   | for yes or "N" for yes Enter "Y" for yes 1.00 an exemption froment for Part A  | for no. yes or "N" f Part B 2.00 om the appli A and Part B   | cation (   | 3.00<br>of the lowe<br>42 CFR §41:<br>N                           | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)  | 148.  |
| 17.00 Was there a change in the statisti 18.00 Was there a change in the order of 19.00 Was there a change to the simplifi  Does this facility contain a provi or charges? Enter "Y" for yes or " 55.00 Hospital 66.00 Subprovider - IPF   | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?   | for yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the sone of the son | for no.  yes or "N" f Part B 2.00  om the appli A and Part E N N   | cation (   | 3.00<br>of the low<br>42 CFR §41:<br>N                            | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N   | 148.<br>149.<br>155.<br>156.  |
| A7.00 Was there a change in the statistion in the statistion and the statistion in the order of the simplifiance of the simpli | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?   | for yes or "N" for yes Enter "Y" for yes 1.00 an exemption froment for Part A  | for no. yes or "N" f Part B 2.00 om the appli A and Part B   | cation (   | 3.00<br>of the lowe<br>42 CFR §41:<br>N                           | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)  | 148.<br>149.<br>155.<br>156.<br>157.  |
| Does this facility contain a provior charges? Enter "Y" for yes or "055.00 Subprovider - IRF 58.00 SUBPROVIDER   | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?   | for yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the sone of the son | for no.  yes or "N" f Part B 2.00  om the appli A and Part E N N   | cation (   | 3.00<br>of the low<br>42 CFR §41:<br>N                            | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N   | 148.<br>149.<br>155.<br>156.<br>157.<br>158.  |
| Does this facility contain a provior charges? Enter "Y" for yes or "65.00 Subprovider - IPF 57.00 Subprovider - IRF 59.00 SNF 60.00 HOME HEALTH AGENCY   | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?   | for yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the second for Part A N N N   | For no.  yes or "N" f  Part B  2.00  ym the appli A and Part E  N  N  N  N   | cation (   | 3.00 of the low 42 CFR §41: N N N N                               | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N   | 148. (<br>149. (<br>155. (<br>156. (<br>157. (<br>158. (<br>159. (<br>160. (                  |
| Does this facility contain a provior charges? Enter "Y" for yes or "65.00 Subprovider - IPF 58.00 Subprovider - IRF 59.00 SNF 60.00 HOME HEALTH AGENCY   | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?   | for yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the sound of | For no.  yes or "N" f  Part B  2.00  om the appli A and Part E  N  N  N  | cation (   | 3.00<br>of the low<br>42 CFR §41:<br>N<br>N<br>N                  | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N   | 148. (<br>149. (<br>155. (<br>156. (<br>157. (<br>158. (<br>159. (<br>160. (                  |
| Does this facility contain a provior charges? Enter "Y" for yes or "  55.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 HOME HEALTH AGENCY 61.00 CMHC  | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?   | for yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the sound of | For no.  yes or "N" f  Part B  2.00  ym the appli A and Part E  N  N  N  N   | cation (   | 3.00 of the low 42 CFR §41: N N N N                               | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N   | 147. 48. 6<br>149. 6<br>155. 156. 6<br>157. 6<br>158. 159. 6<br>160. 6                        |
| 47.00 Was there a change in the statisti 48.00 Was there a change in the order of 49.00 Was there a change to the simplifi  Does this facility contain a provi or charges? Enter "Y" for yes or " 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 61.00 CMHC   | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the second for Part A N N N N N N N N N N N N N N N N N N   | For no.  yes or "N" f  Part B  2.00  The applition of the applitude of the | cation of the ca | 3.00 of the lowe 42 CFR §41.  N N N N N N N N N N N N N N N N N N | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N  | 148. u<br>149. u<br>155. u<br>156. u<br>157. u<br>158. u<br>160. u<br>161. u                  |
| Does this facility contain a provior charges? Enter "Y" for yes or "  55.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 HOME HEALTH AGENCY 61.00 CMHC  | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes Part A 1.00 an exemption from the second for Part A N N N N N N N N N N N N N N N N N N   | For no.  yes or "N" f  Part B  2.00  you the application of the applic | cation (3. (See  | 3.00 of the Low 42 CFR §41. N N N N N N CBSAs?                    | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N   | 148. u<br>149. u<br>155. u<br>156. u<br>157. u<br>158. u<br>160. u<br>161. u                  |
| Does this facility contain a provior charges? Enter "Y" for yes or "  55.00 Subprovider - IPF  58.00 SUBPROVIDER  59.00 HOME HEALTH AGENCY  Multicampus  Multicampus  18.00 Was there a change in the statistical the order of the | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes and a seemption from the seem | For no.  yes or "N" f  Part B  2.00  you the applination of the application of the applic | cation of the ca | 3.00 of the Low 42 CFR §41. N N N N N CBSAS?                      | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N  | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |
| Does this facility contain a provior charges? Enter "Y" for yes or "St. 00 Subprovider - IRF 8.00 Subprovider - IR | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes 1.00 an exemption fromonent for Part A  N N N N N N N N N N N N N N N N N N   | For no.  yes or "N" f  Part B  2.00  ym the applia  A and Part E  N  N  N  N  N  N  N  N  N  N  N  N  N  | cation (3. (See  | 3.00 of the Low 42 CFR §41. N N N N N N CBSAs?                    | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N                                  | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |
| Does this facility contain a provior charges? Enter "Y" for yes or "St. 00 Subprovider - IRF 8.00 Subprovider - IR | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes and a seemption from the seem | For no.  yes or "N" f  Part B  2.00  you the applination of the application of the applic | cation of the ca | 3.00 of the Low 42 CFR §41. N N N N N CBSAS?                      | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N                                  | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |
| Does this facility contain a provior charges? Enter "Y" for yes or "55.00 Hospital Subprovider - IPF Subprovider - IRF S | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes and a seemption from the seem | For no.  yes or "N" f  Part B  2.00  you the applination of the application of the applic | cation of the ca | 3.00 of the Low 42 CFR §41. N N N N N CBSAS?                      | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N                                  | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |
| Does this facility contain a provior charges? Enter "Y" for yes or "65.00 Was there a change to the simplifiable.  Does this facility contain a provior charges? Enter "Y" for yes or "65.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 69.00 SUBPROVIDER 69.00 SNF 60.00 HOME HEALTH AGENCY 61.00 CMHC  Multicampus 65.00 is this hospital part of a Multical Enter "Y" for yes or "N" for no.  Multicampus 65.00 is this hospital part of a Multical Enter "Y" for yes or "N" for no.  Occumpus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,   | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes and a seemption from the seem | For no.  yes or "N" f  Part B  2.00  you the applination of the application of the applic | cation of the ca | 3.00 of the Low 42 CFR §41. N N N N N CBSAS?                      | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N                                  | 148. u<br>149. u<br>155. u<br>156. u<br>157. u<br>158. u<br>160. u<br>161. u                  |
| Does this facility contain a provior charges? Enter "Y" for yes or "Go. 00 Subprovider - IRF 18.00 Sub | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes and a seemption from the seem | For no.  yes or "N" f  Part B  2.00  you the applination of the application of the applic | cation of the ca | 3.00 of the Low 42 CFR §41. N N N N N CBSAS?                      | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N                                  | 148. 149. 1<br>155. 156. 1<br>157. 158. 159. 1<br>160. 1<br>165. 1                            |
| 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifi  Does this facility contain a provi or charges? Enter "Y" for yes or " 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC  Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.  6.00 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,  | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp   | for yes or "N" for yes Enter "Y" for yes and a seemption from the seem | For no.  yes or "N" f  Part B  2.00  you the applination of the application of the applic | cation of the ca | 3.00 of the Low 42 CFR §41. N N N N N CBSAS?                      | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N                                  | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |
| Does this facility contain a provior charges? Enter "Y" for yes or "55.00 Hospital Selection of the Subprovider - IPF Selection of the Subprovider - IRF Selection of the Se | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp  mpus hospital that has  Name  0  | for yes or "N" for yes nor "N" for yes or "N" for yes nor yes  | For no.  yes or "N" f  Part B  2.00  The appliance of the | Gation (3. (See A  | 3.00 of the Lowe 42 CFR §41. N N N N N CBSAS?  CBSA 4.00          | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N                                  | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |
| Does this facility contain a provior charges? Enter "Y" for yes or "55.00 Hospital Subprovider - IPF Subprovider - IPF Subprovider - IPF Subprovider - IRF S | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp  impus hospital that has  Name  0   | for yes or "N" for yes nor "N" for yes or "N" for yes nor yes  | For no.  yes or "N" f  Part B  2.00  The appliance of the | Gation (3. (See A  | 3.00 of the Lowe 42 CFR §41. N N N N N CBSAS?  CBSA 4.00          | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>O<br>FTE/Campus<br>5.00<br>O. | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |
| Does this facility contain a provior charges? Enter "Y" for yes or "55.00 Hospital 66.00 Subprovider - IPF 67.00 Subprovider - IRF 69.00 Subprovider - | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp  impus hospital that has  Name  0  incentive in the Americander §1886(n)? Enter   | for yes or "N" for yes nor "N" for yes or "N" for yes nor yes  | For no.  yes or "N" f  Part B  2.00  The appliance of the | cation (3. (See )  | 3.00 of the Low 42 CFR §41. N N N N N CBSAS? CBSA 4.00            | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>S<br>TI.00               | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |
| 47.00 Was there a change in the statistical 48.00 Was there a change in the order of 49.00 Was there a change to the simplification or charges? Enter "Y" for yes or "55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC  Multicampus  Is this hospital part of a Multicate Enter "Y" for yes or "N" for no.  Multicampus  Is this hospital part of a multicate Enter "Y" for yes or "N" for no.  66.00 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)  Health Information Technology (HII 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 reasonable cost incurred for the Information Technology (HII 59.00 Is this provider is a CAH (line 10 line the Information Technology (HII 59.00 Is this  | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp  impus hospital that has  Name  0  O  incentive in the American services are an early and is a mean lIT assets (see instruct).  | for yes or "N" for yes nor "N" for yes or "N" for yes or "N" for yes or "N" for yes or ingful user (lining).   | ouses in dif   | cation of a cation | 3.00 of the Lowe 42 CFR §41. N N N N N CBSA? CBSA 4.00            | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>O<br>FTE/Campus<br>5.00<br>O. | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.<br>165.<br>3.<br>00 166. |
| Multicampus 15.00   Multic | cal basis? Enter "Y" for allocation? Enter "Y" ed cost finding method?  der that qualifies for N" for no for each comp  mpus hospital that has  Name  0  O  incentive in the American area of the comp | for yes or "N" for yes nor "N" for yes or "N" for yes or "N" for yes on ingful user (linions) oes this provides  | ouses in difference in the second of the application of the applicatio | cation of a second of the cation of a second of a seco | 3.00 of the Lowe 42 CFR §41. N N N N N CBSA? CBSA 4.00            | N<br>N<br>N<br>Title XIX<br>4.00<br>er of costs<br>3.13)<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>N<br>O<br>FTE/Campus<br>5.00<br>O. | 148.<br>149.<br>155.<br>156.<br>157.<br>158.<br>159.<br>160.<br>161.                          |

| Health Financial Systems  | WOODLAWN HOSPITAL        |                       |            |                       | of Form CMS-             | 2552-10   |
|---|--------------------------|-----------------------|------------|-----------------------|--------------------------|-----------|
| HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX   | IDENTIFICATION DATA      | Provider CCN: 15-1313 |            | i od:<br>m 01/01/2020 | Worksheet S-             | 2         |
|   |                          |                       |            |                       | Part  <br>  Date/Time Pr | oparod:   |
|   |                          | То                    | 12/31/2020 | 7/29/2021 4:          |                          |           |
|   |                          | 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 provid   |                          |                       |            | N                     |                          | 0 171. 00 |
| section 1876 Medicare cost plans rep<br>"Y" for yes and "N" for no in column<br>1876 Medicare days in column 2. (see      | 1. If column 1 is yes, e |                       | on         |                       |                          |           |
| 1070 wedicare days in cordini 2. (3cc   | instructions)            |                       | - 1        |                       |                          | 1         |

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1313 Peri od: Worksheet S-2 From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/29/2021 4:15 pm Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1 00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Y/N Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Туре Date 1.00 3.00 2.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ 4.00 Α or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1. 00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing school and/or allied health programs approved and/or renewed during the 8.00 N 8.00 cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education Ν 9.00 program in the current cost report? If yes, see instructions. . Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions γ 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Ν 15.00 Part A Part B Y/N Y/N Date Date 3.00 1.00 2.00 4.00 PS&R Data 02/12/2021 02/12/2021 Was the cost report prepared using the PS&R Report only? Υ 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17 00 Was the cost report prepared using the PS&R Report for Ν 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.
19.00 If line 16 or 17 is yes, were adjustments made to PS&R N N 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

| Heal th | Financial Systems WOODLAWN I  | HOSPI TAL        |                 | In Lie                                       | u of Form CM:  | S-2552-10 |  |  |
|---------|---|------------------|-----------------|--|--|-----------|--|--|
|         | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   |                  | CN: 15-1313     | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet S<br>Part II<br>Date/Time P<br>7/29/2021 4 | repared:  |  |  |
|         |   |                  | i pti on        | Y/N  | Y/N  |           |  |  |
| 20.00   | If line 16 or 17 is was mare adjustments made to DCOD   |                  | 0               | 1. 00<br>N                                   | 3. 00<br>N   | 20.00     |  |  |
| 20.00   | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:     |                  |                 | IN   | IN   | 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)     |  |  |           |  |  |
|         | Capital Related Cost  |                  |                 |  |  |           |  |  |
| 22. 00  | Have assets been relifed for Medicare purposes? If yes, se  |                  | N               | 22. 00                                       |  |           |  |  |
| 23. 00  | Have changes occurred in the Medicare depreciation expense  | ring the cost    | N               | 23. 00                                       |  |           |  |  |
|         | reporting period? If yes, see instructions.   |                  |                 |  |  |           |  |  |
| 24. 00  | Were new leases and/or amendments to existing leases enter-<br>If yes, see instructions                           | ed into during   | this cost re    | eporting period?                             | N  | 24.00     |  |  |
| 25. 00  | Have there been new capitalized leases entered into during  | the cost repo    | rting period    | ? If yes, see                                | N  | 25. 00    |  |  |
|         | i nstructi ons.   |                  |                 |  |  |           |  |  |
| 26. 00  | Were assets subject to Sec. 2314 of DEFRA acquired during tinstructions.  | he cost report   | ing period?     | f yes, see                                   | N  | 26. 00    |  |  |
| 27. 00  | Has the provider's capitalization policy changed during the   | e cost reporti   | ng period? In   | fyes, submit                                 | N  | 27. 00    |  |  |
|         | copy.   | ·                |                 |  |  |           |  |  |
| 28. 00  | Unterest Expense Were new Loans, mortgage agreements or Letters of credit e                                       | ntorod into du   | uning the cos   | t roporting                                  | Υ  | 28.00     |  |  |
| 20.00   | period? If yes, see instructions.   | intered Titto du | irring the cos  | r reporting                                  | '  | 20.00     |  |  |
| 29. 00  | Did the provider have a funded depreciation account and/or  |                  | ebt Service I   | Reserve Fund)                                | N  | 29. 00    |  |  |
| 20.00   | treated as a funded depreciation account? If yes, see inst  |                  |                 |  | N.   | 20.00     |  |  |
| 30. 00  | Has existing debt been replaced prior to its scheduled mat instructions.  | urity with new   | debt? IT yes    | s, see                                       | N  | 30.00     |  |  |
| 31.00   | Has debt been recalled before scheduled maturity without is   | ssuance of new   | debt? If yes    | s, see                                       | N  | 31.00     |  |  |
|         | instructions.   |                  |                 |  |  |           |  |  |
| 32. 00  | Purchased Services Have changes or new agreements occurred in patient care se                                     | rvi cos furni sh | od through o    | ntractual                                    | N  | 32.00     |  |  |
| 32.00   | arrangements with suppliers of services? If yes, see instr  |                  | led thi odgir c | onti actuai                                  | 14   | 32.00     |  |  |
| 33.00   | If line 32 is yes, were the requirements of Sec. 2135.2 ap  |                  | ng to competi   | tive bidding? If                             | N  | 33.00     |  |  |
|         | no, see instructions.   |                  |                 |  |  |           |  |  |
| 34 00   | Provider-Based Physicians  Are services furnished at the provider facility under an a                             | rrangement wit   | h provi der_h:  | ased physicians?                             | Y  | 34.00     |  |  |
| 01.00   | If yes, see instructions.   | Trangement wit   | n provider b    | asca priysi ci aris.                         |  | 01.00     |  |  |
| 35. 00  | If line 34 is yes, were there new agreements or amended ex  |                  | nts with the    | provi der-based                              | N  | 35.00     |  |  |
|         | physicians during the cost reporting period? If yes, see i  | nstructions.     |                 | Y/N  | Date   |           |  |  |
|         |   |                  |                 | 1.00   | 2. 00  |           |  |  |
|         | Home Office Costs   |                  |                 | -  |  |           |  |  |
| 36.00   | Were home office costs claimed on the cost report?  |                  |                 | N  |  | 36. 00    |  |  |
| 37.00   | If line 36 is yes, has a home office cost statement been p  | repared by the   | home office     | ?  |  | 37.00     |  |  |
| 20 00   | If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of                               | fica difforant   | from that a     | F  |  | 38.00     |  |  |
| 36.00   | the provider? If yes, enter in column 2 the fiscal year en  |                  |                 |  |  | 36.00     |  |  |
| 39. 00  | If line 36 is yes, did the provider render services to other  |                  |                 | S,   |  | 39. 00    |  |  |
| 40.00   | see instructions.   |                  | 1.6             |  |  | 40.00     |  |  |
| 40. 00  | If line 36 is yes, did the provider render services to the instructions.  | nome office?     | it yes, see     |  |  | 40.00     |  |  |
|         | prince decrease.  |                  |                 |  |  |           |  |  |
|         | 1.00  |                  |                 |  |  |           |  |  |
| 41 00   | Cost Report Preparer Contact Information  41.00 Enter the first name, last name and the title/position KYLE SMITH |                  |                 |  |  |           |  |  |
| 41. 00  |   |                  | 41.00           |  |  |           |  |  |
|         | held by the cost report preparer in columns 1, 2, and 3, respectively.  |                  |                 |  |  |           |  |  |
| 42.00   | 11 3  | BLUE & CO. LLO   |                 |  |  | 42.00     |  |  |
|         | preparer.   |                  |                 |  |  |           |  |  |
| 43. 00  |   | 317-713-7957     |                 | KCSMI TH@BLUEAN                              | DCO. COM   | 43.00     |  |  |
|         | report preparer in columns 1 and 2, respectively.   | I                |                 | I  |  | II        |  |  |

| Health Financial Sys |                              |                  |             |    | In Lieu of Form CMS-2552 |           |  |        |
|----------------------|------------------------------|------------------|-------------|----|--------------------------|-----------|--|--------|
| HOSPITAL AND HOSPITA | AL HEALTH CARE REIMBURSEMENT | QUESTI ONNAI RE  | Provi der C |    |                          | 1/01/2020 | Worksheet S-2<br>Part II<br>Date/Time Pre<br>7/29/2021 4:1 | pared: |
|                      |                              |                  |             |    |                          |           |  |        |
|                      |                              |                  | 3.          | 00 |                          |           |  |        |
| Cost Report P        | reparer Contact Information  |                  |             |    |                          |           |  |        |
| 41.00 Enter the fir  | st name, last name and the t | title/position   | DI RECTOR   |    |                          |           |  | 41.00  |
| held by the c        | ost report preparer in colum | nns 1, 2, and 3, |             |    |                          |           |  |        |
| respecti vel y.      |                              |                  |             |    |                          |           |  |        |
| 42.00 Enter the emp  | loyer/company name of the co | ost report       |             |    |                          |           |  | 42.00  |
| preparer.            |                              |                  |             |    |                          |           |  |        |
| 43.00 Enter the tel  | ephone number and email addr | ress of the cost |             |    |                          |           |  | 43.00  |
| report prepar        | er in columns 1 and 2, respe | ecti vel y.      |             |    |                          |           |  |        |
|                      |                              |                  |             |    |                          |           |  |        |

Health Financial SystemsWOODHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-1313 

|                  |   |                  |             | 10           | 5 12/31/2020 | 7/29/2021 4:1 |                  |
|------------------|---|------------------|-------------|--------------|--------------|---------------|------------------|
|                  |   |                  |             |              |              | 1/P Days /    | J pili           |
|                  |   |                  |             |              |              | 0/P Visits /  |                  |
|                  |   |                  |             |              |              | Trips         |                  |
|                  | Component   | Worksheet A      | No. of Beds | Bed Days     | CAH Hours    | Title V       |                  |
|                  | <b>'</b>  | 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            | 21          | 7, 686       | 51, 816. 00  | 0             | 1.00             |
|                  | 8 exclude Swing Bed, Observation Bed and  |                  |             |              |              |               |                  |
|                  | Hospice days) (see instructions for col. 2  |                  |             |              |              |               |                  |
|                  | for the portion of LDP room available beds)   |                  |             |              |              |               |                  |
| 2.00             | HMO and other (see instructions)  |                  |             |              |              |               | 2.00             |
| 3.00             | HMO I PF Subprovi der   |                  |             |              |              |               | 3.00             |
| 4.00             | HMO I RF Subprovi der   |                  |             |              |              |               | 4.00             |
| 5.00             | Hospital Adults & Peds. Swing Bed SNF   |                  |             |              |              | 0             | 5.00             |
| 6. 00<br>7. 00   | Hospital Adults & Peds. Swing Bed NF<br>Total Adults and Peds. (exclude observation |                  | 21          | 7, 686       | 51, 816. 00  | _             | 6. 00<br>7. 00   |
| 7.00             | beds) (see instructions)  |                  | 21          | 7,000        | 31, 616. 00  | U             | 7.00             |
| 8. 00            | INTENSIVE CARE UNIT   | 31.00            | 4           | 1, 464       | 9, 384. 00   | 0             | 8. 00            |
| 9. 00            | CORONARY CARE UNIT  | 31.00            | 7           | 1, 404       | 7, 304. 00   |               | 9.00             |
| 10.00            | BURN INTENSIVE CARE UNIT  |                  |             |              |              |               | 10.00            |
| 11. 00           | SURGICAL INTENSIVE CARE UNIT  |                  |             |              |              |               | 11. 00           |
| 12. 00           | OTHER SPECIAL CARE (SPECIFY)  |                  | •           |              |              |               | 12.00            |
| 13. 00           | NURSERY   | 43.00            | •           |              |              | 0             | 13.00            |
| 14.00            | Total (see instructions)  |                  | 25          | 9, 150       | 61, 200. 00  | 0             | 14.00            |
| 15.00            | CAH vi si ts  |                  |             |              |              | 0             | 15.00            |
| 16.00            | SUBPROVI DER - I PF   |                  |             |              |              |               | 16.00            |
| 17.00            | SUBPROVI DER - I RF   |                  |             |              |              |               | 17.00            |
| 18.00            | SUBPROVI DER  |                  |             |              |              |               | 18.00            |
| 19.00            | SKILLED NURSING FACILITY  |                  |             |              |              |               | 19.00            |
| 20.00            |   |                  |             |              |              |               | 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           | , ,   | 30. 00           |             |              |              |               | 24. 10           |
| 25.00            | CMHC - CMHC   | 00.00            |             |              |              |               | 25. 00           |
| 26. 00           | SHAFER MEDICAL CENTER   | 88. 00           |             |              |              | 0             | 26. 00           |
| 26. 01<br>26. 02 | WOODLAWN MEDICAL PROFESSIONALS  | 88. 01<br>88. 02 |             |              |              | 0             | 26. 01<br>26. 02 |
| 26. 02           | FULTON COUNTY MEDICAL CENTER- 700 MA FULTON COUNTY MEDICAL CENTER - 100 E           | 88. 02<br>88. 03 |             |              |              | 0             | 26. 02           |
| 26. 03           |   | 88. 04           |             |              |              | 0             | 26. 03           |
| 26. 05           | ARGOS MEDICAL CLINIC  | 88. 05           |             |              |              | 0             | 26. 04           |
| 26. 25           | FEDERALLY QUALIFIED HEALTH CENTER   | 89. 00           |             |              |              | 0             | 26. 25           |
| 27. 00           |   | 07.00            | 25          |              |              |               | 27. 00           |
| 28. 00           | ,   |                  | 20          |              |              | 0             | 28. 00           |
| 29. 00           | 1   |                  |             |              |              |               | 29.00            |
| 30.00            | ·   |                  |             |              |              |               | 30.00            |
| 31.00            | Employee discount days - IRF  |                  |             |              |              |               | 31.00            |
| 32.00            |   |                  | 0           | 0            |              |               | 32.00            |
| 32. 01           | 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           |
|                  |   |                  |             |              |              |               |                  |

Provider CCN: 15-1313

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/29/2021 4:15 pm

|        |  |                  |              |                   | 1                   | <u>  7/29/2021  4: 1</u> | 5 pm   |
|--------|--|------------------|--------------|-------------------|---------------------|--------------------------|--------|
|        |  | I/P Days         | / O/P Visits | / Tri ps          | Full Time E         | Equi val ents            |        |
|        |  |                  |              |                   |                     |                          |        |
|        | C  | T: +1 - V/// 1 1 | T: ±1 = VIV  | T-+-1 All         | Takal lakasas       | F1 0                     |        |
|        | Component                                    | Title XVIII      | Title XIX    | Total All         | Total Interns       | Employees On             |        |
|        |  | 6. 00            | 7. 00        | Pati ents<br>8.00 | & Residents<br>9.00 | Payrol I<br>10.00        |        |
| 1. 00  | Hospital Adults & Peds. (columns 5, 6, 7 and | 890              | 7.00         | 2, 159            |                     | 10.00                    | 1.00   |
| 1.00   | 8 exclude Swing Bed, Observation Bed and     | 690              | 70           | 2, 137            |                     |                          | 1.00   |
|        | Hospice days) (see instructions for col. 2   |                  |              |                   |                     |                          |        |
|        | for the portion of LDP room available beds)  |                  |              |                   |                     |                          |        |
| 2. 00  | HMO and other (see instructions)             | 517              | 213          |                   |                     |                          | 2.00   |
| 3. 00  | HMO IPF Subprovi der                         | 0 0              | 0            |                   |                     |                          | 3.00   |
| 4. 00  | HMO IRF Subprovider                          | l ol             | ol           |                   |                     |                          | 4.00   |
| 5. 00  | Hospital Adults & Peds. Swing Bed SNF        | 96               | o            | 96                |                     |                          | 5.00   |
| 6. 00  | Hospital Adults & Peds. Swing Bed NF         | , ,              | ol           | 70                |                     |                          | 6.00   |
| 7. 00  | Total Adults and Peds. (exclude observation  | 986              | 70           | 2, 325            |                     |                          | 7. 00  |
|        | beds) (see instructions)                     |                  |              | _,                |                     |                          |        |
| 8.00   | INTENSIVE CARE UNIT                          | 160              | o            | 391               |                     |                          | 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                                      |                  | o            | 321               |                     |                          | 13.00  |
| 14.00  | Total (see instructions)                     | 1, 146           | 70           | 3, 037            | 0.00                | 317. 76                  | 14.00  |
| 15.00  | CAH vi si ts                                 | o                | o            | 0                 |                     |                          | 15.00  |
| 16.00  | SUBPROVI DER - I PF                          |                  |              |                   |                     |                          | 16.00  |
| 17.00  | SUBPROVI DER - I RF                          |                  |              |                   |                     |                          | 17. 00 |
| 18.00  | SUBPROVI DER                                 |                  |              |                   |                     |                          | 18. 00 |
| 19.00  | SKILLED NURSING FACILITY                     |                  |              |                   |                     |                          | 19. 00 |
| 20.00  | NURSING FACILITY                             |                  |              |                   |                     |                          | 20.00  |
| 21.00  | OTHER LONG TERM CARE                         |                  |              |                   |                     |                          | 21.00  |
| 22. 00 | HOME HEALTH AGENCY                           |                  |              |                   |                     |                          | 22. 00 |
| 23.00  | AMBULATORY SURGICAL CENTER (D. P.)           |                  |              |                   |                     |                          | 23. 00 |
| 24.00  | HOSPI CE                                     |                  |              |                   |                     |                          | 24.00  |
| 24. 10 | HOSPICE (non-distinct part)                  |                  |              | 0                 |                     |                          | 24. 10 |
| 25. 00 | CMHC - CMHC                                  |                  |              |                   |                     |                          | 25. 00 |
| 26. 00 | SHAFER MEDICAL CENTER                        | 831              | 558          | 3, 978            |                     | 5. 91                    |        |
| 26. 01 | WOODLAWN MEDICAL PROFESSIONALS               | 369              | 2, 349       | 8, 805            |                     | 16. 62                   | 26. 01 |
| 26. 02 | FULTON COUNTY MEDICAL CENTER- 700 MA         | 1, 163           | 1, 849       | 9, 305            | 0. 00               | 17. 61                   | 26. 02 |
| 26. 03 | FULTON COUNTY MEDICAL CENTER - 100 E         | 331              | 233          | 1, 558            |                     | 0. 60                    | 26. 03 |
| 26. 04 | AKRON MEDICAL CLINIC                         | 427              | 416          | 2, 781            | 0.00                | 4. 20                    | 26.04  |
| 26. 05 | ARGOS MEDICAL CLINIC                         | 1, 324           | 1, 935       | 10, 658           |                     | 10. 92                   | 26. 05 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER            | 0                | 0            | 0                 |                     | 0.00                     | 26. 25 |
| 27. 00 | Total (sum of lines 14-26)                   |                  | 0.4          |                   | 0. 00               | 373. 62                  | 27. 00 |
| 28. 00 | Observation Bed Days                         |                  | 91           | 775               |                     |                          | 28. 00 |
| 29. 00 | Ambul ance Trips                             | 0                |              |                   |                     |                          | 29.00  |
| 30.00  | Employee discount days (see instruction)     |                  |              | 0                 |                     |                          | 30.00  |
| 31.00  | Employee discount days - IRF                 |                  | 2.4          | 0                 |                     |                          | 31.00  |
| 32.00  | Labor & delivery days (see instructions)     | 0                | 34           | 111               |                     |                          | 32.00  |
| 32. 01 | Total ancillary labor & delivery room        |                  |              | 0                 |                     |                          | 32. 01 |
| 33. 00 | outpatient days (see instructions)           | 0                |              |                   |                     |                          | 33.00  |
|        | LTCH site poutral days and discharges        | -1               |              |                   |                     |                          | 33.00  |
| 33.01  | LTCH site neutral days and discharges        | 0                |              |                   |                     |                          | 33.UI  |

Health Financial Systems W00
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1313 

|                  |   |                          |         | 10          | 12/31/2020 | 7/29/2021 4:1 |                  |
|------------------|---|--------------------------|---------|-------------|------------|---------------|------------------|
|                  |   | Full Time<br>Equivalents |         | Di sch      | arges      |               |                  |
|                  | Component   | Nonpai d                 | Title V | Title XVIII | Title XIX  | Total All     |                  |
|                  |   | Workers                  | 40.00   | 10.00       | 14.00      | Pati ents     |                  |
| 1 00             | The state Adulta a Dada (saluma 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 |                          | Ü       | 256         | 29         | 749           | 1. 00            |
|                  | Hospice days) (see instructions for col. 2  |                          |         |             |            |               |                  |
|                  | for the portion of LDP room available beds)   |                          |         |             |            |               |                  |
| 2. 00            | HMO and other (see instructions)  |                          |         | 110         | 81         |               | 2. 00            |
| 3.00             | HMO IPF Subprovider   |                          |         |             | o          |               | 3.00             |
| 4.00             | HMO IRF Subprovider   |                          |         |             | o          |               | 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            |
| 0.00             | beds) (see instructions)  |                          |         |             |            |               | 0.00             |
| 8. 00<br>9. 00   | I NTENSI VE CARE UNI T  |                          |         |             |            |               | 8. 00<br>9. 00   |
| 10.00            | CORONARY CARE UNIT 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       | 256         | 29         | 749           | 14.00            |
| 15.00            | CAH visits  |                          |         |             |            |               | 15.00            |
| 16.00            | SUBPROVIDER - IPF   |                          |         |             |            |               | 16.00            |
| 17. 00           | SUBPROVI DER - I RF   |                          |         |             |            |               | 17.00            |
| 18. 00           | SUBPROVI DER  |                          |         |             |            |               | 18. 00           |
| 19. 00           | SKILLED NURSING FACILITY  |                          |         |             |            |               | 19. 00           |
| 20.00            | NURSING FACILITY  |                          |         |             |            |               | 20.00            |
| 21. 00<br>22. 00 | OTHER LONG TERM CARE HOME HEALTH AGENCY   |                          |         | •           |            |               | 21. 00<br>22. 00 |
| 23. 00           | AMBULATORY SURGICAL CENTER (D. P.)  |                          |         |             |            |               | 23.00            |
| 24. 00           | HOSPICE   |                          |         |             |            |               | 24. 00           |
| 24. 10           | HOSPICE (non-distinct part)   |                          |         |             |            |               | 24. 10           |
| 25. 00           | CMHC - CMHC   |                          |         |             |            |               | 25. 00           |
| 26.00            | SHAFER MEDICAL CENTER   | 0.00                     |         |             |            |               | 26.00            |
| 26. 01           | WOODLAWN MEDICAL PROFESSIONALS  | 0.00                     |         |             |            |               | 26. 01           |
| 26. 02           | FULTON COUNTY MEDICAL CENTER- 700 MA  | 0.00                     |         |             |            |               | 26. 02           |
| 26. 03           | FULTON COUNTY MEDICAL CENTER - 100 E  | 0.00                     |         |             |            |               | 26. 03           |
| 26. 04           | AKRON MEDICAL CLINIC  | 0.00                     |         |             |            |               | 26. 04           |
| 26. 05           | ARGOS MEDICAL CLINIC  | 0.00                     |         |             |            |               | 26. 05           |
| 26. 25<br>27. 00 | FEDERALLY QUALIFIED HEALTH CENTER   Total (sum of lines 14-26)                        | 0. 00<br>0. 00           |         |             |            |               | 26. 25<br>27. 00 |
| 28. 00           | Observation Bed Days  | 0.00                     |         |             |            |               | 28.00            |
| 29. 00           | Ambulance Trips   |                          |         |             |            |               | 29.00            |
| 30. 00           | Employee discount days (see instruction)  |                          |         |             |            |               | 30. 00           |
| 31.00            | Employee discount days - 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           | l          |               | 33. 01           |

|                                  | AL-BASED RHC/FQHC STATISTICAL DATA   | WOODLAWN   |   | CN: 15-1313  | Peri od:  | u of Form CMS-<br>Worksheet S-8                     |                          |
|----------------------------------|--|--|---|--|---|---|--------------------------|
|                                  |  |  | Component   | CCN: 15-8551   | From 01/01/2020<br>To 12/31/2020                  |   |                          |
|                                  |  |  |   |  | RHC I   | Cost  | то ріп                   |
|                                  |  |  |   |  |   |   |                          |
|                                  | Clinic Address and Identification  |  |   |  | 1.  | 00  |                          |
| . 00                             | Street   |  |   |  | 1430 E 9TH STR                                    | EET   | 1.                       |
|                                  |  |  |   | ty   | State   | ZIP Code  |                          |
|                                  |  |  |   | 00   | 2. 00   | 3.00  |                          |
| . 00                             | City, State, ZIP Code, County  |  | ROCHESTER   |  | I N   | 46975   | 2.                       |
|                                  |  |  |   |  |   | 1. 00   |                          |
| . 00                             | HOSPITAL-BASED FQHCs ONLY: Designation - Ent   | er "R" for rur   | al or "U" for   |  |   | С   | 3.                       |
|                                  |  |  |   |  | nt Award  | Date  |                          |
|                                  | Source of Federal Funds  |  |   |  | 1. 00   | 2. 00   |                          |
| . 00                             | Community Health Center (Section 330(d), PHS   | Act)   |   |  |   |   | 4.                       |
| . 00                             | Migrant Health Center (Section 329(d), PHS A   |  |   |  |   |   | 5.                       |
| . 00                             | Health Services for the Homeless (Section 34   | O(d), PHS Act)   |   |  |   |   | 6.                       |
| . 00<br>. 00                     | Appalachian Regional Commission Look-Alikes  |  |   |  |   |   | 7.<br>8.                 |
| . 00                             | OTHER (SPECIFY)  |  |   |  |   |   | 9.                       |
|                                  |  |  |   |  |   |   |                          |
| 0.00                             | Door this facility energts as other than a h   | agni tal bagad   | DUC on FOUCA F  | nton "V" for   | 1. 00<br>N  | 2. 00   | 10                       |
| 0. 00                            | Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)   | ate number of  | other operatio  | ns in column   |   |   | 10.                      |
|                                  | 11.04.0.7  | Sun  | day   | N  | londay  | Tuesday   |                          |
|                                  |  | from   | to  | from   | to  | from  |                          |
|                                  |  |  |   |  |   |   |                          |
|                                  | Facility house of energtions (1)   | 1. 00  | 2. 00   | 3.00   | 4. 00   | 5. 00   |                          |
| 1. 00                            | Facility hours of operations (1)   | 1.00   | 2.00  |  |   |   | 11.                      |
| 1. 00                            | Facility hours of operations (1)   | 1.00   | 2.00  | 3. 00  |   | 5. 00   | 11.                      |
|                                  | CLINIC   |  |   | 08: 00   | 17: 00  |   |                          |
| 2. 00                            | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.  | on to the proded in CMS Pub.   | uctivity stand<br>100-04, chapte<br>enter in colu                       | o8:00 ard? r 9, section mn 2 the                             | 17: 00<br>1. 00<br>Y                              | 08: 00  | 12.                      |
| 2. 00                            | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col   | on to the proded in CMS Pub.   | uctivity stand<br>100-04, chapte<br>enter in colu                       | o8:00  ard? r 9, section mn 2 the ders and                   | 17: 00<br>1. 00<br>Y<br>N                         | 08: 00<br>2. 00                                     | 12.                      |
| 2. 00                            | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.  | on to the proded in CMS Pub.   | uctivity stand<br>100-04, chapte<br>enter in colu                       | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17: 00<br>1. 00<br>Y                              | 08: 00  | 12.                      |
| 2. 00                            | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.  | on to the prod<br>ed in CMS Pub.<br>umn 1. If yes,<br>List the name  | uctivity stand<br>100-04, chapte<br>enter in colu<br>s of all provi     | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00<br>2. 00<br>CCN number<br>2. 00              | 12.                      |
| 2. 00                            | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.   | on to the prod<br>d in CMS Pub.<br>umn 1. If yes,<br>List the name   | uctivity stand<br>100-04, chapte<br>enter in colu<br>s of all provi     | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12.                      |
| 2. 00 3. 00                      | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  | on to the prod<br>ed in CMS Pub.<br>umn 1. If yes,<br>List the name  | uctivity stand<br>100-04, chapte<br>enter in colu<br>s of all provi     | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00<br>2. 00<br>CCN number<br>2. 00              | 12. 13.                  |
| 2. 00 3. 00                      | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.   | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand<br>100-04, chapte<br>enter in colu<br>s of all provi     | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12.<br>13.               |
| 2. 00 3. 00                      | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and   | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand<br>100-04, chapte<br>enter in colu<br>s of all provi     | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12.<br>13.               |
| 2. 00 3. 00                      | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by   | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand<br>100-04, chapte<br>enter in colu<br>s of all provi     | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12. 13.                  |
| 2. 00 3. 00                      | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and   | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand<br>100-04, chapte<br>enter in colu<br>s of all provi     | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12. 13.                  |
| 2. 00 3. 00                      | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by   | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand<br>100-04, chapte<br>enter in colu<br>s of all provi     | o8:00  ard? r 9, section mn 2 the ders and  Prov             | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12. 13.                  |
| 2. 00 3. 00                      | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the   | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00      | o8:00  ard? r 9, section mn 2 the ders and  Prov  XVIII 3.00 | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12. 13.                  |
| 2. 00 3. 00                      | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.                     | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00      | ard? r 9, section mn 2 the ders and  Prov  XVIII 3.00        | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12. 13.                  |
| 2. 00<br>3. 00<br>4. 00<br>5. 00 | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.                     | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00      | o8:00  ard? r 9, section mn 2 the ders and  Prov  XVIII 3.00 | 17:00<br>1.00<br>Y<br>N<br>i der name<br>1.00     | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12. 13. 14. 15.          |
| 2. 00<br>3. 00<br>4. 00<br>5. 00 | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | on to the prod d in CMS Pub. umn 1. If yes, List the name            | uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00  Cou | ard? r 9, section mn 2 the ders and  Prov  XVIII 3.00        | 17: 00  1. 00  Y  N  ider name 1. 00  XI X  4. 00 | 08: 00  2. 00  CCN number 2. 00  Total Visits       | 12.<br>13.               |
| 2. 00                            | Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | on to the product in CMS Pub. umn 1. If yes, List the name  Y/N 1.00 | uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00  Cou | o8:00  ard? r 9, section mn 2 the ders and  Prov  XVIII 3.00 | 17: 00  1. 00  Y  N  ider name 1. 00  XI X  4. 00 | 08: 00  2. 00  CCN number 2. 00  Total Visits 5. 00 | 11.<br>12.<br>13.<br>14. |

| Health Financial Systems                 | WOODLAWN | WOODLAWN HOSPITAL |              |                                  | In Lieu of Form CMS-2552-10 |        |  |
|--|----------|-------------------|--------------|----------------------------------|-----------------------------|--------|--|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |          | Provi der C       | CN: 15-1313  | Peri od:                         | Worksheet S-8               |        |  |
|  |          | Component         | CCN: 15-8551 | From 01/01/2020<br>To 12/31/2020 |                             |        |  |
|  |          |                   |              | RHC I                            | Cost                        |        |  |
|  | Fri      | day               | Sa           | turday                           |                             |        |  |
|  | from     | to                | from         | to                               |                             |        |  |
|  | 11. 00   | 12. 00            | 13.00        | 14. 00                           |                             |        |  |
| Facility hours of operations (1)         |          |                   |              |                                  |                             |        |  |
| 11. 00 CLINIC                            | 08: 00   | 17: 00            |              |                                  |                             | 11. 00 |  |

| 100111                  | FAL-BASED RHC/FQHC STATISTICAL DATA  |  | HOSPI TAL<br>Provi der C                          | CN: 15-1313   | Peri od:                                | Worksheet S-8                      | 2552-<br>R |
|-------------------------|--|--|---|---|---|------------------------------------|------------|
|                         | AL-BASED KIRTURE STATISTICAL DATA  |  |   | CCN: 15-8552  | From 01/01/2020<br>To 12/31/2020        | Date/Time Pre                      | pared      |
|                         |  |  |   |   | RHC II                                  | 7/29/2021 4:1<br>Cost              | 5 pm       |
|                         |  |  |   |   | INIC 11                                 | COST                               |            |
|                         |  |  |   |   | 1.                                      | 00                                 |            |
|                         | Clinic Address and Identification  |  |   |   |   |                                    |            |
| . 00                    | Street   |  | Ci  | ty  | 1400 E 9TH STR<br>State                 | ZIP Code                           | 1.         |
|                         |  |  |   | 00  | 2. 00                                   | 3. 00                              |            |
| . 00                    | City, State, ZIP Code, County  | -  | ROCHESTER   |   |   | 46975                              | 2.         |
|                         |  |  |   |   |   |                                    |            |
|                         | THOCH THE PACED FOUR ONLY Designation For  | II DIII C  |   |   |   | 1.00                               |            |
| . 00                    | HOSPITAL-BASED FQHCs ONLY: Designation - Ent   | er "R" for rur   | al or "U" for                                     |   | nt Award                                | Date 0                             | 3.         |
|                         |  |  |   |   | 1. 00                                   | 2. 00                              |            |
|                         | Source of Federal Funds  |  |   |   |   |                                    |            |
| . 00                    | Community Health Center (Section 330(d), PHS   |  |   |   |   |                                    | 4.         |
| . 00                    | Migrant Health Center (Section 329(d), PHS A   |  |   |   |   |                                    | 5.         |
| . 00<br>. 00            | Health Services for the Homeless (Section 34 Appalachian Regional Commission   | u(a), PHS Act)   |   |   |   |                                    | 6.<br>7.   |
| . 00                    | Look-Alikes  |  |   | •   |   |                                    | 8.         |
| . 00                    | OTHER (SPECIFY)  |  |   |   |   |                                    | 9.         |
|                         |  |  |   | •   |   |                                    |            |
| 2 00                    | December 6 and 1 a |  | DUO - FOURD F                                     |   | 1.00                                    | 2.00                               | 10         |
| J. 00                   | Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)   | ate number of  | other operatio                                    | ns in column  | N                                       | 0                                  | 10.        |
|                         | Thou 3. )  | Sun  | day   | Me  | onday                                   | Tuesday                            |            |
|                         |  | from   | to  | from  | to                                      | from                               |            |
|                         | T  | 1. 00  | 2. 00   | 3. 00   | 4. 00                                   | 5. 00                              |            |
| 1 00                    | Facility hours of operations (1)   |  |   | 08: 00  | 17: 00                                  | 08: 00                             | 11.        |
| 1.00                    | CETNIC   |  |   | 08.00   | 17.00                                   | 08.00                              |            |
|                         |  |  |   |   |   |                                    |            |
|                         |  |  |   |   | 1. 00                                   | 2. 00                              |            |
|                         | Have you received an approval for an excepti<br>Is this a consolidated cost report as define<br>30.8? Enter "Y" for yes or "N" for no in col<br>number of providers included in this report.<br>numbers below.   | d in CMS Pub.<br>umn 1. If yes,                                  | 100-04, chapte<br>enter in colu                   | r 9, section<br>mn 2 the  | 1.00<br>Y<br>N                          | 2.00                               | 12.        |
|                         | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col  | d in CMS Pub.<br>umn 1. If yes,                                  | 100-04, chapte<br>enter in colu                   | r 9, section<br>mn 2 the<br>ders and                              | Y                                       |                                    | 12.        |
| 3. 00                   | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  | d in CMS Pub.<br>umn 1. If yes,                                  | 100-04, chapte<br>enter in colu                   | r 9, section<br>mn 2 the<br>ders and                              | Y<br>N                                  | 0                                  | 12.        |
| 3. 00                   | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.   | ed in CMS Pub.<br>umn 1. If yes,<br>List the name:               | 100-04, chapte<br>enter in colu<br>s of all provi | r 9, section<br>mn 2 the<br>ders and<br>Provi                     | Y<br>N<br>der name<br>1.00              | CCN number                         | 12.        |
| 2. 00 3. 00             | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  | d in CMS Pub.<br>umn 1. If yes,<br>List the name:                | 100-04, chapte<br>enter in colu<br>s of all provi | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 12.        |
| 4. 00                   | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  | d in CMS Pub.<br>umn 1. If yes,<br>List the name:                | 100-04, chapte<br>enter in colu<br>s of all provi | r 9, section<br>mn 2 the<br>ders and<br>Provi                     | Y<br>N<br>der name<br>1.00              | CCN number                         | 12.<br>13. |
| 4. 00                   | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.  | d in CMS Pub.<br>umn 1. If yes,<br>List the name:                | 100-04, chapte enter in colus of all provi        | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 12.<br>13. |
| 4. 00<br>5. 00          | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)   | d in CMS Pub.<br>umn 1. If yes,<br>List the name:                | V 2.00  | r 9, section mn 2 the ders and  Provi  XVIII  3.00                | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 12.<br>13. |
| 3. 00<br>4. 00<br>5. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.  | d in CMS Pub.<br>umn 1. If yes,<br>List the name:<br>Y/N<br>1.00 | 100-04, chapte enter in colus of all provi        | r 9, section mn 2 the ders and  Provi  XVIII  3.00                | Y N N der name 1.00 XIX 4.00            | CCN number 2.00  Total Visits 5.00 | 12.<br>13. |
| 3. 00<br>4. 00<br>5. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)   | d in CMS Pub. umn 1. If yes, List the name:  Y/N 1.00            | V 2.00  Cou                                       | r 9, section mn 2 the ders and  Provi  XVIII  3.00  unty 00 esday | Y N N N N N N N N N N N N N N N N N N N | CCN number 2.00  Total Visits 5.00 | 12.        |
| 4. 00                   | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)   | d in CMS Pub. umn 1. If yes, List the name:  Y/N 1.00            | 100-04, chapte enter in colus of all provi        | r 9, section mn 2 the ders and  Provi  XVIII  3.00                | Y N N der name 1.00 XIX 4.00            | CCN number 2.00  Total Visits 5.00 | 12.<br>13. |

| Health Financial Systems                 | WOODLAWN I | WOODLAWN HOSPITAL |        |                                  | In Lieu of Form CMS-2552-10 |        |  |  |
|--|------------|-------------------|--------|----------------------------------|-----------------------------|--------|--|--|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |            | Provi der C       |        | Peri od:                         | Worksheet S-8               |        |  |  |
|  |            | Component         |        | From 01/01/2020<br>To 12/31/2020 |                             |        |  |  |
|  |            |                   |        | RHC II                           | Cost                        |        |  |  |
|  | Fri        | day               | Sa     | turday                           |                             |        |  |  |
|  | from       | to                | from   | to                               |                             |        |  |  |
|  | 11. 00     | 12. 00            | 13. 00 | 14. 00                           |                             |        |  |  |
| Facility hours of operations (1)         | _          |                   |        |                                  |                             |        |  |  |
| 11. 00 CLINIC                            | 08: 00     | 17: 00            |        |                                  |                             | 11. 00 |  |  |

| Heal th          | n Financial Systems  | WOODLAWN                         | HOSPI TAL                       |                          | In Lie                           | u of Form CMS- | 2552-10        |
|------------------|--|----------------------------------|---------------------------------|--------------------------|----------------------------------|----------------|----------------|
| HOSPI 7          | TAL-BASED RHC/FQHC STATISTICAL DATA  |                                  | Provi der C                     | CN: 15-1313              | Peri od:                         | Worksheet S-8  | 3              |
|                  |  |                                  | Component                       | CCN: 15-8550             | From 01/01/2020<br>To 12/31/2020 |                |                |
|                  |  |                                  |                                 |                          | RHC III                          | Cost           |                |
|                  |  |                                  |                                 |                          | 4                                | 00             |                |
|                  | Clinic Address and Identification  |                                  |                                 |                          |                                  | 00             |                |
| 1. 00            | Street   |                                  |                                 |                          | 700 MAIN STREE                   | T              | 1.00           |
|                  |  |                                  |                                 | ty                       | State                            | ZIP Code       |                |
| 0.00             | 011 0111 710 011 011   |                                  |                                 | 00                       | 2. 00                            | 3.00           | 0.00           |
| 2. 00            | City, State, ZIP Code, County  |                                  | ROCHESTER                       |                          | IN                               | 46975          | 2.00           |
|                  |  |                                  |                                 |                          |                                  | 1.00           |                |
| 3. 00            | HOSPITAL-BASED FQHCs ONLY: Designation - Ent   | er "R" for rur                   | al or "U" for                   |                          |                                  | 0              | 3.00           |
|                  |  |                                  |                                 |                          | nt Award                         | Date           | 1              |
|                  | Source of Federal Funds  |                                  |                                 |                          | 1. 00                            | 2. 00          | _              |
| 4. 00            | Community Health Center (Section 330(d), PHS   | Act)                             |                                 |                          |                                  |                | 4.00           |
| 5. 00            | Migrant Health Center (Section 329(d), PHS A   |                                  |                                 |                          |                                  |                | 5.00           |
| 6.00             | Health Services for the Homeless (Section 34   | O(d), PHS Act)                   |                                 |                          |                                  |                | 6.00           |
| 7. 00<br>8. 00   | Appalachian Regional Commission Look-Alikes  |                                  |                                 |                          |                                  |                | 7.00           |
| 9. 00            | OTHER (SPECIFY)  |                                  |                                 |                          |                                  |                | 9.00           |
|                  |  |                                  |                                 |                          |                                  |                |                |
| 10.00            | December 6 and 1 a |                                  | DUO - FOUND F                   |                          | 1.00                             | 2.00           | 10.00          |
| 10. 00           | yes or "N" for no in column 1. If yes, indic<br>2. (Enter in subscripts of line 11 the type o  | ate number of                    | other operatio                  | ns in column             |                                  | 0              | 10.00          |
|                  | hours.)  | Sur                              | ıday                            | I                        | Monday                           | Tuesday        |                |
|                  |  | from                             | to                              | from                     | to                               | from           |                |
|                  |  | 1. 00                            | 2.00                            | 3. 00                    | 4. 00                            | 5. 00          |                |
| 11 00            | Facility hours of operations (1)   |                                  |                                 | 00.00                    | 17. 00                           | 00.00          | 11 00          |
| 11.00            | CLINIC   |                                  |                                 | 08: 00                   | 17: 00                           | 08: 00         | 11.00          |
|                  |  |                                  |                                 |                          | 1. 00                            | 2.00           |                |
| 12. 00<br>13. 00 |  | ed in CMS Pub.<br>umn 1. If yes, | 100-04, chapte<br>enter in colu | r 9, section<br>mn 2 the | Y<br>N                           | 0              | 12.00<br>13.00 |
|                  |  |                                  |                                 | Prov                     | ider name                        | CCN number     |                |
| 14.05            | DUO (FOLIO   |                                  |                                 |                          | 1. 00                            | 2. 00          | 4.5            |
| 14.00            | RHC/FQHC name, CCN number  | Y/N                              | V                               | XVIII                    | XIX                              | Total Visits   | 14.00          |
|                  |  | 1.00                             | 2.00                            | 3. 00                    | 4.00                             | 5. 00          |                |
| 15. 00           | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)   |                                  |                                 |                          |                                  |                | 15.00          |
|                  |  |                                  |                                 | inty                     |                                  |                |                |
| 2 00             | City State 71D Code County   |                                  |                                 | 00                       |                                  |                | 2.00           |
| 2. 00            | City, State, ZIP Code, County  | Tuesday                          | FULTON Wedn                     | esday                    | Thur                             | sday           | 2.00           |
|                  |  | to                               | from                            | to                       | from                             | to             |                |
|                  |  | 6. 00                            | 7. 00                           | 8. 00                    | 9. 00                            | 10.00          |                |
| 44.05            | Facility hours of operations (1)   | 17.00                            | 00.00                           | 17.00                    | 00.00                            | 1.7.00         | 4              |
| 11.00            | CLINIC   | 17: 00                           | 08: 00                          | 17: 00                   | 08: 00                           | 17: 00         | 11.00          |

| Health Financial Systems                 | WOODLAWN | WOODLAWN HOSPITAL |       |                                  | In Lieu of Form CMS-2552-10 |        |  |
|--|----------|-------------------|-------|----------------------------------|-----------------------------|--------|--|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |          | Provi der C       |       | Peri od:                         | Worksheet S-8               | }      |  |
|  |          | Component         |       | From 01/01/2020<br>To 12/31/2020 |                             |        |  |
|  | _        |                   |       | RHC III                          | Cost                        |        |  |
|  | Fri      | day               | Sa    | turday                           |                             |        |  |
|  | from     | to                | from  | to                               |                             |        |  |
|  | 11. 00   | 12. 00            | 13.00 | 14. 00                           |                             |        |  |
| Facility hours of operations (1)         |          |                   |       |                                  |                             |        |  |
| 11. 00 CLINIC                            | 08: 00   | 17: 00            |       |                                  |                             | 11. 00 |  |

|          | n Financial Systems TAL-BASED RHC/FQHC STATISTICAL DATA  | WOODLAWN I      |                            | CN: 15-1313                  | Peri od:                         | eu of Form CMS-<br>          |       |
|----------|--|-----------------|----------------------------|------------------------------|----------------------------------|------------------------------|-------|
| UUFI     | TAL-BASED KNO/FUNC STATISTICAL DATA  |                 |                            | CCN: 15-1313<br>CCN: 15-8549 | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre                | epare |
|          |  |                 |                            |                              | DUC IV                           | 7/29/2021 4:                 | 15 pm |
|          |  |                 |                            |                              | RHC I V                          | Cost                         |       |
|          |  |                 |                            |                              | 1                                | . 00                         |       |
|          | Clinic Address and Identification  |                 |                            |                              | 1                                |                              |       |
| 00       | Street   |                 | Ci                         | ty                           | 100 EAST DUNI<br>State           | ZIP Code                     | 1.    |
|          |  |                 |                            | 00                           | 2.00                             | 3. 00                        | +     |
| 00       | City, State, ZIP Code, County  |                 | FULTON                     | 00                           |                                  | V 46931                      | 2.    |
|          |  |                 |                            |                              |                                  |                              |       |
| 00       | HOSPITAL-BASED FQHCs ONLY: Designation - Ent   | or "D" for rur  | al or "II" for             | urban                        |                                  | 1.00                         | ) 3.  |
| 00       | THOSPITAL-BASED FUNCS ONLY: DESIGNATION - ENT  | er k for rur    | ai oi u ioi                |                              | nt Award                         | Date                         | ) 3.  |
|          |  |                 |                            |                              | 1. 00                            | 2.00                         |       |
|          | Source of Federal Funds  |                 |                            |                              |                                  |                              |       |
| 00       | Community Health Center (Section 330(d), PHS   |                 |                            |                              |                                  |                              | 4     |
| 00<br>00 | Migrant Health Center (Section 329(d), PHS A<br>Health Services for the Homeless (Section 34   |                 |                            |                              |                                  |                              | 5     |
| 00       | Appal achi an Regional Commission  | O(d), FIIS ACT) |                            |                              |                                  |                              | 7     |
| 00       | Look-Alikes  |                 |                            |                              |                                  |                              | 8     |
| 00       | OTHER (SPECIFY)  |                 |                            |                              |                                  |                              | 9     |
|          |  |                 |                            |                              | 1 00                             | 2.00                         | -     |
| 00       | Does this facility operate as other than a h   | osni tal -hased | RHC or FOHC2 F             | nter "Y" for                 | 1. 00<br>N                       | 2.00                         | 10    |
| . 00     | yes or "N" for no in column 1. If yes, indic<br>2. (Enter in subscripts of line 11 the type o<br>hours.)   | ate number of   | other operatio             | ns in column                 |                                  |                              |       |
|          | 1110di 3. )  | Sun             | nday                       | M                            | onday                            | Tuesday                      |       |
|          |  | from            | to                         | from                         | to                               | from                         |       |
|          |  | 1. 00           | 2.00                       | 3. 00                        | 4. 00                            | 5. 00                        | -     |
| 00       | Facility hours of operations (1)   |                 |                            | 08: 00                       | 17: 00                           | 08: 00                       | 11    |
| . 00     | oer in o   |                 | 1                          | 00.00                        | 17.00                            | 00.00                        |       |
|          |  |                 |                            |                              | 1. 00                            | 2. 00                        |       |
| . 00     | Have you received an approval for an exception to the productivity standard?   |                 |                            |                              |                                  |                              | 12    |
|          |  | List the name   | s of all provi             | ders and                     |                                  |                              |       |
|          | number of providers included in this report. numbers below.  | List the name   | s of all provi             | -                            | der name                         | CCN number                   |       |
|          | numbers below.   | List the name   | s of all provi             | Provi                        | der name<br>1.00                 | CCN number<br>2.00           |       |
| . 00     |  |                 |                            | Provi                        | 1. 00                            | 2. 00                        | 14    |
| . 00     | numbers below.   | Y/N             | V                          | Provi                        | 1. 00 XI X                       | 2.00<br>Total Visits         | 14    |
|          | RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by   | Y/N<br>1.00     |                            | Provi                        | 1. 00                            | 2. 00                        |       |
|          | RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and   | Y/N<br>1.00     | V<br>2.00                  | XVIII<br>3.00                | 1. 00 XI X                       | 2.00<br>Total Visits         |       |
|          | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.                    | Y/N<br>1.00     | V 2.00                     | XVIII<br>3.00                | 1. 00 XI X                       | 2.00<br>Total Visits         |       |
| . 00     | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | Y/N<br>1.00     | V 2.00                     | XVIII<br>3.00                | 1. 00 XI X                       | 2.00<br>Total Visits         | 15    |
|          | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.                    | Y/N<br>1.00     | V 2. 00 Cot 4. FULTON      | XVIII<br>3.00                | 1. 00<br>XI X<br>4. 00           | 2.00<br>Total Visits<br>5.00 | 15.   |
| i. 00    | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | Y/N<br>1.00     | V 2. 00 Cot 4. FULTON      | XVIII<br>3.00                | 1. 00<br>XI X<br>4. 00           | 2.00<br>Total Visits         | 15    |
| . 00     | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | Y/N<br>1.00     | V 2.00  Cou 4. FULTON Wedn | XVIII 3.00  anty 00  esday   | 1. 00<br>XI X<br>4. 00           | 2.00 Total Visits 5.00       | 15    |

| Health Financial Systems                 | WOODLAWN | WOODLAWN HOSPITAL |              |                                  | In Lieu of Form CMS-2552-10 |        |  |  |
|--|----------|-------------------|--------------|----------------------------------|-----------------------------|--------|--|--|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |          | Provi der C       | CN: 15-1313  | Peri od:                         | Worksheet S-8               |        |  |  |
|  |          | Component         | CCN: 15-8549 | From 01/01/2020<br>To 12/31/2020 |                             |        |  |  |
|  | _        |                   |              | RHC IV                           | Cost                        |        |  |  |
|  | Fri      | day               | Sa           | turday                           |                             |        |  |  |
|  | from     | to                | from         | to                               |                             |        |  |  |
|  | 11. 00   | 12. 00            | 13.00        | 14. 00                           |                             |        |  |  |
| Facility hours of operations (1)         |          |                   |              |                                  |                             |        |  |  |
| 11. 00 CLINIC                            | 08: 00   | 17: 00            |              |                                  |                             | 11. 00 |  |  |

| Heal th        | Financial Systems   | WOODLAWN H                        | HOSPI TAL                       |                          | In Lie                           | eu of Form C | MS-2 | 552-10         |
|----------------|---|-----------------------------------|---------------------------------|--------------------------|----------------------------------|--------------|------|----------------|
|                | TAL-BASED RHC/FQHC STATISTICAL DATA   |                                   |                                 | CN: 15-1313              | Peri od:                         | Worksheet    |      |                |
|                |   |                                   | Component                       | CCN: 15-8547             | From 01/01/2020<br>To 12/31/2020 |              |      |                |
|                |   |                                   |                                 |                          | RHC V                            | Cos          |      | , рііі         |
|                |   |                                   |                                 |                          |                                  |              |      |                |
|                |   |                                   |                                 |                          | 1.                               | . 00         |      |                |
| 1. 00          | Clinic Address and Identification   |                                   |                                 |                          | 105 SR 14 N                      |              |      | 1. 00          |
| 1.00           | Street  |                                   | Ci                              | ty                       | State                            | ZIP Code     |      | 1.00           |
|                |   |                                   |                                 | 00                       | 2.00                             | 3. 00        |      |                |
| 2.00           | City, State, ZIP Code, County   | ı                                 | AKRON                           |                          | 11                               | 46910        |      | 2.00           |
|                |   |                                   |                                 |                          |                                  |              |      |                |
| 3. 00          | HOSPITAL-BASED FQHCs ONLY: Designation - Ent  | or "D" for rur                    | al or "II" for                  | urban                    |                                  | 1. 00        | 0    | 2 00           |
| 3.00           | THOSPITAL-BASED FUNCS ONLY. DESIGNATION - EITH  | el K TOLTULA                      | ai 0i 0 10i                     |                          | nt Award                         | Date         | U    | 3. 00          |
|                |   |                                   |                                 |                          | 1. 00                            | 2. 00        |      |                |
|                | Source of Federal Funds   |                                   |                                 | •                        |                                  |              |      |                |
| 4. 00          | Community Health Center (Section 330(d), PHS  |                                   |                                 |                          |                                  |              |      | 4.00           |
| 5.00           | Migrant Health Center (Section 329(d), PHS A  |                                   |                                 |                          |                                  |              |      | 5.00           |
| 6.00           | Health Services for the Homeless (Section 34)   | J(d), PHS Act)                    |                                 |                          |                                  |              | ŀ    | 6. 00<br>7. 00 |
| 7. 00<br>8. 00 | Appalachian Regional Commission Look-Alikes   |                                   |                                 |                          |                                  |              | l    | 8. 00          |
| 9. 00          | OTHER (SPECIFY)   |                                   |                                 |                          |                                  |              | l    | 9. 00          |
|                |   |                                   |                                 | '                        |                                  |              |      |                |
|                |   |                                   |                                 |                          | 1. 00                            | 2. 00        |      |                |
| 10. 00         | Does this facility operate as other than a house or "N" for no in column 1. If yes, indical. (Enter in subscripts of line 11 the type of hours.)  | ate number of d                   | other operatio                  | ns in column             | N                                |              | 0    | 10.00          |
|                | Tiour S. )  | Sund                              | dav                             | Т                        | ondav                            | Tuesday      |      |                |
|                |   | from                              | to                              | from                     | to                               | from         |      |                |
|                |   | 1. 00                             | 2. 00                           | 3. 00                    | 4. 00                            | 5. 00        |      |                |
| 44 00          | Facility hours of operations (1)  |                                   |                                 | loo 00                   | 47.00                            | loo oo       |      | 44 00          |
| 11.00          | CLI NI C  |                                   |                                 | 08: 00                   | 17: 00                           | 08: 00       |      | 11. 00         |
|                |   |                                   |                                 |                          | 1. 00                            | 2.00         |      |                |
| 12. 00         | Have you received an approval for an exception  | on to the produ                   | uctivity stand                  | ard?                     | Υ Υ                              | 2.00         |      | 12.00          |
| 13. 00         | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.   | d in CMS Pub. 1<br>umn 1. If yes, | 100-04, chapte<br>enter in colu | r 9, section<br>mn 2 the | N                                |              | 0    | 13.00          |
|                | Trainbot 3 bot ow.  |                                   |                                 | Provi                    | der name                         | CCN numbe    | r    |                |
|                |   |                                   |                                 |                          | 1. 00                            | 2. 00        |      |                |
| 14.00          | RHC/FQHC name, CCN number   |                                   |                                 |                          |                                  |              |      | 14.00          |
|                |   | Y/N                               | V 2.00                          | XVIII                    | XIX                              | Total Visi   | ts   |                |
|                |   | 1. 00                             | 2. 00                           | 3. 00                    | 4. 00                            | 5. 00        |      | 15. 00         |
| 15 00          | Have you provided all or substantially all  |                                   |                                 |                          |                                  |              |      |                |
| 15. 00         | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in   |                                   |                                 |                          |                                  |              |      | 13.00          |
| 15. 00         | Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and   |                                   |                                 |                          |                                  |              |      | 15.00          |
| 15. 00         | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by  |                                   |                                 |                          |                                  |              |      | 15.00          |
| 15. 00         | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and  |                                   |                                 |                          |                                  |              |      | 15.00          |
| 15. 00         | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the  |                                   |                                 |                          |                                  |              |      | 13.00          |
| 15. 00         | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.                    |                                   |                                 |                          |                                  |              |      | 13.00          |
| 15. 00         | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the  |                                   | Соц                             | inty                     |                                  |              |      | 15.00          |
|                | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) |                                   | 4.                              | inty<br>00               |                                  |              |      |                |
|                | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.                    |                                   | 4.<br>FULTON                    | 00                       |                                  |              |      | 2.00           |
|                | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | Tuesday                           | 4.<br>FULTON<br>Wedn            | 00<br>esday              |                                  | rsday        |      |                |
| 2. 00          | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | Tuesday<br>to                     | 4.<br>FULTON<br>Wedn<br>from    | esday to                 | from                             | to           |      |                |
|                | GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | Tuesday                           | 4.<br>FULTON<br>Wedn            | 00<br>esday              |                                  |              |      |                |

| Health Financial Systems                 | WOODLAWN | WOODLAWN HOSPITAL |              |                                  | In Lieu of Form CMS-2552-10 |        |  |  |
|--|----------|-------------------|--------------|----------------------------------|-----------------------------|--------|--|--|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |          | Provi der C       | CN: 15-1313  | Peri od:                         | Worksheet S-8               |        |  |  |
|  |          | Component         | CCN: 15-8547 | From 01/01/2020<br>To 12/31/2020 |                             |        |  |  |
|  | _        |                   |              | RHC V                            | Cost                        |        |  |  |
|  | Fri      | day               | Sa           | turday                           |                             |        |  |  |
|  | from     | to                | from         | to                               |                             |        |  |  |
|  | 11. 00   | 12. 00            | 13.00        | 14. 00                           |                             |        |  |  |
| Facility hours of operations (1)         |          |                   |              |                                  |                             |        |  |  |
| 11. 00 CLINIC                            | 08: 00   | 17: 00            |              |                                  |                             | 11. 00 |  |  |

| 0011  | Financial Systems  FAL-BASED RHC/FQHC STATISTICAL DATA   | WOODLAWN F  |   | CN: 15-1313   | Peri od:                                | worksheet S-                       |        |
|-------|--|---|---|---|---|------------------------------------|--------|
|       | THE BROLD WIND THE STATISTICAL BATTA   |   |   | CCN: 15-8548  | From 01/01/2020<br>To 12/31/2020        | Date/Time Pro                      | epare  |
|       |  |   |   |   | RHC VI                                  | 7/29/2021 4: Cost                  | ı bili |
|       |  |   |   |   |   | 3001                               |        |
|       |  |   |   |   | 1.                                      | 00                                 |        |
| 00    | Clinic Address and Identification Street   |   |   |   | 530 N MI CHI GAN                        | LCTDEET                            | 1.     |
| . 00  | 311 ee t   |   | Ci  | ty  | State                                   | ZIP Code                           | 1.     |
|       |  |   |   | 00  | 2.00                                    | 3. 00                              |        |
| 00    | City, State, ZIP Code, County  |   | ARGOS   |   | IN                                      | 46501                              | 2.     |
|       |  |   |   |   |   | 1.00                               |        |
| 00    | HOSPITAL-BASED FQHCs ONLY: Designation - Ent   | er "R" for rur  | al or "II" for  | urban   |   | 1.00                               | 3.     |
| -     | THOSE THE BROCK TELL BOOK GRACE OF LINE  |   | <u></u>   |   | nt Award                                | Date                               |        |
|       |  |   |   |   | 1. 00                                   | 2. 00                              |        |
| 00    | Source of Federal Funds  | · ^ - + >   |   | ı   |   | I                                  | ١,     |
| 00    | Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A  |   |   |   |   |                                    | 5.     |
| 00    | Health Services for the Homeless (Section 34   |   |   |   |   |                                    | 6      |
| 00    | Appal achi an Regi onal Commi ssi on   |   |   |   |   |                                    | 7      |
| 00    | Look-Alikes  |   |   |   |   |                                    | 8      |
| 00    | OTHER (SPECI FY)   |   |   |   |   |                                    | 9      |
|       |  |   |   |   | 1. 00                                   | 2. 00                              |        |
| . 00  | Does this facility operate as other than a h   |   |   |   | N                                       | (                                  | 10     |
|       | yes or "N" for no in column 1. If yes, indic   |   |   |   |   |                                    |        |
|       | 2. (Enter in subscripts of line 11 the type o hours.)  | f other operati   | ion(s) and the  | operating   |   |                                    |        |
|       | Triodi 3. )  | Sun   | day   | M   | onday                                   | Tuesday                            |        |
|       |  | from  | to  | from  | to                                      | from                               |        |
|       |  | 1. 00   | 2. 00   | 3.00  | 4. 00                                   | 5. 00                              |        |
| 00    | Facility hours of operations (1)   |   |   | 08: 00  | 17: 00                                  | 08: 00                             | 11.    |
| . 00  | 0211110  |   |   | 00.00   | 17.00                                   | 00.00                              | +      |
|       |  |   |   |   |   |                                    |        |
|       |  |   |   |   | 1. 00                                   | 2. 00                              |        |
|       | Have you received an approval for an excepti   |   |   |   | Y                                       |                                    |        |
|       | Is this a consolidated cost report as define   | d in CMS Pub.   | 100-04, chapte  | r 9, section  |   | 2.00                               |        |
|       |  | d in CMS Pub. '<br>umn 1. If yes,                               | 100-04, chapte<br>enter in colu                         | r 9, section<br>mn 2 the  | Y                                       |                                    |        |
|       | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col  | d in CMS Pub. '<br>umn 1. If yes,                               | 100-04, chapte<br>enter in colu                         | r 9, section<br>mn 2 the<br>ders and                              | Y<br>N                                  | C                                  |        |
|       | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.   | d in CMS Pub. '<br>umn 1. If yes,                               | 100-04, chapte<br>enter in colu                         | r 9, section<br>mn 2 the<br>ders and                              | Y<br>N<br>der name                      | CCN number                         |        |
| 5. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.   | d in CMS Pub. '<br>umn 1. If yes,                               | 100-04, chapte<br>enter in colu                         | r 9, section<br>mn 2 the<br>ders and                              | Y<br>N                                  | C                                  | 13.    |
| . 00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  | d in CMS Pub. umn 1. If yes, List the name:                     | 100-04, chapte<br>enter in colu<br>s of all provi       | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number                         | 13.    |
| . 00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number   | d in CMS Pub.<br>umn 1. If yes,<br>List the names               | 100-04, chapte<br>enter in colu<br>s of all provi       | r 9, section<br>mn 2 the<br>ders and<br>Provi                     | Y<br>N<br>der name<br>1.00              | CCN number                         | 14.    |
| . 00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all   | d in CMS Pub. umn 1. If yes, List the names  Y/N 1.00           | 100-04, chapte<br>enter in colu<br>s of all provi       | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 14     |
| . 00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in  | d in CMS Pub. umn 1. If yes, List the names  Y/N 1.00           | 100-04, chapte<br>enter in colu<br>s of all provi       | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 14     |
| . 00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by  | d in CMS Pub. umn 1. If yes, List the names  Y/N 1.00           | 100-04, chapte<br>enter in colu<br>s of all provi       | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 14.    |
| . 00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and  | d in CMS Pub. umn 1. If yes, List the names  Y/N 1.00           | 100-04, chapte<br>enter in colu<br>s of all provi       | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 14.    |
| 1. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the  | d in CMS Pub. umn 1. If yes, List the names  Y/N 1.00           | 100-04, chapte<br>enter in colu<br>s of all provi       | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 14.    |
| . 00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and  | d in CMS Pub. umn 1. If yes, List the names  Y/N 1.00           | 100-04, chapte<br>enter in colu<br>s of all provi       | r 9, section mn 2 the ders and  Provi                             | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 14.    |
| 1. 00 | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.                    | d in CMS Pub. umn 1. If yes, List the names  Y/N 1.00           | 100-04, chapte enter in colus of all provi              | r 9, section mn 2 the ders and  Provi  XVIII  3.00                | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 14.    |
| 1.00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | d in CMS Pub. umn 1. If yes, List the name:  Y/N 1.00           | 100-04, chapte enter in colus of all provi              | r 9, section mn 2 the ders and Provi                              | Y<br>N<br>der name<br>1.00              | CCN number 2.00  Total Visits      | 14.    |
|       | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.                    | d in CMS Pub. umn 1. If yes, List the name:  Y/N 1.00           | 100-04, chapte enter in colus of all provi  V 2.00  Cou | r 9, section mn 2 the ders and  Provi  XVIII 3.00                 | Y N N der name 1.00 XIX 4.00            | CCN number 2.00  Total Visits 5.00 | 14.    |
| 1.00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | d in CMS Pub. umn 1. If yes, List the name:  Y/N  1.00  Tuesday | 100-04, chapte enter in colus of all provi              | r 9, section mn 2 the ders and  Provi  XVIII  3.00  unty 00 esday | Y N N N N N N N N N N N N N N N N N N N | CCN number 2.00  Total Visits 5.00 | 14.    |
| 1.00  | Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.  RHC/FQHC name, CCN number  Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) | d in CMS Pub. umn 1. If yes, List the name:  Y/N 1.00           | 100-04, chapte enter in colus of all provi  V 2.00  Cou | r 9, section mn 2 the ders and  Provi  XVIII 3.00                 | Y N N der name 1.00 XIX 4.00            | CCN number 2.00  Total Visits 5.00 | 12.    |

| Health Financial Systems                 | WOODLAWN | HOSPI TAL   |              | In Lieu of Form CMS-2552-10      |               |        |  |
|--|----------|-------------|--------------|----------------------------------|---------------|--------|--|
| HOSPITAL-BASED RHC/FQHC STATISTICAL DATA |          | Provi der C | CN: 15-1313  | Peri od:                         | Worksheet S-8 |        |  |
|  |          | Component   | CCN: 15-8548 | From 01/01/2020<br>To 12/31/2020 |               |        |  |
|  |          |             |              | RHC VI                           | Cost          |        |  |
|  | Fri      | day         | Sa           | turday                           |               |        |  |
|  | from     | to          | from         | to                               |               |        |  |
|  | 11. 00   | 12. 00      | 13.00        | 14. 00                           |               |        |  |
| Facility hours of operations (1)         |          |             |              |                                  |               |        |  |
| 11. 00 CLINIC                            | 08: 00   | 17: 00      |              |                                  |               | 11. 00 |  |

|         | Financial Systems WOODLAWN HOSPI TAL UNCOMPENSATED AND INDIGENT CARE DATA  | Provider CCN:   | 15_1212      | Peri od:         | u of Form CMS-2<br>Worksheet S-1 |                |
|---------|--|-----------------|--------------|------------------|----------------------------------|----------------|
| 103PT 1 | AL UNCOMPENSATED AND INDIGENT CARE DATA  | Provider CCN.   |              | From 01/01/2020  | worksneet 3-1                    | 0              |
|         |  |                 |              | To 12/31/2020    | Date/Time Pre<br>7/29/2021 4:1   | epared<br>5 pm |
|         |  |                 | '            |                  | 1. 00                            |                |
|         | Uncompensated and indigent care cost computation   |                 |              |                  | 1.00                             |                |
| . 00    | Cost to charge ratio (Worksheet C, Part I line 202 column 3 di   | vided by line   | 202 col um   | n 8)             | 0. 352463                        | 1.0            |
| . 00    | Medicaid (see instructions for each line)  | 11 dod 25 11110 | 202 00. 4    | 1 0/             | 0.002.00                         | 1              |
| . 00    | Net revenue from Medicaid  |                 |              |                  | 1, 238, 464                      | 2.0            |
| . 00    | Did you receive DSH or supplemental payments from Medicaid?  |                 |              |                  | Υ                                | 3.             |
| . 00    | If line 3 is yes, does line 2 include all DSH and/or supplemen   | tal payments    | from Medic   | ai d?            | Υ                                | 4.             |
| . 00    | If line 4 is no, then enter DSH and/or supplemental payments f   | rom Medicaid    |              |                  | 0                                | 1              |
| . 00    | Medicaid charges   |                 |              |                  | 18, 951, 526                     | 1              |
| . 00    | Medicaid cost (line 1 times line 6)  | (line 7 minus   | oum of Li    | and F. if        | 6, 679, 712                      | 1              |
| 00      | Difference between net revenue and costs for Medicaid program < zero then enter zero)  | (Tine / minus   | Sull of II   | nes 2 and 5; 11  | 5, 441, 248                      | 8.             |
|         | Children's Health Insurance Program (CHIP) (see instructions for   | or each line)   |              |                  |                                  |                |
| . 00    | Net revenue from stand-alone CHIP  |                 |              |                  | 0                                | 9.             |
|         | Stand-alone CHIP charges   |                 |              |                  | 0                                |                |
| 1. 00   | Stand-alone CHIP cost (line 1 times line 10)   |                 |              |                  | 0                                | 1              |
| 2. 00   |  | (line 11 minu   | ıs line 9;   | if < zero then   | 0                                | 12.            |
|         | enter zero)  Other state or local government indigent care program (see ins  | tructions for   | ooch Line    | \                |                                  | -              |
| 3. 00   | Other state or local government indigent care program (see ins<br>Net revenue from state or local indigent care program (Not inc |                 |              |                  | 0                                | 13.            |
|         | Charges for patients covered under state or local indigent care  |                 |              |                  | 0                                | 1              |
| . 00    | 10)  | e program (Ne   | 7 THOI daca  | 111 111103 0 01  | Ü                                | ' ''           |
| 5. 00   | 1 (  | 4)              |              |                  | 0                                | 15.            |
| 5. 00   | Difference between net revenue and costs for state or local in   | digent care p   | rogram (li   | ne 15 minus line | 0                                | 16.            |
|         | 13; if < zero then enter zero)   |                 |              |                  |                                  | 1              |
|         | Grants, donations and total unreimbursed cost for Medicaid, CH instructions for each line)                                       | IP and state/   | local indi   | gent care progra | ms (see                          |                |
| 7. 00   | Private grants, donations, or endowment income restricted to f   | unding charit   | y care       |                  | 0                                | 17.            |
| 3. 00   | Government grants, appropriations or transfers for support of  | hospital oper   | ati ons      |                  | 0                                | 18.            |
| 9. 00   | Total unreimbursed cost for Medicaid , CHIP and state and Loca 8, 12 and 16)   | l indigent ca   | ire program  | s (sum of lines  | 5, 441, 248                      | 19.            |
|         | ,  |                 | Uni nsured   | Insured          | Total (col. 1                    |                |
|         |  |                 | patients     | pati ents        | + col . 2)                       |                |
|         |  |                 | 1. 00        | 2. 00            | 3. 00                            |                |
| 0. 00   | Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa               | cility          | 1, 044, 33   | 3 0              | 1, 044, 333                      | 20.            |
| J. 00   | (see instructions)   | Cirrey          | 1,044,00     |                  | 1,044,333                        | 20.            |
| 1. 00   | Cost of patients approved for charity care and uninsured disco   | unts (see       | 368, 08      | 9 0              | 368, 089                         | 21.            |
|         | instructions)  | , l             |              |                  |                                  |                |
| 2. 00   | Payments received from patients for amounts previously written   | off as          |              | 0 0              | 0                                | 22.            |
|         | charity care   |                 | 0.40         |                  | 0.40.000                         |                |
| 3. 00   | Cost of charity care (line 21 minus line 22)   |                 | 368, 08      | 9 0              | 368, 089                         | 23.            |
|         |  |                 |              |                  | 1. 00                            |                |
| 1. 00   | Does the amount on line 20 column 2, include charges for patie   | nt days beyor   | nd a Length  | of stay limit    | N                                | 24.            |
| 5. 00   | imposed on patients covered by Medicaid or other indigent care<br>If line 24 is yes, enter the charges for patient days beyond t |                 | are progra   | m's Length of    | 0                                | 25.            |
| . 50    | stay limit   | mar gent c      | o progra     | o rongtii oi     | O                                | 20.            |
| 5. 00   | Total bad debt expense for the entire hospital complex (see in   | structions)     |              |                  | 2, 844, 678                      | 26.            |
| 7. 00   | Medicare reimbursable bad debts for the entire hospital comple   |                 | ıcti ons)    |                  | 565, 077                         |                |
| 7. 01   | Medicare allowable bad debts for the entire hospital complex (   | see instructi   | ons)         |                  | 869, 349                         | 27.            |
| 3. 00   | Non-Medicare bad debt expense (see instructions)   |                 |              |                  | 1, 975, 329                      | 1              |
| 9. 00   | Cost of non-Medicare and non-reimbursable Medicare bad debt ex   | pense (see ir   | nstructi ons | )                | 1, 000, 502                      | 1              |
|         | Cost of uncompensated care (line 23 column 3 plus line 29)   |                 |              |                  | 1, 368, 591                      | 30.            |
| 0.00    | Total unreimbursed and uncompensated care cost (line 19 plus I   |                 |              | ı                | 6, 809, 839                      | 1 00           |

| Heal th | Financial Systems                              | WOODLAWN HO  | SPI TAL      |               | In Lie                           | u of Form CMS-2 | 2552-10 |
|---------|--|--------------|--------------|---------------|----------------------------------|-----------------|---------|
| RECLAS  | SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES   | Provi der Co | CN: 15-1313 F | Peri od:                         | Worksheet A     |         |
|         |  |              |              | <u>F</u>      | From 01/01/2020<br>To 12/31/2020 |                 |         |
|         |  |              |              |               | o 12/31/2020                     | Date/Time Pre   |         |
|         | Coot Conton Decemintion                        | Colorias     | O+box        | Total (ool 1  | Dool oooi fi oot                 | 7/29/2021 4: 1  | 5 pm    |
|         | Cost Center Description                        | Sal ari es   | Other        |               | Reclassificat                    | Reclassified    |         |
|         |  |              |              | + col . 2)    | i ons (See                       | Trial Balance   |         |
|         |  |              |              |               | A-6)                             | (col. 3 +-      |         |
|         |  | 1.00         | 0.00         | 2.00          | 4.00                             | col . 4)        |         |
|         |  | 1. 00        | 2. 00        | 3. 00         | 4. 00                            | 5. 00           |         |
|         | GENERAL SERVICE COST CENTERS                   |              |              |               |                                  |                 |         |
| 1. 00   | 00100 CAP REL COSTS-BLDG & FLXT                |              | 2, 527, 213  |               |                                  |                 | 1.00    |
| 1. 02   | 00102 AKRON BUILDING                           |              | 47, 411      | 47, 411       |                                  | ,               | 1. 02   |
| 1. 03   | 00103 ARGOS BUILDING                           |              | 109, 342     |               |                                  | 109, 342        | 1.03    |
| 1. 04   | 00101 CLAYS BUILDING                           |              | 28, 329      | 28, 329       | 133, 980                         |                 | 1.04    |
| 4.00    | 00400 EMPLOYEE BENEFITS DEPARTMENT             | 0            | 3, 120, 758  |               |                                  | 3, 120, 758     | 4.00    |
| 5.00    | 00500 ADMINISTRATIVE & GENERAL                 | 3, 201, 109  | 5, 898, 493  | 9, 099, 602   | -377, 088                        | 8, 722, 514     | 5.00    |
| 7.00    | 00700 OPERATION OF PLANT                       | 379, 067     | 1, 138, 900  | 1, 517, 967   | 1, 461, 082                      | 2, 979, 049     | 7. 00   |
| 8.00    | 00800 LAUNDRY & LINEN SERVICE                  | 18, 135      | 129, 563     | 147, 698      | 0                                | 147, 698        | 8.00    |
| 9.00    | 00900 HOUSEKEEPI NG                            | 381, 576     | 195, 821     | 577, 397      | -1, 065                          | 576, 332        | 9.00    |
| 10.00   | 01000 DI ETARY                                 | 405, 595     | 329, 438     | 735, 033      | -443, 527                        | 291, 506        | 10.00   |
| 11.00   | 01100 CAFETERI A                               | 0            | 0            |               | 433, 589                         | 433, 589        | 11.00   |
| 13.00   | 01300 NURSING ADMINISTRATION                   | 330, 636     | 110, 902     | 441, 538      |                                  | 660, 489        | 13.00   |
| 14.00   | 01400 CENTRAL SERVICES & SUPPLY                | 0            | 0            | (             |                                  | 0               | 14.00   |
| 15. 00  | 01500 PHARMACY                                 | 393, 171     | 3, 404, 643  | 3, 797, 814   | -35, 348                         |                 |         |
| 16. 00  | 01600 MEDICAL RECORDS & LIBRARY                | 446, 779     | 717, 291     | 1, 164, 070   |                                  |                 |         |
| 10.00   | INPATIENT ROUTINE SERVICE COST CENTERS         | 110, 777     | 717,271      | 1, 101, 070   | 12,707                           | 1, 121, 101     | 10.00   |
| 30. 00  | 03000 ADULTS & PEDIATRICS                      | 2, 212, 522  | 908, 906     | 3, 121, 428   | -650, 778                        | 2, 470, 650     | 30.00   |
| 31. 00  | 03100 I NTENSI VE CARE UNI T                   | 481, 915     | 197, 295     |               |                                  |                 |         |
| 43. 00  | 04300 NURSERY                                  | 401, 713     | 177, 273     |               |                                  |                 | 43.00   |
| 43.00   | ANCILLARY SERVICE COST CENTERS                 | U            | 0            |               | 170,099                          | 170, 077        | 43.00   |
| EO 00   |  | 828, 651     | 1 770 F/O    | 2 500 210     | 12 024                           | 2 554 105       | FO 00   |
| 50.00   | 05000 OPERATING ROOM                           |              | 1, 770, 568  |               |                                  |                 |         |
| 51.00   | 05100 RECOVERY ROOM                            | 384, 462     | 175, 317     |               |                                  |                 | 1       |
| 52.00   | 05200 DELIVERY ROOM & LABOR ROOM               | 0            | 0            | 700 000       | ,                                | 411, 881        |         |
| 53.00   | 05300 ANESTHESI OLOGY                          | 0            | 792, 806     |               |                                  | 792, 031        | 1       |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C                  | 1, 590, 775  | 1, 394, 775  |               |                                  | 2, 674, 243     |         |
| 60.00   | 06000 LABORATORY                               | 873, 808     | 2, 025, 758  |               |                                  | 2, 834, 842     |         |
| 65.00   | 06500 RESPI RATORY THERAPY                     | 913, 470     | 355, 624     |               |                                  |                 | 65.00   |
| 66. 00  | 06600 PHYSI CAL THERAPY                        | 695, 407     | 199, 689     |               |                                  | 891, 534        |         |
| 67. 00  | 06700 OCCUPATI ONAL THERAPY                    | 232, 377     | 47, 351      |               |                                  | 279, 728        | 1       |
| 68. 00  | 06800 SPEECH PATHOLOGY                         | 107, 046     | 20, 955      | 1             |                                  | 128, 001        | 1       |
| 71. 00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT      | 0            | 0            | (             | <u> </u>                         | 0               | 71.00   |
| 72.00   | 07200 I MPL. DEV. CHARGED TO PATIENTS          | 0            | 1, 054, 584  | 1, 054, 584   | 1 0                              | 1, 054, 584     | 72.00   |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS                | 0            | 0            | (             | 0                                | 0               | 73.00   |
|         | OUTPATIENT SERVICE COST CENTERS                |              |              |               |                                  |                 |         |
| 88. 00  | 08800 SHAFER MEDICAL CENTER                    | 304, 962     | 593, 946     |               | -201, 996                        | 696, 912        | 88. 00  |
| 88. 01  | 08801 WOODLAWN MEDICAL PROFESSIONALS           | 2, 762, 517  | 1, 705, 000  | 4, 467, 517   | -2, 046, 364                     | 2, 421, 153     | 88. 01  |
| 88. 02  | 08802 FULTON COUNTY MEDICAL CENTER- 700 MA     | 1, 450, 311  | 929, 820     | 2, 380, 131   | -577, 913                        | 1, 802, 218     | 88. 02  |
| 88. 03  | 08803 FULTON COUNTY MEDICAL CENTER - 100 E     | 176, 769     | 70, 587      | 247, 356      | 49, 957                          | 297, 313        | 88. 03  |
| 88. 04  | 08804 AKRON MEDICAL CLINIC                     | 545, 631     | 192, 238     | 737, 869      | -183, 151                        | 554, 718        | 88. 04  |
| 88. 05  | 08805 ARGOS MEDICAL CLINIC                     | 1, 575, 858  | 493, 644     | 2, 069, 502   | -471, 116                        | 1, 598, 386     | 88. 05  |
| 91.00   | 09100 EMERGENCY                                | 1, 658, 854  | 2, 277, 676  |               |                                  |                 | 91.00   |
|         | 09200 OBSERVATION BEDS (NON-DISTINCT PART      | , ,          | , , , , ,    |               |                                  |                 | 92.00   |
|         | 04950 WOODLAWN MEDICAL PROFESSIONALS           | 830, 123     | 572, 562     | 1, 402, 685   | 1, 171, 573                      | 2, 574, 258     |         |
|         | 04951 SHAFER MEDICAL CENTER                    | 2, 832, 403  | 468, 002     |               |                                  |                 | 93. 01  |
| 70.01   | SPECIAL PURPOSE COST CENTERS                   | 2,002,100    | 100, 002     | 0,000,100     | 200, 072                         | 0,000,077       | 70.01   |
| 113 00  | 11300 I NTEREST EXPENSE                        |              | 0            |               | 0                                | 0               | 113.00  |
| 118. 00 | 1 1  | 26, 013, 929 | 34, 005, 207 |               |                                  |                 |         |
| 110.00  | NONREI MBURSABLE COST CENTERS                  | 20,013,727   | 34, 003, 207 | 00,017,130    | -1,470,270                       | 30, 340, 030    | 1110.00 |
| 100 00  | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN        |              | 0            |               |                                  | 0               | 190. 00 |
|         | 19200 PHYSICIANS PRIVATE OFFICES               | 0            | 0            |               |                                  |                 | 192.00  |
|         | 1 19201 FCMC                                   | 0            | 0            |               |                                  |                 |         |
|         |  | -            | 0            | (             | , =                              |                 |         |
|         | 19202 ARGOS MEDICAL CENTER                     | 0            | 0            |               |                                  |                 |         |
|         | 3 19203 AKRON MEDICAL CENTER                   | 0            | 0            |               | 210, 888                         |                 |         |
|         | 19300 NONPALD WORKERS                          | - 0          | 0            | (             | 0 0                              |                 | 193.00  |
|         | 07950 ADVERTI SI NG                            | 74, 342      | 383, 507     |               |                                  | 432, 038        |         |
| 200.00  | TOTAL (SUM OF LINES 118 through 199)           | 26, 088, 271 | 34, 388, 714 | 60, 476, 985  | 5  0                             | 60, 476, 985    | 200.00  |
|         |  |              |              |               |                                  |                 |         |

Provider CCN: 15-1313

Period: Worksheet A From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 4:15 pm

|          |  |               |               | 7/29/2021 4: 1 | 15 pm   |
|----------|--|---------------|---------------|----------------|---------|
|          | Cost Center Description                    | Adjustments   | Net Expenses  |                |         |
|          | ·  | (See A-8)     | For           |                |         |
|          |  |               | Allocation    |                |         |
|          |  | 6. 00         | 7. 00         |                |         |
| <u> </u> | GENERAL SERVICE COST CENTERS               |               |               |                |         |
| 1.00     | 00100 CAP REL COSTS-BLDG & FIXT            | -2, 415       | 2, 390, 818   |                | 1.00    |
| 1.02     | 00102 AKRON BUILDING                       | 0             | 47, 411       |                | 1. 02   |
| 1.03     | 00103 ARGOS BUILDING                       | 0             | 109, 342      |                | 1.03    |
| 1.04     | 00101 CLAYS BUILDING                       | 0             | 162, 309      |                | 1.04    |
| 4.00     | 00400 EMPLOYEE BENEFITS DEPARTMENT         | 0             | 3, 120, 758   |                | 4.00    |
| 5.00     | 00500 ADMINISTRATIVE & GENERAL             | -2, 477, 922  |               | •              | 5.00    |
| 7.00     | 00700 OPERATION OF PLANT                   | 0             | 2, 979, 049   | •              | 7.00    |
| 8.00     | 00800 LAUNDRY & LINEN SERVICE              | 0             | 147, 698      | 1              | 8.00    |
| 9.00     | 00900 HOUSEKEEPI NG                        | 0             | 576, 332      | •              | 9.00    |
| 10.00    | 01000 DI ETARY                             | -22, 649      |               |                | 10.00   |
| 11. 00   | 01100 CAFETERI A                           | -109, 428     |               | 1              | 11.00   |
| 13. 00   | 01300 NURSING ADMINISTRATION               | 0             | 660, 489      | •              | 13.00   |
| 14. 00   | 01400 CENTRAL SERVICES & SUPPLY            | 0             | 0             | •              | 14.00   |
| 15. 00   | 01500 PHARMACY                             | -5, 473       |               | 1              | 15.00   |
| 16. 00   | 01600 MEDICAL RECORDS & LIBRARY            | -21, 662      |               | 1              | 16.00   |
| 10.00    | INPATIENT ROUTINE SERVICE COST CENTERS     | -21,002       | 1,077,477     |                | 10.00   |
| 30. 00   | 03000 ADULTS & PEDIATRICS                  | 0             | 2, 470, 650   |                | 30.00   |
| 31.00    | 03100 INTENSIVE CARE UNIT                  | 0             |               | •              | 31.00   |
| 43.00    |  | 0             |               |                | 1       |
| 43.00    | 04300 NURSERY                              | 0             | 176, 899      |                | 43. 00  |
| EO 00    | ANCILLARY SERVICE COST CENTERS             | 0             | 2 554 105     |                | F0 00   |
| 50.00    | 05000 OPERATING ROOM                       | 0             | _, -, ,       | •              | 50.00   |
| 51.00    | 05100 RECOVERY ROOM                        | 0             | 559, 654      | •              | 51.00   |
| 52.00    | 05200 DELIVERY ROOM & LABOR ROOM           | 727 227       | 411, 881      | •              | 52.00   |
| 53.00    | 05300 ANESTHESI OLOGY                      | -736, 327     |               | •              | 53.00   |
| 54.00    | 05400 RADI OLOGY-DI AGNOSTI C              | -200, 824     |               | l .            | 54.00   |
| 60.00    | 06000 LABORATORY                           | 0             | _, _, _, _, _ |                | 60.00   |
| 65.00    | 06500 RESPI RATORY THERAPY                 | -95, 673      |               | •              | 65.00   |
| 66. 00   | 06600 PHYSI CAL THERAPY                    | -59, 070      |               | •              | 66. 00  |
| 67.00    | 06700 OCCUPATI ONAL THERAPY                | 0             | 279, 728      | •              | 67.00   |
| 68.00    | 06800 SPEECH PATHOLOGY                     | 0             | 128, 001      |                | 68. 00  |
| 71.00    | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0             | 0             | l .            | 71. 00  |
| 72. 00   | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0             | 1, 054, 584   | •              | 72.00   |
| 73. 00   | 07300 DRUGS CHARGED TO PATIENTS            | 0             | 0             |                | 73. 00  |
|          | OUTPATIENT SERVICE COST CENTERS            |               |               |                |         |
| 88. 00   | 08800 SHAFER MEDICAL CENTER                | 0             |               | 1              | 88. 00  |
| 88. 01   | 08801 WOODLAWN MEDICAL PROFESSIONALS       | 0             | 2, 421, 153   | •              | 88. 01  |
| 88. 02   | 08802 FULTON COUNTY MEDICAL CENTER- 700 MA | 0             | 1, 802, 218   | •              | 88. 02  |
| 88. 03   | 08803 FULTON COUNTY MEDICAL CENTER - 100 E | 0             | 297, 313      |                | 88. 03  |
| 88. 04   | 08804 AKRON MEDICAL CLINIC                 | 0             | 554, 718      |                | 88. 04  |
| 88. 05   | 08805 ARGOS MEDICAL CLINIC                 | 0             | 1, 598, 386   |                | 88. 05  |
| 91.00    | 09100 EMERGENCY                            | -1, 701, 066  | 2, 155, 550   |                | 91.00   |
| 92.00    | 09200 OBSERVATION BEDS (NON-DISTINCT PART  |               |               |                | 92.00   |
| 93.00    | 04950 WOODLAWN MEDICAL PROFESSIONALS       | -1, 824, 829  | 749, 429      |                | 93.00   |
| 93.01    | 04951 SHAFER MEDICAL CENTER                | -2, 747, 456  | 788, 641      |                | 93. 01  |
|          | SPECIAL PURPOSE COST CENTERS               |               |               |                |         |
| 113.00   | 11300 I NTEREST EXPENSE                    | 0             | 0             |                | 113. 00 |
| 118.00   | SUBTOTALS (SUM OF LINES 1 through 117)     | -10, 004, 794 | 48, 544, 064  |                | 118.00  |
|          | NONREI MBURSABLE COST CENTERS              |               |               |                |         |
| 190.00   | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN    | 0             | 0             |                | 190.00  |
| 192.00   | 19200 PHYSICIANS PRIVATE OFFICES           | 0             | 0             |                | 192.00  |
|          | 19201 FCMC                                 | 0             | 694, 205      | •              | 192.01  |
|          | 19202 ARGOS MEDICAL CENTER                 | 0             | 590, 996      | •              | 192. 02 |
|          | 19203 AKRON MEDICAL CENTER                 | 0             | 210, 888      | •              | 192. 03 |
|          | 19300 NONPALD WORKERS                      | n             | 0             | •              | 193.00  |
|          | 07950 ADVERTI SI NG                        | 0             | 432, 038      | i e            | 194.00  |
| 200.00   |  | -10, 004, 794 |               | •              | 200.00  |
|          | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1      | , , . , . , . |               | 1              | 1       |

Health Financial Systems RECLASSIFICATIONS WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet A-6 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-1313

|                  |  |                                       |                        |                     | 10   12/31/2020   Date/IIME Prepar<br>  7/29/2021 4:15 p |                |
|------------------|--|---------------------------------------|------------------------|---------------------|--|----------------|
|                  |  | Increases                             |                        |                     |  |                |
|                  | Cost Center  | Li ne #                               | Sal ary                | 0ther               |  |                |
|                  | 2. 00  | 3. 00                                 | 4. 00                  | 5. 00               |  |                |
|                  | A - CAFETERIA  |                                       |                        |                     |  |                |
| 1. 00            | CAFETERI A   |                                       | 24 <u>2, 5</u> 36      | 19 <u>1, 0</u> 53   | 1  | 1. 00          |
|                  | B - ADVERTI SI NG  |                                       | 242, 536               | 191, 053            |  |                |
| 1. 00            | ADMINISTRATIVE & GENERAL   | 5. 00                                 | 4, 191                 | 21, 620             |  | 1. 00          |
| 1.00             | 0  |                                       | $-\frac{4,171}{4,191}$ | 21, 620             | '  | 1.00           |
|                  | C - DEPRECIATION   | ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' |                        |                     |  |                |
| 1.00             | CLAYS BUILDING   | 1. 04                                 | 0                      | 133, 980            | 1  | 1.00           |
|                  | 0  |                                       | 0                      | 133, 980            |  |                |
|                  | D - NURSERY  |                                       |                        |                     |  |                |
| 1.00             | NURSERY  | 43.00                                 | 134, 999               | 41, 900             |  | 1.00           |
| 2. 00            | DELIVERY ROOM & LABOR ROOM   | 5200                                  | 314, 324               | 97, 557             |  | 2. 00          |
|                  | E - NURSING SUPERVISOR   |                                       | 449, 323               | 139, 457            |  |                |
| 1. 00            | NURSI NG ADMI NI STRATI ON   | 13. 00                                | 220, 983               | 0                   | 1  | 1. 00          |
| 2. 00            | The terms of the track of the terms of the t | 0.00                                  | 0                      | 0                   |  | 2. 00          |
| 3.00             |  | 0.00                                  | O                      | 0                   | 3  | 3. 00          |
| 4.00             |  | 0.00                                  | 0                      | 0                   | 4  | 4. 00          |
|                  | 0  |                                       | 220, 983               | 0                   |  |                |
|                  | F - MAINTENANCE RECLASS  |                                       |                        |                     |  |                |
| 1.00             | OPERATION OF PLANT   | 7. 00                                 | 0                      | 1, 461, 082         |  | 1.00           |
| 2.00             |  | 0. 00<br>0. 00                        | 0                      | 0                   |  | 2.00           |
| 3. 00<br>4. 00   |  | 0.00                                  | 0                      | 0                   |  | 3. 00<br>4. 00 |
| 5. 00            |  | 0.00                                  | 0                      | 0                   |  | 5. 00          |
| 6. 00            |  | 0. 00                                 | 0                      | 0                   |  | 5. 00          |
| 7. 00            |  | 0.00                                  | Ö                      | 0                   |  | 7. 00          |
| 8.00             |  | 0.00                                  | 0                      | 0                   |  | 3. 00          |
| 9.00             |  | 0.00                                  | O                      | 0                   | 9  | 9. 00          |
| 10.00            |  | 0.00                                  | 0                      | 0                   | 10   | 0. 00          |
| 11.00            |  | 0. 00                                 | 0                      | 0                   |  | 1. 00          |
| 12.00            |  | 0. 00                                 | 0                      | 0                   | · ·  | 2. 00          |
| 13.00            |  | 0.00                                  | 0                      | 0                   | · ·  | 3.00           |
| 14.00            |  | 0.00                                  | 0                      | 0                   | · ·  | 4.00           |
| 15. 00<br>16. 00 |  | 0. 00<br>0. 00                        | 0                      | 0                   | · ·  | 5. 00<br>6. 00 |
| 17. 00           |  | 0.00                                  | 0                      | 0                   | · ·  | 7. 00          |
| 18. 00           |  | 0.00                                  | 0                      | 0                   |  | 3. 00          |
| 19. 00           |  | 0.00                                  | Ö                      | Ö                   |  | 9. 00          |
| 20.00            |  | 0.00                                  | o                      | 0                   |  | 0.00           |
| 21.00            |  | 0.00                                  | O                      | 0                   | 21   | 1. 00          |
| 22.00            |  | 0.00                                  | 0                      | 0                   | 22   | 2. 00          |
|                  | 0  |                                       | 0                      | 1, 461, 082         |  |                |
| 1 00             | G - RHC RECLASS  | 00.00                                 | 005 70                 | 2/2 :25             |  | 1 00           |
| 1. 00            | WOODLAWN MEDICAL   | 93. 00                                | 805, 734               | 369, 423            | 1  | 1. 00          |
| 2. 00            | PROFESSIONALS SHAFER MEDICAL CENTER  | 93. 01                                | 88, 947                | 172, 948            |  | 2. 00          |
| 3. 00            | FCMC   | 192. 01                               | 423, 008               | 271, 197            |  | 3. 00          |
| 4. 00            | ARGOS MEDICAL CENTER   | 192. 02                               | 459, 625               | 131, 371            |  | 4. 00          |
| 5.00             | AKRON MEDICAL CENTER   | 192. 03                               | 159, 142               | 51, 746             |  | 5. 00          |
|                  | 0  |                                       | 1, 936, 456            | 996, 685            |  |                |
|                  | H - RENT RECLASS   |                                       |                        |                     |  |                |
| 1.00             | FULTON COUNTY MEDICAL CENTER   | 88. 03                                | 0                      | 26, 113             | 1  | 1. 00          |
|                  | - 100 E  | +                                     |                        |                     |  |                |
|                  | TOTALS   |                                       | 0                      | 26, 113             |  |                |
| 1 00             | I - RHC OVERHEAD RECLASS SHAFER MEDICAL CENTER   | 88. 00                                | 18, 051                | 42, 829             | 1  | 1 00           |
| 1. 00<br>2. 00   | FULTON COUNTY MEDICAL  | 88. 00<br>88. 02                      | 42, 223                | 42, 829<br>100, 182 |  | 1. 00<br>2. 00 |
| 2.00             | CENTER- 700 MA   | 00. 02                                | 72, 223                | 100, 102            |  | 00             |
| 3. 00            | FULTON COUNTY MEDICAL CENTER   | 88. 03                                | 7, 070                 | 16, 774             | 9  | 3. 00          |
| 50               | - 100 E  | 33. 33                                | .,                     |                     |  |                |
| 4.00             | AKRON MEDICAL CLINIC   | 88. 04                                | 12, 619                | 29, 942             | 4  | 4. 00          |
| 5.00             | ARGOS MEDICAL CLINIC   |                                       | 4 <u>8, 3</u> 62       | 11 <u>4, 7</u> 49   | 5  | 5. 00          |
|                  | TOTALS   |                                       | 128, 325               | 304, 476            |  |                |
| 500.00           | Grand Total: Increases   |                                       | 2, 981, 814            | 3, 274, 466         | 500  | 0. 00          |

Provider CCN: 15-1313

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 4:15 pm

|         |                             |                |                    |                   |               | 7/29/2021 4:15 pm |
|---------|-----------------------------|----------------|--------------------|-------------------|---------------|-------------------|
|         |                             | Decreases      |                    |                   |               |                   |
|         | Cost Center                 | Li ne #        | Sal ary            |                   | kst. A-7 Ref. |                   |
|         | 6. 00                       | 7. 00          | 8. 00              | 9. 00             | 10. 00        |                   |
|         | A - CAFETERIA               |                |                    |                   |               |                   |
| 1. 00   | DI ETARY                    | 1000           | 24 <u>2, 5</u> 36  | 19 <u>1, 0</u> 53 | 0             | 1.0               |
|         | 0                           |                | 242, 536           | 191, 053          |               |                   |
|         | B - ADVERTISING             |                |                    |                   |               |                   |
| 1.00    | ADVERTI SI NG               | 194. 00        | 4, 191             | 21, 620           | 0             | 1. (              |
|         |                             | +              | 4, 191             | 21, 620           | 1             |                   |
|         | C - DEPRECIATION            |                | ., ., .,           | 2., 020           |               |                   |
| 1. 00   | CAP REL COSTS-BLDG & FLXT   | 1.00           | 0                  | 133, 980          | 9             | 1.0               |
| 1.00    | O REE COSTS-BEDG & LIXI     |                | — — — <del>ў</del> | 133, 980          |               | 1.0               |
|         | D NUDCEDY                   |                | U                  | 133, 900          |               |                   |
|         | D - NURSERY                 |                | 440.000            | 400 457           |               |                   |
| 1. 00   | ADULTS & PEDIATRICS         | 30. 00         | 449, 323           | 139, 457          | 0             | 1. 0              |
| 2.00    |                             | 0.00           |                    | 0                 | 0             | 2.0               |
|         | 0                           |                | 449, 323           | 139, 457          |               |                   |
|         | E - NURSING SUPERVISOR      |                |                    |                   |               |                   |
| 1.00    | ADULTS & PEDIATRICS         | 30.00          | 36, 279            | 0                 | 0             | 1. 0              |
| 2.00    | INTENSIVE CARE UNIT         | 31.00          | 69, 098            | 0                 | 0             | 2.0               |
| 3.00    | RADI OLOGY-DI AGNOSTI C     | 54. 00         | 44, 763            | 0                 | o             | 3.0               |
| 4. 00   | EMERGENCY                   | 91.00          | 70, 843            | 0                 | 0             | 4.0               |
| 4.00    | EWERGENCY                   | <u> </u>       |                    |                   | 4             | 4.0               |
|         | 0                           |                | 220, 983           | 0                 |               |                   |
|         | F - MAINTENANCE RECLASS     |                |                    |                   |               |                   |
| 1. 00   | ADMINISTRATIVE & GENERAL    | 5. 00          | 0                  | 402, 899          | 0             | 1.0               |
| 2.00    | HOUSEKEEPI NG               | 9. 00          | 0                  | 1, 065            | 0             | 2.0               |
| 3.00    | DI ETARY                    | 10.00          | 0                  | 9, 938            | 0             | 3.0               |
| 4. 00   | NURSING ADMINISTRATION      | 13. 00         | o                  | 2, 032            | o             | 4.0               |
| 5. 00   | PHARMACY                    | 15. 00         | Ö                  | 35, 348           | o             | 5.0               |
|         | •                           | l .            | -                  |                   | - 1           |                   |
| 6. 00   | MEDI CAL RECORDS & LI BRARY | 16.00          | 0                  | 42, 909           | 0             | 6. 0              |
| 7. 00   | ADULTS & PEDIATRICS         | 30.00          | 0                  | 25, 719           | 0             | 7.0               |
| 8.00    | INTENSIVE CARE UNIT         | 31. 00         | 0                  | 4, 406            | 0             | 8.0               |
| 9.00    | OPERATING ROOM              | 50.00          | 0                  | 43, 034           | 0             | 9.0               |
| 10.00   | RECOVERY ROOM               | 51.00          | ol                 | 125               | ol            | 10.0              |
| 11. 00  | ANESTHESI OLOGY             | 53. 00         | ol                 | 775               | o             | 11. 0             |
| 12. 00  | RADI OLOGY-DI AGNOSTI C     | 54.00          | Ö                  | 266, 544          | 0             | 12.0              |
|         | •                           | l .            | -                  |                   | - 1           | 1                 |
| 13.00   | LABORATORY                  | 60.00          | 0                  | 64, 724           | 0             | 13. (             |
| 14. 00  | RESPI RATORY THERAPY        | 65. 00         | 0                  | 21, 702           | 0             | 14.0              |
| 15.00   | PHYSI CAL THERAPY           | 66. 00         | 0                  | 3, 562            | 0             | 15.0              |
| 16.00   | SHAFER MEDICAL CENTER       | 88. 00         | 0                  | 981               | 0             | 16.0              |
| 17.00   | WOODLAWN MEDICAL            | 88. 01         | o                  | 438, 406          | ol            | 17.0              |
|         | PROFESSI ONALS              |                |                    |                   |               |                   |
| 18.00   | AKRON MEDICAL CLINIC        | 88. 04         | o                  | 14, 824           | 0             | 18.0              |
| 19. 00  | ARGOS MEDICAL CLINIC        | 88. 05         | 0                  | 43, 231           | o             | 19.0              |
|         |                             |                |                    | · ·               |               | •                 |
| 20.00   | EMERGENCY                   | 91.00          | 0                  | 9, 071            | 0             | 20.0              |
| 21. 00  | WOODLAWN MEDICAL            | 93. 00         | O                  | 3, 584            | 0             | 21.0              |
|         | PROFESSI ONALS              |                |                    |                   |               |                   |
| 22.00   | SHAFER MEDICAL CENTER       | 93. 01         | 0                  | <u>26, 2</u> 03   | 0             | 22.0              |
|         | 0                           |                | 0                  | 1, 461, 082       |               |                   |
|         | G - RHC RECLASS             |                |                    |                   |               |                   |
| 1.00    | SHAFER MEDICAL CENTER       | 88. 00         | 88, 947            | 172, 948          | 0             | 1. (              |
| 2. 00   | WOODLAWN MEDICAL            | 88. 01         | 805, 734           | 369, 423          | o             | 2.0               |
| 2. 50   | PROFESSI ONALS              | 55.51          | 550, 754           | 337, 123          | ٩             | 2.0               |
| 3. 00   | FULTON COUNTY MEDICAL       | 88. 02         | 423, 008           | 271, 197          | 0             | 3.0               |
| 3.00    |                             | 00. 02         | 423, 008           | 2/1, 19/          | ٩             | 3.0               |
| 4 66    | CENTER- 700 MA              |                | 450 44-            | E                 | _             |                   |
| 4.00    | AKRON MEDICAL CLINIC        | 88. 04         | 159, 142           | 51, 746           | 0             | 4.0               |
| 5.00    | ARGOS MEDICAL CLINIC        | <u>88.</u> 05  | <u>459, 6</u> 25   | 13 <u>1, 3</u> 71 | 0             | 5.0               |
|         | 0                           |                | 1, 936, 456        | 996, 685          |               |                   |
|         | H - RENT RECLASS            |                |                    |                   |               |                   |
| 1.00    | FULTON COUNTY MEDICAL       | 88. 02         | 0                  | 26, 113           | 0             | 1. (              |
|         | CENTER- 700 MA              |                | ٦                  | ,                 | ٦             |                   |
|         | TOTALS                      | $\vdash$ $  +$ |                    | 26, 113           | +             |                   |
|         | I - RHC OVERHEAD RECLASS    |                | 9                  | 20, 110           |               |                   |
| 1 00    |                             | 00.01          | 120 225            | 204 474           |               | 1.0               |
| 1. 00   | WOODLAWN MEDICAL            | 88. 01         | 128, 325           | 304, 476          | 0             | 1.0               |
|         | PROFESSI ONALS              |                |                    |                   |               |                   |
| 2.00    |                             | 0.00           | 0                  | 0                 | 0             | 2.0               |
| 3.00    |                             | 0.00           | 0                  | 0                 | 0             | 3.0               |
| 4.00    |                             | 0.00           | ol                 | O                 | 0             | 4.0               |
| 5. 00   |                             | 0. 00          | n                  | 0                 | n n           | 5.0               |
| 3. 50   | TOTALS — — — —              | <u> </u>       | 128, 325           | 304, 476          | — —           | 3.0               |
| E00 00  |                             |                |                    |                   |               | F00 6             |
| 300. UU | Grand Total: Decreases      | 1              | 2, 981, 814        | 3, 274, 466       |               | 500.0             |
|         |                             |                |                    |                   |               |                   |

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS WOODLAWN HOSPITAL Provider CCN: 15-1313

|        |  |              |              |                 | То | 12/31/2020  | Date/Time Pre<br>7/29/2021 4:1 |        |
|--------|--|--------------|--------------|-----------------|----|-------------|--------------------------------|--------|
|        |  |              |              | Acqui si ti ons | 5  |             |                                |        |
|        |  | Begi nni ng  | Purchases    | Donati on       |    | Total       | Disposals and                  |        |
|        |  | Bal ances    |              |                 |    |             | Retirements                    |        |
|        |  | 1. 00        | 2. 00        | 3. 00           |    | 4. 00       | 5. 00                          |        |
|        | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE |              |              |                 |    |             |                                |        |
| 1.00   | Land   | 596, 216     | 0            |                 | 0  | 0           | 0                              | 1.00   |
| 2.00   | Land Improvements                            | 510, 775     | 0            |                 | 0  | 0           | 2, 087                         | 2.00   |
| 3.00   | Buildings and Fixtures                       | 27, 302, 119 | 146, 576     |                 | 0  | 146, 576    | 2, 783                         | 3.00   |
| 4.00   | Building Improvements                        | 0            | 0            |                 | 0  | 0           | 0                              | 4.00   |
| 5.00   | Fi xed Equipment                             | 0            | 0            |                 | 0  | 0           | 0                              | 5.00   |
| 6.00   | Movable Equipment                            | 10, 521, 060 | 949, 582     |                 | 0  | 949, 582    | 602, 019                       | 6.00   |
| 7. 00  | HIT designated Assets                        | 0            | 0            |                 | 0  | 0           | 0                              | 7.00   |
| 8.00   | Subtotal (sum of lines 1-7)                  | 38, 930, 170 | 1, 096, 158  |                 | 0  | 1, 096, 158 | 606, 889                       | 8.00   |
| 9.00   | Reconciling Items                            | 0            | 0            |                 | 0  | 0           | 0                              | 9.00   |
| 10.00  | Total (line 8 minus line 9)                  | 38, 930, 170 | 1, 096, 158  |                 | 0  | 1, 096, 158 | 606, 889                       | 10.00  |
|        |  | Endi ng      | Fully        |                 |    |             |                                |        |
|        |  | Bal ance     | Depreci ated |                 |    |             |                                |        |
|        |  |              | Assets       |                 |    |             |                                |        |
|        |  | 6. 00        | 7. 00        |                 |    |             |                                |        |
| 4 00   | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE |              |              |                 |    |             |                                | 4 00   |
| 1.00   | Land   | 596, 216     | 0            |                 |    |             |                                | 1.00   |
| 2. 00  | Land Improvements                            | 508, 688     | 0            |                 |    |             |                                | 2.00   |
| 3. 00  | Buildings and Fixtures                       | 27, 445, 912 | 0            |                 |    |             |                                | 3.00   |
| 4.00   | Building Improvements                        | 0            | 0            |                 |    |             |                                | 4.00   |
| 5.00   | Fi xed Equi pment                            | 0            | 0            |                 |    |             |                                | 5.00   |
| 6. 00  | Movable Equipment                            | 10, 868, 623 | 0            |                 |    |             |                                | 6.00   |
| 7.00   | HIT designated Assets                        | 0            | 0            |                 |    |             |                                | 7.00   |
| 8.00   | Subtotal (sum of lines 1-7)                  | 39, 419, 439 | 0            |                 |    |             |                                | 8.00   |
| 9.00   | Reconciling Items                            | 0 440 400    | 0            |                 |    |             |                                | 9.00   |
| 10. 00 | Total (line 8 minus line 9)                  | 39, 419, 439 | 0            |                 |    |             | l                              | 10. 00 |

| Health Financial Systems                | WOODLAWN HOSPITAL      | In Lieu         | u of Form CMS-2552-10  |
|---|------------------------|-----------------|--|
| RECONCILIATION OF CAPITAL COSTS CENTERS | Provi der CCN: 15-1313 | From 01/01/2020 | Worksheet A-7<br>Part II<br>Date/Time Prepared:<br>7/29/2021 4:15 pm |
|   | SUMMARY OF CAP         | PITAL           |  |

|       |  |                  |                    | 1        | 0 12/31/2020      | 7/29/2021 4:1            |       |  |
|-------|--|------------------|--------------------|----------|-------------------|--------------------------|-------|--|
|       |  |                  | SUMMARY OF CAPITAL |          |                   |                          |       |  |
|       | Cost Center Description                      | Depreciation     | Lease              | Interest | Insurance<br>(see | Taxes (see instructions) |       |  |
|       |  |                  |                    |          | instructions)     | ŕ                        |       |  |
|       |  | 9. 00            | 10. 00             | 11. 00   | 12. 00            | 13. 00                   |       |  |
|       | PART II - RECONCILIATION OF AMOUNTS FROM WOR |                  |                    | and 2    | i                 |                          |       |  |
| 1.00  | CAP REL COSTS-BLDG & FLXT                    | 1, 307, 056      |                    | 490, 254 | 653, 642          | 0                        | 1.00  |  |
| 1. 02 | AKRON BUILDING                               | 28, 466          |                    | 0        | 0                 | 0                        | 1. 02 |  |
| 1.03  | ARGOS BUILDING                               | 51, 768          | 0                  | 0        | 22, 621           | 0                        | 1.03  |  |
| 1.04  | CLAYS BUILDING                               | 0                | 0                  | 0        | 0                 | 0                        | 1.04  |  |
| 3.00  | Total (sum of lines 1-2)                     | 1, 387, 290      | 0                  | 490, 254 | 676, 263          | 0                        | 3.00  |  |
|       |  | SUMMARY 0        | F CAPITAL          |          |                   |                          |       |  |
|       |  |                  |                    |          |                   |                          |       |  |
|       | Cost Center Description                      | 0ther            | Total (1)          |          |                   |                          |       |  |
|       |  | Capi tal -Rel at |                    |          |                   |                          |       |  |
|       |  | ed Costs (see    | 9 through 14)      |          |                   |                          |       |  |
|       |  | instructions)    |                    |          |                   |                          |       |  |
|       |  | 14. 00           | 15. 00             |          |                   |                          |       |  |
|       | PART II - RECONCILIATION OF AMOUNTS FROM WOR |                  |                    |          |                   |                          |       |  |
| 1.00  | CAP REL COSTS-BLDG & FLXT                    | 76, 261          | 2, 527, 213        |          |                   |                          | 1.00  |  |
| 1. 02 | AKRON BUILDING                               | 18, 945          | 47, 411            |          |                   |                          | 1.02  |  |
| 1.03  | ARGOS BUILDING                               | 34, 953          | 109, 342           |          |                   |                          | 1.03  |  |
| 1.04  | CLAYS BUILDING                               | 28, 329          | 28, 329            |          |                   |                          | 1.04  |  |
| 3.00  | Total (sum of lines 1-2)                     | 158, 488         | 2, 712, 295        |          |                   |                          | 3.00  |  |

| Heal th | n Financial Systems                          | WOODLAWN F   | HOSPI TAL                |                           | In Lie                                      | u of Form CMS-2                  | 2552-10 |
|---------|--|--------------|--------------------------|---------------------------|---|----------------------------------|---------|
| RECON   | CILIATION OF CAPITAL COSTS CENTERS           |              | Provi der C              |                           | Period:<br>From 01/01/2020<br>To 12/31/2020 | Date/Time Prep<br>7/29/2021 4:15 | pared:  |
|         |  | COMF         | PUTATION OF RA           | TIOS                      | ALLOCATION OF                               | OTHER CAPITAL                    |         |
|         | Cost Center Description                      | Gross Assets | Capi tal i zed<br>Leases | Gross Assets<br>for Ratio | Ratio (see instructions)                    | Insurance                        |         |
|         |  |              |                          | (col. 1 -<br>col. 2)      | ,   |                                  |         |
|         |  | 1. 00        | 2. 00                    | 3.00                      | 4. 00                                       | 5. 00                            |         |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C |              |                          |                           | _   |                                  |         |
| 1.00    | CAP REL COSTS-BLDG & FIXT                    | 29, 954, 138 |                          |                           |   |                                  | 1.00    |
| 1.02    | AKRON BUILDING                               | 984, 445     |                          | 984, 44                   |   |                                  | 1.02    |
| 1.03    | ARGOS BUILDING                               | 2, 109, 526  |                          | 2, 109, 52                |   |                                  | 1.03    |
| 1.04    | CLAYS BUILDING                               | 6, 371, 330  |                          | 6, 371, 33                |   |                                  | 1.04    |
| 3. 00   | Total (sum of lines 1-2)                     | 39, 419, 439 | TION OF OTHER (          | 39, 419, 43               |   | OF CAPITAL                       | 3. 00   |
|         |  | ALLUCA       | IION OF OTHER (          | JAPITAL                   | SUMMART                                     | F CAPITAL                        |         |
|         | Cost Center Description                      | Taxes        | Other                    | Total (sum of             | Depreciation                                | Lease                            |         |
|         |  |              | Capi tal -Rel at         |                           |   |                                  |         |
|         |  |              | ed Costs                 | through 7)                |   |                                  |         |
|         |  | 6. 00        | 7. 00                    | 8. 00                     | 9. 00                                       | 10.00                            |         |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C | ENTERS       |                          |                           |   |                                  |         |
| 1.00    | CAP REL COSTS-BLDG & FIXT                    | 0            | 0                        |                           | 0 1, 170, 661                               |                                  | 1.00    |
| 1. 02   | AKRON BUILDING                               | 0            | 0                        |                           | 0 28, 466                                   |                                  | 1. 02   |
| 1. 03   | ARGOS BUILDING                               | 0            | 0                        | 1                         | 51, 768                                     |                                  | 1. 03   |
| 1.04    | CLAYS BUILDING                               | 0            | 0                        | 1                         | 0 133, 980                                  |                                  | 1.04    |
| 3. 00   | Total (sum of lines 1-2)                     | 0            | 0                        |                           | 1, 384, 875                                 | 0                                | 3. 00   |
|         |  |              | St                       | JMMARY OF CAPI            | IAL   |                                  |         |
|         | Cost Center Description                      | Interest     | Insurance                | Taxes (see                | Other                                       | Total (2)                        |         |
|         | •  |              | (see                     | instructions)             | Capi tal -Rel at                            |                                  |         |
|         |  |              | instructions)            |                           | ed Costs (see                               | 9 through 14)                    |         |
|         |  |              |                          |                           | instructions)                               |                                  |         |
|         |  | 11. 00       | 12. 00                   | 13. 00                    | 14.00                                       | 15. 00                           |         |
|         | PART III - RECONCILIATION OF CAPITAL COSTS C |              |                          |                           |   |                                  |         |
| 1.00    | CAP REL COSTS-BLDG & FIXT                    | 490, 254     | 653, 642                 | 1                         | 76, 261                                     |                                  | 1.00    |
| 1.02    | AKRON BUILDING                               | 0            | 0                        | 1                         | 0 18, 945                                   |                                  | 1.02    |
| 1.03    | ARGOS BUILDING                               | 0            | 22, 621                  | l .                       | 0 34, 953                                   |                                  | 1.03    |
| 1.04    | CLAYS BUILDING                               | 100.054      | 0                        | 1                         | 0 28, 329                                   |                                  | 1.04    |
| 3. 00   | Total (sum of lines 1-2)                     | 490, 254     | 676, 263                 | 1                         | 0 158, 488                                  | 2, 709, 880                      | 3. 00   |

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-1313

|                  |  |                    |                |  | From 01/01/2020<br>o 12/31/2020 | Date/Time Pre     |        |
|------------------|--|--------------------|----------------|--|---------------------------------|-------------------|--------|
|                  |  |                    |                | Expense Classification on                  | Worksheet A                     | 7/29/2021 4:1     | 5 pm   |
|                  |  |                    |                | To/From Which the Amount is                |                                 |                   |        |
|                  |  |                    |                |  |                                 |                   |        |
|                  |  |                    |                |  |                                 |                   |        |
|                  |  |                    |                |  |                                 |                   |        |
|                  | October 1997   | D                  |                | 0  |                                 | W                 |        |
|                  | Cost Center Description  | Basi s/Code<br>(2) | Amount         | Cost Center                                | Li ne #                         | Wkst. A-7<br>Ref. |        |
|                  |  | 1. 00              | 2. 00          | 3.00                                       | 4. 00                           | 5. 00             |        |
| 1. 00            | Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)        |                    | 0              | CAP REL COSTS-BLDG & FLXT                  | 1.00                            | 0                 | 1. 00  |
| 1. 02            | Investment income - AKRON  |                    | 0              | AKRON BUILDING                             | 1. 02                           | 0                 | 1. 02  |
| 1. 03            | BUILDING (chapter 2) Investment income - ARGOS                   |                    | 0              | ARGOS BUILDING                             | 1. 03                           | 0                 | 1.03   |
|                  | BUILDING (chapter 2)   |                    |                |  |                                 |                   |        |
| 1. 04            | Investment income - CLAYS BUILDING (chapter 2)                   |                    | 0              | CLAYS BUILDING                             | 1. 04                           | 0                 | 1.04   |
| 2.00             | Investment income - CAP REL                                      |                    | 0              | *** Cost Center Deleted ***                | 2.00                            | 0                 | 2. 00  |
| 3. 00            | COSTS-MVBLE EQUIP (chapter 2)                                    |                    | 0              |  | 0.00                            | 0                 | 3.00   |
|                  | (chapter 2)  |                    | J              |  | 0.00                            | 9                 | 0.00   |
| 4. 00            | Trade, quantity, and time discounts (chapter 8)                  |                    | 0              |  | 0.00                            | 0                 | 4.00   |
| 5.00             | Refunds and rebates of   |                    | 0              |  | 0. 00                           | 0                 | 5.00   |
| 6. 00            | expenses (chapter 8) Rental of provider space by                 |                    | 0              |  | 0.00                            | 0                 | 6. 00  |
| 0.00             | suppliers (chapter 8)  |                    | J              |  | 0.00                            | 0                 | 0.00   |
| 7. 00            | Tel ephone services (pay stations 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                 | 9. 00  |
| 10.00            | Provi der-based physician  | A-8-2              | -7, 210, 502   |  |                                 | 0                 | 10.00  |
| 11. 00           | adjustment<br>Sale of scrap, waste, etc.                         |                    | 0              |  | 0.00                            | 0                 | 11.00  |
| 12.00            | (chapter 23)   | A O 1              | 0              |  |                                 | 0                 | 12.00  |
| 12. 00           | Related organization<br>transactions (chapter 10)                | A-8-1              | U              |  |                                 | Ü                 | 12.00  |
| 13.00            | Laundry and linen service  | D                  | 100 414        | CAFETERIA                                  | 0.00                            | 0                 |        |
| 14. 00<br>15. 00 | Cafeteria-employees and guests<br>Rental of quarters to employee | В                  | -109, 416<br>0 | CAFETERI A                                 | 11. 00<br>0. 00                 | 0                 |        |
| 47.00            | and others   |                    | 0              |  | 0.00                            | 0                 | 1, 00  |
| 16. 00           | Sale of medical and surgical supplies to other than              |                    | O              |  | 0.00                            | 0                 | 16. 00 |
| 47.00            | patients   |                    | 0              |  | 0.00                            | 0                 | 47.00  |
| 17.00            | Sale of drugs to other than patients                             |                    | O              |  | 0.00                            | 0                 | 17. 00 |
| 18. 00           | Sale of medical records and                                      | В                  | -21, 662       | MEDICAL RECORDS & LIBRARY                  | 16. 00                          | 0                 | 18. 00 |
| 19. 00           | abstracts Nursing and allied health                              |                    | 0              |  | 0. 00                           | 0                 | 19.00  |
|                  | education (tuition, fees,  |                    |                |  |                                 |                   |        |
| 20. 00           | books, etc.)<br>Vending machines                                 | В                  | -12            | CAFETERI A                                 | 11. 00                          | 0                 | 20.00  |
| 21. 00           | Income from imposition of  |                    | 0              |  | 0. 00                           | 0                 | 21. 00 |
|                  | interest, finance or penalty charges (chapter 21)                |                    |                |  |                                 |                   |        |
| 22. 00           | Interest expense on Medicare                                     |                    | 0              |  | 0. 00                           | 0                 | 22. 00 |
|                  | overpayments and borrowings to repay Medicare overpayments       |                    |                |  |                                 |                   |        |
| 23. 00           | Adjustment for respiratory                                       | A-8-3              | 0              | RESPI RATORY THERAPY                       | 65. 00                          |                   | 23. 00 |
|                  | therapy costs in excess of limitation (chapter 14)               |                    |                |  |                                 |                   |        |
| 24. 00           | Adjustment for physical  | A-8-3              | 0              | PHYSI CAL THERAPY                          | 66. 00                          |                   | 24. 00 |
|                  | therapy costs in excess of limitation (chapter 14)               |                    |                |  |                                 |                   |        |
| 25. 00           | Utilization review -   |                    | 0              | *** Cost Center Deleted ***                | 114. 00                         |                   | 25. 00 |
|                  | physicians' compensation<br>(chapter 21)                         |                    |                |  |                                 |                   |        |
| 26. 00           | Depreciation - CAP REL   |                    | 0              | CAP REL COSTS-BLDG & FLXT                  | 1.00                            | 0                 | 26. 00 |
| 26. 02           | COSTS-BLDG & FIXT Depreciation - AKRON BUILDING                  |                    | O              | AKRON BUILDING                             | 1. 02                           | 0                 | 26. 02 |
| 26. 03           | Depreciation - ARGOS BUILDING                                    |                    | 0              | ARGOS BUILDING                             | 1. 03                           | 0                 | 26. 03 |
| 26. 04<br>27. 00 | Depreciation - CLAYS BUILDING Depreciation - CAP REL             |                    |                | CLAYS BUILDING *** Cost Center Deleted *** | 1. 04<br>2. 00                  | 0                 |        |
|                  | COSTS-MVBLE EQUIP  |                    |                | 20.000                                     |                                 | 0                 |        |
|                  |  |                    |                |  |                                 |                   |        |

From 01/01/2020 | Date/Time Prepared:

|        |                              |            |  |                             | 12/31/2020  | 7/29/2021 4:1 |        |
|--------|------------------------------|------------|--|-----------------------------|-------------|---------------|--------|
|        |                              |            |  | Expense Classification on   | Worksheet A |               |        |
|        |                              |            |  | To/From Which the Amount is |             |               |        |
|        |                              |            |  |                             | , j         |               |        |
|        |                              |            |  |                             |             |               |        |
|        |                              |            |  |                             |             |               |        |
|        |                              |            |  |                             |             |               |        |
|        |                              |            |  |                             |             |               |        |
|        |                              |            |  |                             |             |               |        |
|        | Cost Center Description      | Basis/Code | Amount   | Cost Center                 | Li ne #     | Wkst. A-7     |        |
|        | 5551 551151 25551 Pt. 511    | (2)        | 711104111  | 0001 0011101                | 20 "        | Ref.          |        |
|        |                              | 1. 00      | 2. 00  | 3.00                        | 4. 00       | 5. 00         |        |
| 28. 00 | Non-physician Anesthetist    |            | 0  | *** Cost Center Deleted *** | 19, 00      |               | 28. 00 |
| 29. 00 | Physicians' assistant        |            | 0  |                             | 0.00        | 0             | 29.00  |
| 30.00  | Adjustment for occupational  | A-8-3      | 0  | OCCUPATI ONAL THERAPY       | 67. 00      | _             | 30.00  |
| 00.00  | therapy costs in excess of   | ,, , ,     | , and the second | 00001711101012 1112101111   | 07.00       |               | 00.00  |
|        | limitation (chapter 14)      |            |  |                             |             |               |        |
| 30. 99 | Hospice (non-distinct) (see  |            | 0  | ADULTS & PEDIATRICS         | 30. 00      |               | 30. 99 |
| 00. 77 | instructions)                |            |  | ABOETS & LESTATION OS       | 00.00       |               | 00. 77 |
| 31.00  | Adjustment for speech        | A-8-3      | 0  | SPEECH PATHOLOGY            | 68. 00      |               | 31.00  |
| 01.00  | pathology costs in excess of | ,, , ,     | , and the second | 0. 2201. 1711102001         | 00.00       |               | 01100  |
|        | limitation (chapter 14)      |            |  |                             |             |               |        |
| 32.00  |                              | В          | -2 415   | CAP REL COSTS-BLDG & FIXT   | 1. 00       | 9             | 32.00  |
| 02.00  | Depreciation and Interest    |            | 2, 110   | ON REE GOOTS BEBS & TTAT    | 1.00        | ,             | 02.00  |
| 33.00  |                              | Α          | -6 995   | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             | 33. 00 |
| 34.00  | PHYSI CI AN RECRUITMENT      | A          |  | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             |        |
| 35. 00 | HAF EXPENSE                  | A          |  | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             |        |
| 36.00  | EDUCATION OTHER REVENUE      | В          |  | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             |        |
| 37. 00 | CHAPLAIN - OTHER REVENUE     | В          |  | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             |        |
| 38.00  | HOME MEAL PROGRAM            | В          |  | DI ETARY                    | 10. 00      | 0             |        |
| 39. 00 | DIETARY SPEC EVENTS          | В          |  | DI ETARY                    | 10. 00      | 0             |        |
| 40.00  | DRUG SALES                   | В          |  | PHARMACY                    | 15. 00      | 0             |        |
| 41. 00 | PT - OTHER REVENUE           | В          |  | PHYSI CAL THERAPY           | 66. 00      | 0             |        |
| 42.00  | OCC THER OTH REV             | В          |  | PHYSI CAL THERAPY           | 66. 00      | 0             |        |
| 43.00  | ATHLETIC TRAINING -OTH REV   | В          |  | PHYSI CAL THERAPY           | 66, 00      | 0             |        |
| 44. 00 | MISC REV -OTH REV            | В          |  | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             |        |
| 45. 00 | STAFF RENTAL AGREEMENTS      | В          |  | RESPI RATORY THERAPY        | 65. 00      | 0             |        |
| 45. 01 | I HA LOBBYI NG               | Ä          |  | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             |        |
| 45. 02 | PART B BILLING OFFSET        | A          |  | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             |        |
| 45. 02 | LTC EXPENSES                 | A          |  | ADMINISTRATIVE & GENERAL    | 5. 00       | 0             |        |
| 50.00  |                              |            | -10, 004, 794  |                             | 3.00        | U             | 50.00  |
| 30.00  | (Transfer to Worksheet A,    |            | -10,004,774  |                             |             |               | 30.00  |
|        | column 6, line 200.)         |            |  |                             |             |               |        |
| (4) 5  | cordinir o, Title 200.)      |            |  |                             |             |               |        |

<sup>(1)</sup> 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.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1313

Peri od: Worksheet A-8-2 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

7/29/2021 4:15 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 3. 00 4.00 5.00 6 00 7 00 53. 00 ANESTHESI OLOGY 1.00 736, 327 736, 327 0 0 1.00 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 200, 824 200, 824 0 0 2.00 0 91. 00 EMERGENCY 671, 284 3.00 2, 372, 350 1, 701, 066 0 3.00 93. OO WOODLAWN MEDICAL 1, 824, 829 0 4.00 1,824,829 0 4.00 PROFESSI ONALS 5.00 93. 01 SHAFER MEDICAL CENTER 2, 747, 456 2, 747, 456 0 5.00 6.00 0.00 0 0 0 6.00 0.00 0 7.00 0 7.00 0 0 0.00 0 8.00 0 0 8.00 9.00 0.00 0 9.00 10.00 0.00 0 10.00 200.00 7.881.786 7, 210, 502 671, 284 0 200.00 Cost Center/Physician Unadjusted RCE 5 Percent of Wkst. A Line # Cost of Provi der Physician Cost I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Conti nui ng Share of col Insurance Limit Educati on 12 2.00 9. 00 14.00 1. 00 8. 00 12.00 13.00 1.00 53. 00 ANESTHESI OLOGY 0 1.00 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 2.00 0 3.00 91. 00 EMERGENCY 0 0 0 3.00 0 4.00 93. 00 WOODLAWN MEDICAL 0 4.00 PROFESSI ONALS 5.00 93.01 SHAFER MEDICAL CENTER 0 5.00 0 6.00 0.00 6.00 0 7.00 0.00 0 0 0 7.00 0 8.00 0.00 0 0 0 8.00 0 9.00 0.00 0 0 9.00 10.00 0.00 0 0 0 10.00 0 200.00 200.00 Cost Center/Physician Provi der Adjusted RCE RCE Wkst. A Line # Adjustment I denti fi er Component Limit Di sal I owance Share of col 14 2.00 17. 00 1. 00 15. 00 16.00 18. 00 1.00 53. 00 ANESTHESI OLOGY 736, 327 1.00 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 200, 824 2.00 0 3.00 91 ON EMERGENCY 0 0 1, 701, 066 3 00 4.00 93. 00 WOODLAWN MEDICAL 0 0 1, 824, 829 4.00 PROFESSI ONALS 93. 01 SHAFER MEDICAL CENTER 5.00 0 2, 747, 456 5.00 6.00 0.00 0 0 6.00 0 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 8.00 0 9.00 0.00 0 9.00 0 10.00 0.00 0 0 C 10.00 200.00 200.00 7, 210, 502

Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

|  |                            |                    | 10                  | 12/31/2020          | 7/29/2021 4:1       |                    |
|--|----------------------------|--------------------|---------------------|---------------------|---------------------|--------------------|
|  |                            |                    | CAPI TAL REL        | ATED COSTS          |                     |                    |
| Cost Conton Decemintion  | Not Evnences               | DIDC 0 FLVT        | AKDON               | ADCOC               | CLAVC               |                    |
| Cost Center Description  | Net Expenses<br>for Cost   | BLDG & FIXT        | AKRON<br>BUI LDI NG | ARGOS<br>BUI LDI NG | CLAYS<br>BUI LDI NG |                    |
|  | Allocation                 |                    | DUI LUI NG          | DUI LUI NG          | DUI LUI NG          |                    |
|  | (from Wkst A               |                    |                     |                     |                     |                    |
|  | col. 7)                    |                    |                     |                     |                     |                    |
|  | 0                          | 1.00               | 1. 02               | 1. 03               | 1. 04               |                    |
| GENERAL SERVICE COST CENTERS   |                            |                    |                     |                     |                     |                    |
| 1.00 O0100 CAP REL COSTS-BLDG & FLXT                                       | 2, 390, 818                | 2, 390, 818        |                     |                     |                     | 1.00               |
| 1. 02   00102   AKRON BUILDING   | 47, 411                    | 0                  | 47, 411             |                     |                     | 1. 02              |
| 1. 03   00103   ARGOS BUILDING   | 109, 342                   | 0                  | 0                   | 109, 342            |                     | 1. 03              |
| 1. 04   00101   CLAYS   BUI LDI NG   | 162, 309                   | 0                  | 0                   | 0                   | 162, 309            | 1. 04              |
| 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT                               | 3, 120, 758                | 0                  | 0                   | 0                   | 0                   | 4.00               |
| 5. 00 00500 ADMINISTRATIVE & GENERAL                                       | 6, 244, 592                | 263, 186           | 5, 418              | 8, 747              | 127                 | 5.00               |
| 7. 00   00700   OPERATION OF PLANT   | 2, 979, 049                | 232, 965           | 3, 251              | 9, 972              | 37, 027             | 7.00               |
| 8. 00   00800   LAUNDRY & LI NEN SERVI CE<br>9. 00   00900   HOUSEKEEPI NG | 147, 698                   | 7, 060             | 0                   | O O                 | 0                   | 8. 00<br>9. 00     |
| 10. 00   01000 DI ETARY  | 576, 332<br>268, 857       | 26, 679<br>47, 970 | 0                   | 0                   | 342<br>0            | 10.00              |
| 11. 00   01100   CAFETERI A  | 324, 161                   | 71, 328            | 0                   | 0                   | 0                   | 11.00              |
| 13. 00 01300 NURSI NG ADMI NI STRATI ON                                    | 660, 489                   | 56, 196            | 0                   | 0                   | 0                   | 13. 00             |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY                                     | 000, 407                   | 0                  | 0                   | 0                   | 0                   | 14. 00             |
| 15. 00 01500 PHARMACY  | 3, 756, 993                | 30, 484            | 0                   | 0                   | 0                   | 15. 00             |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY                                   | 1, 099, 499                | 29, 033            | 0                   | o                   | 33, 783             | 16.00              |
| INPATIENT ROUTINE SERVICE COST CENTERS                                     |                            | ,                  | -                   | - 1                 |                     |                    |
| 30. 00 03000 ADULTS & PEDIATRICS   | 2, 470, 650                | 298, 882           | 0                   | 0                   | 0                   | 30.00              |
| 31.00 03100 INTENSIVE CARE UNIT  | 605, 706                   | 45, 265            | 0                   | 0                   | 0                   | 31.00              |
| 43. 00 04300 NURSERY   | 176, 899                   | 4, 113             | 0                   | 0                   | 0                   | 43.00              |
| ANCILLARY SERVICE COST CENTERS   |                            |                    |                     |                     |                     |                    |
| 50.00 05000 OPERATING ROOM   | 2, 556, 185                | 181, 278           | 0                   | 0                   | 0                   | 50.00              |
| 51. 00   05100   RECOVERY ROOM   | 559, 654                   | 108, 587           | 0                   | 0                   | 0                   | 51.00              |
| 52. 00   05200   DELI VERY ROOM & LABOR ROOM                               | 411, 881                   | 52, 325            | 0                   | 0                   | 0                   | 52.00              |
| 53. 00 05300 ANESTHESI OLOGY   | 55, 704                    | 3, 013             | 0                   | 0                   | 0                   | 53.00              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C<br>60. 00   06000   LABORATORY    | 2, 473, 419                | 264, 703           | 0                   | O O                 | 0                   | 54. 00<br>60. 00   |
| 65. 00   06500   RESPI RATORY   THERAPY                                    | 2, 834, 842<br>1, 151, 719 | 57, 691<br>91, 475 | 0                   | 0                   | 0                   | 65.00              |
| 66. 00   06600 PHYSI CAL THERAPY   | 832, 464                   | 65, 895            | 0                   | 0                   | 0                   | 66.00              |
| 67. 00 06700 OCCUPATI ONAL THERAPY   | 279, 728                   | 03, 073            | 0                   | 0                   | 0                   | 67. 00             |
| 68. 00 06800 SPEECH PATHOLOGY  | 128, 001                   | Ö                  | 0                   | o                   | 0                   | 68. 00             |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                            | 0                          | o                  | 0                   | o                   | 0                   | 71. 00             |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS                                 | 1, 054, 584                | O                  | 0                   | 0                   | 0                   | 72.00              |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                                      | 0                          | o                  | 0                   | 0                   | 0                   | 73. 00             |
| OUTPATIENT SERVICE COST CENTERS  |                            |                    |                     |                     |                     |                    |
| 88.00 08800 SHAFER MEDICAL CENTER  | 696, 912                   | 0                  | 0                   | 0                   | 32, 702             | 88. 00             |
| 88. 01 08801 WOODLAWN MEDICAL PROFESSIONALS                                | 2, 421, 153                | 119, 606           | 0                   | 0                   | 0                   | 88. 01             |
| 88. 02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA                          | 1, 802, 218                | 0                  | 0                   | 0                   | 0                   | 88. 02             |
| 88. 03   08803   FULTON COUNTY MEDICAL CENTER - 100 E                      | 297, 313                   | 0                  | 0                   | 0                   | 0                   | 88. 03             |
| 88. 04   08804   AKRON MEDICAL CLINIC                                      | 554, 718                   | 0                  | 27, 445             | (4.101              | 0                   | 88. 04             |
| 88. 05   08805   ARGOS   MEDI CAL   CLI NI C<br>91. 00   09100   EMERGENCY | 1, 598, 386<br>2, 155, 550 | 127 441            | 0                   | 64, 191             | 0                   | 88. 05<br>91. 00   |
| 92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART                        | 2, 155, 550                | 137, 641           | U                   | ٩                   | Ü                   | 91.00              |
| 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS                                | 749, 429                   | 175, 120           | 0                   | 0                   | 0                   | 93.00              |
| 93. 01 04951 SHAFER MEDICAL CENTER   | 788, 641                   | 173, 120           | 0                   | 0                   | 58, 328             | 93. 01             |
| SPECIAL PURPOSE COST CENTERS   | 700,041                    | <u> </u>           | O I                 | <u> </u>            | 30, 320             | 73.01              |
| 113. 00 11300 I NTEREST EXPENSE  |                            |                    |                     |                     |                     | 113.00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                              | 48, 544, 064               | 2, 370, 495        | 36, 114             | 82, 910             | 162, 309            |                    |
| NONREI MBURSABLE COST CENTERS  |                            |                    |                     |                     |                     |                    |
| 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN                             | 0                          | 0                  | 0                   | 0                   | 0                   | 190. 00            |
| 192.00 19200 PHYSICIANS PRIVATE OFFICES                                    | 0                          | 12, 867            | 0                   | 0                   |                     | 192. 00            |
| 192. 01 19201 FCMC   | 694, 205                   | 0                  | 0                   | 0                   |                     | 192. 01            |
| 192. 02 19202 ARGOS MEDICAL CENTER   | 590, 996                   | 0                  | 0                   | 26, 432             |                     | 192. 02            |
| 192. 03 19203 AKRON MEDICAL CENTER   | 210, 888                   | 0                  | 11, 297             | 0                   |                     | 192. 03            |
| 193. 00 19300 NONPALD WORKERS  | 0                          | 0                  | 0                   | 0                   |                     | 193.00             |
| 194. 00 07950 ADVERTISING  | 432, 038                   | 7, 456             | U                   | O                   | 0                   | 194.00             |
| 200.00 Cross Foot Adjustments<br>201.00 Negative Cost Centers              |                            |                    | 0                   |                     | 0                   | 200. 00<br>201. 00 |
| 202.00 TOTAL (sum lines 118 through 201)                                   | 50, 472, 191               | 2, 390, 818        | 47, 411             | 109, 342            | 162, 309            |                    |
|  | 33, 1,2, 1,1               | 2, 3, 3, 3, 3, 5   | 17, 111             | .0,,042             | 102, 007            | 00                 |

|   |                                    |                      | 11                           | 0 12/31/2020          | 7/29/2021 4:1              |                  |
|---|------------------------------------|----------------------|------------------------------|-----------------------|----------------------------|------------------|
| Cost Center Description   | EMPLOYEE<br>BENEFITS<br>DEPARTMENT | Subtotal             | ADMINISTRATIV<br>E & GENERAL | OPERATION OF<br>PLANT | LAUNDRY &<br>LINEN SERVICE |                  |
|   | 4. 00                              | 4A                   | 5. 00                        | 7. 00                 | 8. 00                      |                  |
| GENERAL SERVICE COST CENTERS  | <u> </u>                           |                      |                              |                       |                            |                  |
| 1.00 O0100 CAP REL COSTS-BLDG & FLXT  |                                    |                      |                              |                       |                            | 1.00             |
| 1. 02   00102   AKRON BUILDING  |                                    |                      |                              |                       |                            | 1.02             |
| 1. 03  00103  ARGOS BUILDING  |                                    |                      |                              |                       |                            | 1.03             |
| 1. 04   00101   CLAYS BUILDING  |                                    |                      |                              |                       |                            | 1. 04            |
| 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT  | 3, 120, 758                        |                      |                              |                       |                            | 4.00             |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL   | 455, 007                           | 6, 977, 077          |                              | 0.040.000             |                            | 5.00             |
| 7. 00 00700 OPERATION OF PLANT  | 53, 810                            | 3, 316, 074          | 531, 935                     | 3, 848, 009           | 1                          | 7.00             |
| 8. 00   00800   LAUNDRY & LINEN SERVICE   | 2, 574                             | 157, 332             |                              | 11, 502               |                            | 8.00             |
| 9. 00   00900 HOUSEKEEPI NG<br>10. 00   01000 DI ETARY                                    | 54, 166                            | 657, 519<br>339, 974 |                              |                       |                            | 9. 00<br>10. 00  |
| 11. 00   01100   CAFETERI A   | 23, 147<br>34, 429                 | 429, 918             | · ·                          | 78, 151<br>116, 205   | 3, 426<br>0                | 11.00            |
| 13. 00 01300 NURSING ADMINISTRATION   | 78, 305                            | 794, 990             |                              | 91, 552               |                            | 13.00            |
| 14. 00 01400 CENTRAL SERVI CES & SUPPLY   | 70, 303                            | 7 74, 770            | 127, 323                     | 71, 332<br>0          | 0                          | 14. 00           |
| 15. 00 01500 PHARMACY   | 55, 812                            | 3, 843, 289          | _                            | 49, 664               |                            | 15. 00           |
| 16. 00 01600 MEDICAL RECORDS & LIBRARY  | 63, 422                            | 1, 225, 737          |                              | 199, 551              | l ől                       | 16. 00           |
| INPATIENT ROUTINE SERVICE COST CENTERS  | 00, 122                            | 1,220,707            | 170,022                      | 177,001               |                            | 10.00            |
| 30. 00 03000 ADULTS & PEDIATRICS  | 245, 143                           | 3, 014, 675          | 483, 587                     | 486, 925              | 36, 232                    | 30.00            |
| 31. 00 03100 I NTENSI VE CARE UNI T   | 58, 601                            | 709, 572             | · ·                          | ·                     |                            | 31.00            |
| 43. 00   04300   NURSERY  | 19, 164                            | 200, 176             |                              | 6, 701                | 0                          | 43.00            |
| ANCILLARY SERVICE COST CENTERS  |                                    |                      |                              |                       |                            |                  |
| 50.00   05000   OPERATING ROOM  | 117, 630                           | 2, 855, 093          | 457, 988                     | 295, 331              | 21, 739                    | 50.00            |
| 51.00   05100   RECOVERY ROOM   | 54, 576                            | 722, 817             | 115, 948                     |                       |                            | 51.00            |
| 52.00   05200   DELI VERY ROOM & LABOR ROOM   | 44, 620                            | 508, 826             |                              | 85, 245               |                            | 52.00            |
| 53. 00   05300   ANESTHESI OLOGY  | 0                                  | 58, 717              | · ·                          |                       | 1                          | 53.00            |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C  | 219, 463                           | 2, 957, 585          | · ·                          | 431, 243              |                            | 54.00            |
| 60. 00 06000 LABORATORY   | 124, 041                           | 3, 016, 574          |                              | 93, 988               |                            | 60.00            |
| 65. 00   06500   RESPI RATORY THERAPY<br>66. 00   06600   PHYSI CAL THERAPY               | 129, 671                           | 1, 372, 865          |                              | 149, 027              | 6, 719                     | 65.00            |
| 66. 00   06600   PHYSI CAL THERAPY<br>67. 00   06700   OCCUPATI ONAL THERAPY              | 98, 716<br>32, 987                 | 997, 075<br>312, 715 |                              | 107, 354              | 3, 426<br>0                | 66. 00<br>67. 00 |
| 68.00   06800   SPEECH PATHOLOGY  | 15, 196                            | 143, 197             | 22, 970                      | 0                     |                            | 68.00            |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 15, 170                            | 143, 177             | 22, 970                      | 0                     |                            | 71.00            |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS   |                                    | 1, 054, 584          | 169, 167                     | 0                     | l ől                       | 72.00            |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS  |                                    | 0,001,001            | 0                            | 0                     |                            | 73.00            |
| OUTPATIENT SERVICE COST CENTERS   | -1                                 | -                    |                              | -                     |                            |                  |
| 88. 00 08800 SHAFER MEDICAL CENTER  | 33, 227                            | 762, 841             | 122, 368                     | 147, 379              | 0                          | 88.00            |
| 88.01 08801 WOODLAWN MEDICAL PROFESSIONALS  | 259, 557                           | 2, 800, 316          | 449, 201                     | 194, 857              | 0                          | 88.01            |
| 88.02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA  | 151, 823                           | 1, 954, 041          | 313, 450                     | 0                     | 4, 084                     | 88. 02           |
| 88.03 08803 FULTON COUNTY MEDICAL CENTER - 100 E  | 26, 097                            | 323, 410             |                              | 0                     | 1, 186                     | 88.03            |
| 88.04 08804 AKRON MEDICAL CLINIC  | 56, 655                            | 638, 818             |                              | 72, 597               | 1, 186                     | 88. 04           |
| 88. 05 08805 ARGOS MEDICAL CLINIC   | 165, 319                           | 1, 827, 896          |                              |                       |                            | 88. 05           |
| 91. 00   09100   EMERGENCY  | 172, 483                           | 2, 465, 674          | 395, 521                     | 224, 239              | 19, 499                    | 91.00            |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 40.007                             | 070.004              | 457 440                      | 005 000               |                            | 92.00            |
| 93. 00   04950   WOODLAWN MEDICAL PROFESSIONALS<br>93. 01   04951   SHAFER MEDICAL CENTER | 48, 837                            | 973, 386             |                              | 285, 298              | 0                          | 93.00            |
| 93. 01 04951 SHAFER MEDICAL CENTER SPECIAL PURPOSE COST CENTERS                           | 68, 437                            | 915, 406             | 146, 841                     | 262, 867              | U                          | 93. 01           |
| 113. 00 11300   NTEREST EXPENSE   |                                    |                      |                              |                       |                            | 113. 00          |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 2, 962, 915                        | 48, 328, 169         | 6, 633, 153                  | 3, 848, 009           |                            |                  |
| NONREI MBURSABLE COST CENTERS   | 2/ /02/ / / 0                      | 10,020,107           | 0,000,100                    | 0,010,007             | 1717072                    |                  |
| 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN   | 0                                  | 0                    | 0                            | 0                     | 0                          | 190.00           |
| 192.00 19200 PHYSICIANS PRIVATE OFFICES   | 0                                  | 12, 867              | 2, 064                       | 0                     | 0                          | 192.00           |
| 192. 01 19201 FCMC  | 60, 048                            | 754, 253             | 120, 990                     |                       |                            | 192. 01          |
| 192.02 19202 ARGOS MEDICAL CENTER   | 65, 246                            | 682, 674             |                              |                       |                            | 192. 02          |
| 192. 03 19203 AKRON MEDICAL CENTER  | 22, 591                            | 244, 776             | 39, 265                      | 0                     |                            | 192. 03          |
| 193. 00 19300 NONPAI D WORKERS  | 0                                  | 0                    | 0                            | 0                     |                            | 193.00           |
| 194. 00 07950 ADVERTI SI NG   | 9, 958                             | 449, 452             | 72, 097                      | 0                     |                            | 194.00           |
| 200.00 Cross Foot Adjustments   |                                    | 0                    | _                            | _                     |                            | 200.00           |
| 201.00 Negative Cost Centers  | 2 120 750                          | ()<br>EO 472 101     | 0 4 077 077                  | 2 040 000             |                            | 201.00           |
| 202.00   TOTAL (sum lines 118 through 201)  | 3, 120, 758                        | 50, 472, 191         | 6, 977, 077                  | 3, 848, 009           | 194, 072                   | ∠U∠. UU          |

|  |               |          |            | 0 12/31/2020     | Date/Time Pre<br>7/29/2021 4:1 |                |
|--|---------------|----------|------------|------------------|--------------------------------|----------------|
| Cost Center Description  | HOUSEKEEPI NG | DI ETARY | CAFETERI A | NURSI NG         | CENTRAL                        | J DIII         |
|  |               |          |            | ADMI NI STRATI O | SERVICES &                     |                |
|  |               |          |            | N                | SUPPLY                         |                |
|  | 9. 00         | 10. 00   | 11. 00     | 13. 00           | 14. 00                         |                |
| GENERAL SERVICE COST CENTERS   |               |          |            |                  |                                |                |
| 1. 00   00100 CAP REL COSTS-BLDG & FLXT                                      |               |          |            |                  |                                | 1.00           |
| 1. 02   00102   AKRON BUILDING   |               |          |            |                  |                                | 1.02           |
| 1. 03   00103   ARGOS BUILDING   |               |          |            |                  |                                | 1.03           |
| 1.04   00101   CLAYS BUILDING<br>4.00   00400   EMPLOYEE BENEFITS DEPARTMENT |               |          |            |                  |                                | 1. 04<br>4. 00 |
| 5. 00 00500 ADMINISTRATIVE & GENERAL   |               |          |            |                  |                                | 5.00           |
| 7. 00   00700   OPERATION OF PLANT   |               |          |            |                  |                                | 7.00           |
| 8. 00 00800 LAUNDRY & LINEN SERVICE  |               |          |            |                  |                                | 8.00           |
| 9. 00   00900   HOUSEKEEPI NG  | 833, 822      |          |            |                  |                                | 9. 00          |
| 10. 00   01000   DI ETARY  | 1, 189        | 477, 276 |            |                  |                                | 10.00          |
| 11. 00 01100 CAFETERI A  | 13, 793       | 0        | 628, 880   |                  |                                | 11.00          |
| 13. 00 01300 NURSING ADMINISTRATION  | 951           | 0        | 20, 689    | l .              |                                | 13.00          |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY                                       | 0             | o        | 0          | 0                | 0                              | 14.00          |
| 15. 00 01500 PHARMACY  | 9, 608        | 0        | 19, 776    | o                | 0                              | 15. 00         |
| 16.00 01600 MEDICAL RECORDS & LIBRARY  | 5, 137        | 0        | 36, 155    | 21, 577          | 0                              | 16.00          |
| INPATIENT ROUTINE SERVICE COST CENTERS                                       |               |          |            |                  |                                |                |
| 30. 00 03000 ADULTS & PEDIATRICS   | 193, 580      | 408, 567 | 80, 844    | 760, 607         | 0                              | 30.00          |
| 31.00 03100 INTENSIVE CARE UNIT  | 39, 715       | 68, 709  | 30, 733    | 135, 688         | 0                              | 31.00          |
| 43. 00   04300   NURSERY   | 0             | 0        | 4, 908     | 0                | 0                              | 43.00          |
| ANCILLARY SERVICE COST CENTERS   |               |          |            |                  |                                |                |
| 50.00   05000   OPERATING ROOM   | 105, 732      | 0        | 64, 920    | 0                | 0                              | 50.00          |
| 51.00   05100   RECOVERY ROOM  | 77, 147       | 0        | 22, 401    | 0                | 0                              | 51.00          |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM                                   | 0             | 0        | 11, 386    | 0                | 0                              | 52.00          |
| 53. 00   05300   ANESTHESI OLOGY   | 0             | 0        | 0          | 0                | 0                              | 53.00          |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                                     | 79, 810       | 0        | 79, 644    | 0                | 0                              | 54.00          |
| 60. 00   06000   LABORATORY  | 26, 825       | 0        | 50, 909    | 0                | 0                              | 60.00          |
| 65. 00 06500 RESPI RATORY THERAPY  | 27, 777       | 0        | 34, 557    | 0                | 0                              | 65.00          |
| 66. 00   06600   PHYSI CAL THERAPY   | 17, 741       | 0        | 28, 622    | 0                | 0                              | 66. 00         |
| 67. 00   06700   0CCUPATI ONAL THERAPY                                       | 0             | 0        | 8, 104     | 0                | 0                              | 67.00          |
| 68. 00   06800   SPEECH PATHOLOGY  | 0             | 0        | 3, 681     | 0                | 0                              | 68.00          |
| 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT                          | 0             | 0        | 0          | 0                | 0                              | 71.00          |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS                                  | 0             | 0        | 0          | 0                | 0                              | 72.00          |
| 73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS       | 0             | 0        | 0          | l U              | 0                              | 73. 00         |
| 88. 00   08800   SHAFER   MEDICAL CENTER                                     | 20, 214       | 0        | 0          | ol               | 0                              | 88. 00         |
| 88. 01   08801   WOODLAWN   MEDICAL   PROFESSIONALS                          | 36, 014       | o        | 47, 427    | 0                | 0                              | 88. 01         |
| 88. 02   08802   FULTON COUNTY MEDICAL CENTER- 700 MA                        | 36,014        | 0        | 47,427     | 0                | 0                              | 88. 02         |
| 88. 03   08803   FULTON COUNTY   MEDICAL CENTER - 100   E                    |               | 0        | 0          | 0                | 0                              | 88. 03         |
| 88. 04   08804   AKRON MEDICAL CLINIC  | 0             | 0        | 0          | 0                | 0                              | 88. 04         |
| 88. 05   08805   ARGOS   MEDICAL CLINIC                                      |               | 0        | 0          |                  | 0                              | 88. 05         |
| 91. 00   09100   EMERGENCY   | 108, 253      | 0        | 45, 772    | 117, 835         | 0                              | 91.00          |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                              | 100, 233      |          | 45, 772    | 117,033          | O                              | 92.00          |
| 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS                                  | 31, 382       | 0        | 35, 670    | 0                | 0                              | 93.00          |
| 93. 01 04951 SHAFER MEDICAL CENTER   | 38, 098       | 0        | 00,070     | 0                | 0                              | 93. 01         |
| SPECIAL PURPOSE COST CENTERS   | 337373        | <u> </u> |            | ٩١               |                                | 70.0.          |
| 113. 00 11300 I NTEREST EXPENSE  |               |          |            |                  |                                | 113. 00        |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                                | 832, 966      | 477, 276 | 626, 198   | 1, 035, 707      | 0                              | 118.00         |
| NONREI MBURSABLE COST CENTERS  | ,             | , ,      |            | , ,              |                                |                |
| 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN                               | 856           | 0        | 0          | 0                | 0                              | 190. 00        |
| 192.00 19200 PHYSICIANS PRIVATE OFFICES                                      | o             | O        | 0          | 0                | 0                              | 192.00         |
| 192. 01 19201 FCMC   | o             | O        | 0          | O                | 0                              | 192. 01        |
| 192. 02 19202 ARGOS MEDICAL CENTER   | 0             | 0        | 0          | 0                |                                | 192. 02        |
| 192.03 19203 AKRON MEDICAL CENTER  | o             | o        | 0          | 0                |                                | 192. 03        |
| 193. 00 19300 NONPAI D WORKERS   | 0             | 0        | 0          | 0                |                                | 193. 00        |
| 194. 00 07950 ADVERTI SI NG  | 0             | 0        | 2, 682     | 0                | 0                              | 194. 00        |
| 200.00 Cross Foot Adjustments  |               |          |            |                  |                                | 200. 00        |
| 201.00 Negative Cost Centers   | 0             | 0        | 0          | 0                |                                | 201.00         |
| 202.00   TOTAL (sum lines 118 through 201)                                   | 833, 822      | 477, 276 | 628, 880   | 1, 035, 707      | 0                              | 202. 00        |
|  |               |          |            |                  |                                |                |

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1313 Peri od: Worksheet B From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/29/2021 4:15 pm Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Total RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00102 AKRON BULLDING 1.02 1 02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 4, 538, 825 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1,684,779 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 62, 695 5, 527, 712 5, 527, 712 30.00 03100 INTENSIVE CARE UNIT 0 1, 187, 403 1, 187, 403 31.00 13, 707 0 31.00 246, 941 04300 NURSERY 0 3,046 246, 941 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 206, 841 4,007,644 0 4,007,644 50.00 05100 RECOVERY ROOM 0 51.00 22, 739 1, 160, 091 0 1, 160, 091 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 4 860 691, 938 0 691, 938 52 00 05300 ANESTHESI OLOGY 0 53.00 25, 775 98, 820 98, 820 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 375, 495 4, 442, 343 0 4, 442, 343 54.00 0 60.00 06000 LABORATORY 0 0 325, 086 3, 997, 274 3, 997, 274 60.00 0 06500 RESPIRATORY THERAPY 1, 919, 349 65 00 108, 181 1, 919, 349 65 00 66.00 06600 PHYSI CAL THERAPY 30, 268 1, 344, 428 1, 344, 428 66.00 0 11, 540 06700 OCCUPATI ONAL THERAPY 382, 522 0 382, 522 67.00 67.00 0 6, 033 0 68.00 06800 SPEECH PATHOLOGY 175, 881 175, 881 68.00 o 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 29,842 1, 253, 593 0 1, 253, 593 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 538, 825 73.00 254, 519 4, 793, 344 4, 793, 344 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 SHAFER MEDICAL CENTER 8.402 1,061,204 0 1, 061, 204 88 00 0 08801 WOODLAWN MEDICAL PROFESSIONALS 0 38, 710 3, 566, 525 0 3, 566, 525 88.01 88.01 88 02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA 0 20, 932 2, 292, 507 0 2, 292, 507 88 02 0 0 08803 FULTON COUNTY MEDICAL CENTER - 100 E 4.413 380, 888 380, 888 88.03 88.03 08804 AKRON MEDICAL CLINIC 88 04 6, 597 821, 671 821, 671 88 04 88.05 08805 ARGOS MEDICAL CLINIC 0 24, 681 2, 306, 329 0 2, 306, 329 88.05 0 09100 EMERGENCY 0 91.00 73, 459 3, 450, 252 3, 450, 252 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 9, 497 1, 491, 375 0 1, 491, 375 93.00 93. 01 04951 SHAFER MEDICAL CENTER 0 17, 461 1, 380, 673 1, 380, 673 93.01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 538, 825 1,684,779 47, 980, 707 47, 980, 707 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 856 190.00 0 856 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 Ω 14, 931 0 14, 931 192. 00 0 192. 01 19201 FCMC 0 875, 243 0 875, 243 192. 01 0 192. 02 19202 ARGOS MEDICAL CENTER 792, 182 792, 182 192. 02 0 0 0 192. 03 19203 AKRON MEDICAL CENTER 284, 041 192. 03 0 284, 041 0 193. 00 19300 NONPALD WORKERS 0 C 0 193.00 0 0 524, 231 194. 00 194. 00 07950 ADVERTI SI NG 524, 231 0 0 200.00 0 200.00 Cross Foot Adjustments

 $\cap$ 

1, 684, 779

4, 538, 825

 $\cap$ 

50, 472, 191

0 201, 00

50, 472, 191 202. 00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS | Peri od: | Worksheet B | From 01/01/2020 | Part I I | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-1313

|  |  |  |  | To  | 12/31/2020                                 | Date/Time Pre<br>7/29/2021 4:1                  |  |
|--|--|--|--|---|--|---|--|
|  |  |  |  | CAPITAL REL                               | ATED COSTS                                 | 7, 27, 202                                      | <u> </u>   |
| Cost Center  | Description  | Directly<br>Assigned New<br>Capital<br>Related Costs | BLDG & FIXT  | AKRON<br>BUI LDI NG                       | ARGOS<br>BUI LDI NG                        | CLAYS<br>BUI LDI NG                             |  |
| OFNEDAL CEDITION   | OCT OFNITFIC   | 0  | 1. 00  | 1. 02                                     | 1. 03                                      | 1. 04   |  |
| GENERAL SERVI CE C 1. 00 00100 CAP REL COS 1. 02 00102 AKRON BUI LDI 1. 03 00103 ARGOS BUI LDI 1. 04 00101 CLAYS BUI LDI 4. 00 00400 EMPLOYEE BEI 5. 00 00500 ADMI NI STRATI 7. 00 00700 OPERATI ON OI 8. 00 00800 LAUNDRY & LI 9. 00 00900 HOUSEKEEPI NO 10. 00 01100 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01400 CENTRAL SERVI | FS-BLDG & FIXT NG NG NG NG NG WEFITS DEPARTMENT VE & GENERAL F PLANT NEN SERVICE O   | 0<br>0<br>0<br>0<br>0<br>0                           | 0<br>263, 186<br>232, 965<br>7, 060<br>26, 679<br>47, 970<br>71, 328<br>56, 196                  | 3, 251<br>0<br>0<br>0                     | 0<br>8, 747<br>9, 972<br>0<br>0<br>0<br>0  | 0<br>127<br>37, 027<br>0<br>342<br>0<br>0       | 1. 00<br>1. 02<br>1. 03<br>1. 04<br>4. 00<br>5. 00<br>7. 00<br>8. 00<br>9. 00<br>10. 00<br>11. 00<br>13. 00<br>14. 00          |
| 15.00 01500 PHARMACY   |  | 0  | 30, 484  | 0   | o  | 0   | 15.00  |
| 16. 00 01600 MEDI CAL RECO   |  | 0  | 29, 033  | 0   | 0  | 33, 783   | 16. 00   |
| 30. 00 03000 ADULTS & PEI<br>31. 00 03100 I NTENSI VE CA<br>43. 00 04300 NURSERY   | ARE UNIT   | 0<br>0<br>0  | 298, 882<br>45, 265<br>4, 113  | 0<br>0<br>0                               | 0<br>0<br>0                                | 0<br>0<br>0                                     | 30.00<br>31.00<br>43.00  |
| ANCILLARY SERVICE  |  | I 0  | 101 270  |   | O.   | 0   | 50 00  |
|  | OM OM & LABOR ROOM OGY AGNOSTIC  THERAPY ERAPY - THERAPY OLOGY PLIES CHARGED TO PATIENT CHARGED TO PATIENTS ED TO PATIENTS                                     | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0            | 181, 278<br>108, 587<br>52, 325<br>3, 013<br>264, 703<br>57, 691<br>91, 475<br>65, 895<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0  | 0<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0       | 50. 00<br>51. 00<br>52. 00<br>53. 00<br>54. 00<br>60. 00<br>65. 00<br>66. 00<br>67. 00<br>68. 00<br>71. 00<br>72. 00<br>73. 00 |
| 88. 01   08800   SHAFER MEDI (<br>88. 01   08801   WOODLAWN MEI<br>88. 02   08802   FULTON COUN  | CAL CENTER DICAL PROFESSIONALS TY MEDICAL CENTER - 700 MA TY MEDICAL CENTER - 100 E AL CLINIC AL CLINIC BEDS (NON-DISTINCT PART DICAL PROFESSIONALS CAL CENTER | 0<br>0<br>0<br>0<br>0<br>0<br>0                      | 0<br>119, 606<br>0<br>0<br>0<br>0<br>137, 641<br>175, 120  | 0<br>0<br>0<br>0<br>27, 445<br>0<br>0     | 0<br>0<br>0<br>0<br>0<br>0<br>64, 191<br>0 | 32, 702<br>0<br>0<br>0<br>0<br>0<br>0<br>0<br>0 | 88. 01<br>88. 02<br>88. 03<br>88. 04<br>88. 05<br>91. 00<br>92. 00<br>93. 00   |
| 113. 00 11300   INTEREST EXI<br>118. 00   SUBTOTALS (\$  | PENSE<br>SUM OF LINES 1 through 117)   | 0  | 2, 370, 495  | 36, 114                                   | 82, 910                                    | 162, 309  | 113. 00<br>118. 00   |
| 192. 00 19200 PHYSI CLANS I 192. 01 19201 FCMC 192. 02 19202 ARGOS MEDI C/ 192. 03 19203 AKRON MEDI C/ 193. 00 19300 NONPAL D WORI 194. 00 07950 ADVERTI SLNG 200. 00 Cross Foot / 201. 00 Negati ve Cos   | R COFFEE SHOP & CANTEEN PRIVATE OFFICES AL CENTER AL CENTER KERS Adjustments   | 0<br>0<br>0<br>0<br>0<br>0<br>0                      | 0<br>12, 867<br>0<br>0<br>0<br>0<br>7, 456   | 0   | 0<br>0<br>0<br>26, 432<br>0<br>0<br>0<br>0 | 0<br>0<br>0<br>0<br>0                           | 190. 00<br>192. 00<br>192. 01<br>192. 02<br>192. 03<br>193. 00<br>194. 00<br>200. 00<br>201. 00<br>202. 00                     |

| Peri od: | Worksheet B | From 01/01/2020 | Part I I | To 12/31/2020 | Date/Time Prepared:

|   |                   |                                    | 1                            | 0 12/31/2020          | 7/29/2021 4:1              |                     |
|---|-------------------|------------------------------------|------------------------------|-----------------------|----------------------------|---------------------|
| Cost Center Description   | Subtotal          | EMPLOYEE<br>BENEFITS<br>DEPARTMENT | ADMINISTRATIV<br>E & GENERAL | OPERATION OF<br>PLANT | LAUNDRY &<br>LINEN SERVICE |                     |
|   | 2A                | 4.00                               | 5.00                         | 7. 00                 | 8. 00                      |                     |
| GENERAL SERVICE COST CENTERS  |                   |                                    |                              |                       |                            |                     |
| 1. 00   00100   CAP REL COSTS-BLDG & FIXT   |                   |                                    |                              |                       |                            | 1.00                |
| 1. 02 00102 AKRON BUILDING  |                   |                                    |                              |                       |                            | 1.02                |
| 1. 03   00103   ARGOS BUI LDI NG  |                   |                                    |                              |                       |                            | 1.03                |
| 1.04   00101 CLAYS BUILDING<br>4.00   00400 EMPLOYEE BENEFITS DEPARTMENT                            | 0                 | 0                                  |                              |                       |                            | 1. 04<br>4. 00      |
| 5. 00   00500 ADMINISTRATIVE & GENERAL  | 277, 478          | 0                                  | 277, 478                     |                       |                            | 5.00                |
| 7. 00   00700   OPERATION OF PLANT  | 283, 215          | 0                                  | 21, 157                      | 304, 372              |                            | 7. 00               |
| 8. 00   00800 LAUNDRY & LINEN SERVICE   | 7, 060            | 0                                  | 1, 004                       |                       |                            | 8. 00               |
| 9. 00   00900   HOUSEKEEPI NG   | 27, 021           | 0                                  | 1                            |                       |                            | 9. 00               |
| 10. 00 01000 DI ETARY   | 47, 970           | 0                                  | 1                            |                       |                            | 10.00               |
| 11. 00   01100   CAFETERI A   | 71, 328           | 0                                  | 2, 743                       | 9, 192                | 0                          | 11.00               |
| 13.00 01300 NURSING ADMINISTRATION  | 56, 196           | 0                                  | 5, 072                       | 7, 242                | 0                          | 13.00               |
| 14.00 01400 CENTRAL SERVICES & SUPPLY   | 0                 | 0                                  | 0                            | 0                     | 0                          | 14.00               |
| 15. 00   01500   PHARMACY   | 30, 484           | 0                                  |                              |                       |                            | 15. 00              |
| 16. 00 01600 MEDI CAL RECORDS & LI BRARY  | 62, 816           | 0                                  | 7, 820                       | 15, 784               | 0                          | 16. 00              |
| INPATIENT ROUTINE SERVICE COST CENTERS  | 200 000           |                                    | 10.004                       | 00 545                | 4 (75                      | 00.00               |
| 30. 00   03000   ADULTS & PEDI ATRI CS  | 298, 882          | 0                                  |                              | 38, 515               |                            | 30.00               |
| 31. 00   03100   I NTENSI VE CARE UNI T<br>43. 00   04300   NURSERY                                 | 45, 265<br>4, 113 | 0                                  |                              | 5, 833<br>530         |                            | 31. 00<br>43. 00    |
| ANCI LLARY SERVI CE COST CENTERS  | 4, 113            | 0                                  | 1,211                        | 530                   | 0                          | 43.00               |
| 50. 00 05000 OPERATING ROOM   | 181, 278          | 0                                  | 18, 215                      | 23, 360               | 1, 005                     | 50.00               |
| 51. 00   05100   RECOVERY ROOM  | 108, 587          | 0                                  |                              |                       |                            | 51.00               |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM  | 52, 325           | 0                                  | 1                            |                       |                            | 52.00               |
| 53. 00   05300   ANESTHESI OLOGY  | 3, 013            | 0                                  |                              |                       |                            | 53.00               |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C  | 264, 703          | 0                                  | 18, 869                      | 34, 111               | 2, 041                     | 54.00               |
| 60. 00   06000   LABORATORY   | 57, 691           | 0                                  | 19, 246                      | 7, 434                | 0                          | 60.00               |
| 65. 00 06500 RESPI RATORY THERAPY   | 91, 475           | 0                                  | -,                           |                       |                            | 65.00               |
| 66. 00   06600   PHYSI CAL THERAPY  | 65, 895           | 0                                  | 6, 361                       | 8, 492                |                            | 66. 00              |
| 67. 00 06700 OCCUPATI ONAL THERAPY  | 0                 | 0                                  | 1, 995                       | 0                     | 0                          | 67.00               |
| 68. 00 06800 SPEECH PATHOLOGY   | 0                 | 0                                  | 914                          | 0                     | 0                          | 68.00               |
| 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72. 00   07200   MPL. DEV. CHARGED TO PATIENTS | 0                 | 0                                  | 0                            | 0                     | 0                          | 71. 00<br>72. 00    |
| 73. 00 07300 DRUGS CHARGED TO PATTENTS  | 0                 | 0                                  |                              | 0                     |                            | 73.00               |
| OUTPATIENT SERVICE COST CENTERS   | <u> </u>          |                                    | 0                            | 0                     |                            | 73.00               |
| 88. 00 08800 SHAFER MEDICAL CENTER  | 32, 702           | 0                                  | 4, 867                       | 11, 657               | 0                          | 88. 00              |
| 88. 01   08801   WOODLAWN MEDICAL PROFESSIONALS   | 119, 606          | 0                                  | .,                           |                       |                            | 88. 01              |
| 88.02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA  | 0                 | 0                                  |                              | 0                     | 189                        | 88. 02              |
| 88.03 08803 FULTON COUNTY MEDICAL CENTER - 100 E  | 0                 | 0                                  | 2, 063                       | 0                     | 55                         | 88. 03              |
| 88.04 08804 AKRON MEDICAL CLINIC  | 27, 445           | 0                                  | 4, 076                       | 5, 742                | 55                         | 88. 04              |
| 88. 05 08805 ARGOS MEDICAL CLINIC   | 64, 191           | 0                                  | 11, 662                      |                       |                            | 88. 05              |
| 91. 00   09100   EMERGENCY  | 137, 641          | 0                                  | 15, 731                      | 17, 737               | 902                        | 91.00               |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART  | 0                 |                                    | ,                            | 00 5/7                |                            | 92.00               |
| 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS   | 175, 120          | 0                                  |                              |                       | 0                          | 93.00               |
| 93. 01 04951 SHAFER MEDICAL CENTER SPECIAL PURPOSE COST CENTERS                                     | 58, 328           | 0                                  | 5, 840                       | 20, 792               | 0                          | 93. 01              |
| 113. 00 11300 I NTEREST EXPENSE   |                   |                                    |                              |                       |                            | 113. 00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)   | 2, 651, 828       | 0                                  | 263, 799                     | 304, 372              |                            | 118.00              |
| NONREI MBURSABLE COST CENTERS   | 2,031,020         |                                    | 203, 177                     | 304, 372              | 0,774                      | 1110.00             |
| 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN   | 0                 | 0                                  | 0                            | 0                     | 0                          | 190. 00             |
| 192.00 19200 PHYSICIANS PRIVATE OFFICES   | 12, 867           | 0                                  | 82                           | 0                     | 0                          | 192. 00             |
| 192. 01 19201 FCMC  | 0                 | 0                                  | 4, 812                       |                       | 0                          | 192. 01             |
| 192.02 19202 ARGOS MEDICAL CENTER   | 26, 432           | 0                                  | 4, 355                       |                       |                            | 192. 02             |
| 192. 03 19203 AKRON MEDICAL CENTER  | 11, 297           | 0                                  | 1, 562                       | 0                     |                            | 192. 03             |
| 193. 00 19300 NONPAI D WORKERS  | 0                 | 0                                  | 0                            | 0                     |                            | 193.00              |
| 194. 00 07950 ADVERTI SI NG   | 7, 456            | 0                                  | 2, 868                       | 0                     |                            | 194.00              |
| 200.00 Cross Foot Adjustments   | 0                 | ^                                  | _                            | ^                     |                            | 200. 00<br>201. 00  |
| 201.00 Negative Cost Centers<br>202.00 TOTAL (sum lines 118 through 201)                            | 2, 709, 880       | 0                                  | 1                            | 0<br>304, 372         |                            | 201.00              |
| 202.00   TOTAL (Suil TITIES TTO LITTUUGIT 201)  | 2, 109, 080       | 0                                  | 277, 478                     | 304, 372              | 0, 9/4                     | <sub> </sub> 202.00 |

| Peri od: | Worksheet B | From 01/01/2020 | Part I I | To 12/31/2020 | Date/Time Prepared:

|   |               |          | '          | 0 12/31/2020                            | 7/29/2021 4:1 |                    |
|---|---------------|----------|------------|---|---------------|--------------------|
| Cost Center Description   | HOUSEKEEPI NG | DI ETARY | CAFETERI A | NURSI NG                                | CENTRAL       |                    |
| · ·   |               |          |            | ADMI NI STRATI O                        | SERVICES &    |                    |
|   |               |          |            | N                                       | SUPPLY        |                    |
| CENEDAL SERVICE COST SENTERS  | 9. 00         | 10. 00   | 11. 00     | 13. 00                                  | 14. 00        |                    |
| GENERAL SERVICE COST CENTERS  1.00 00100 CAP REL COSTS-BLDG & FIXT          |               |          |            |   |               | 1.00               |
| 1. 02   00100 CAP REL COSTS-BLDG & FTXT                                     |               |          |            |   |               | 1.00               |
| 1. 03   00103   ARGOS   BUI LDI NG  |               |          |            |   |               | 1.02               |
| 1. 04   00101 CLAYS BUILDING  |               |          |            |   |               | 1.03               |
| 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT                                |               |          |            |   |               | 4.00               |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL                                     |               |          |            |   |               | 5.00               |
| 7. 00 O0700 OPERATION OF PLANT  |               |          |            |   |               | 7.00               |
| 8. 00   00800 LAUNDRY & LINEN SERVICE                                       |               |          |            |   |               | 8.00               |
| 9. 00   00900   HOUSEKEEPI NG   | 35, 970       |          |            |   |               | 9.00               |
| 10. 00 01000 DI ETARY   | 51            | 56, 530  |            |   |               | 10.00              |
| 11. 00   01100   CAFETERI A   | 595           | 0        | 83, 858    | 3                                       |               | 11.00              |
| 13.00 01300 NURSING ADMINISTRATION  | 41            | 0        | 2, 759     | I I                                     |               | 13.00              |
| 14.00 01400 CENTRAL SERVICES & SUPPLY                                       | 0             | 0        | C          | 0                                       | 0             | 14.00              |
| 15. 00 01500 PHARMACY   | 414           | 0        | 2, 637     | 0                                       | 0             | 15.00              |
| 16.00 01600 MEDICAL RECORDS & LIBRARY                                       | 222           | 0        | 4, 821     | 1, 486                                  | 0             | 16.00              |
| INPATIENT ROUTINE SERVICE COST CENTERS                                      |               |          |            |   |               |                    |
| 30. 00 03000 ADULTS & PEDIATRICS  | 8, 352        | 48, 392  | 10, 781    | 52, 369                                 | 0             | 30.00              |
| 31.00 03100 INTENSIVE CARE UNIT   | 1, 713        | 8, 138   | 4, 098     | 9, 342                                  | 0             | 31.00              |
| 43. 00 04300 NURSERY  | 0             | 0        | 654        | 0                                       | 0             | 43.00              |
| ANCILLARY SERVICE COST CENTERS  |               |          |            |   |               |                    |
| 50.00   05000   OPERATING ROOM  | 4, 561        | 0        | 8, 657     |   | 0             | 50.00              |
| 51.00   05100   RECOVERY ROOM   | 3, 328        | 0        | 2, 987     |   | 0             | 51.00              |
| 52. 00   05200   DELI VERY ROOM & LABOR ROOM                                | 0             | 0        | 1, 518     | 1                                       | 0             | 52.00              |
| 53. 00   05300   ANESTHESI OLOGY  | 0             | 0        | 0          | 1                                       | 0             | 53.00              |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C                                    | 3, 443        | 0        | 10, 620    |   | 0             | 54.00              |
| 60. 00   06000   LABORATORY   | 1, 157        | 0        | 6, 788     | 1                                       | 0             | 60.00              |
| 65. 00 06500 RESPIRATORY THERAPY  | 1, 198        | 0        | 4, 608     | 1                                       | 0             | 65.00              |
| 66. 00 06600 PHYSI CAL THERAPY  | 765<br>0      | 0        | 3, 817     | 1                                       | 0             | 66.00              |
| 67. 00   06700   0CCUPATI ONAL THERAPY<br>68. 00   06800   SPEECH PATHOLOGY |               | 0        | 1, 081     | 1                                       | 0             | 67.00              |
| 71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT                        | 0             | 0        | 491<br>C   | 1                                       | 0             | 68. 00<br>71. 00   |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS                                 |               | 0        |            |   | 0             | 72.00              |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                                      |               | 0        |            |   | 0             | 73.00              |
| OUTPATIENT SERVICE COST CENTERS   | <u> </u>      | <u> </u> |            | ,                                       | 0             | 73.00              |
| 88. 00 08800 SHAFER MEDICAL CENTER  | 872           | ol       | C          | ol                                      | 0             | 88. 00             |
| 88. 01 08801 WOODLAWN MEDICAL PROFESSIONALS                                 | 1, 554        | o        | 6, 324     |   | 0             | 88. 01             |
| 88. 02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA                           | 0             | Ö        | 0,02       |   | 0             | 88. 02             |
| 88. 03   08803 FULTON COUNTY MEDICAL CENTER - 100 E                         | l ol          | o        | C          | ol                                      | 0             | 88. 03             |
| 88. 04   08804 AKRON MEDICAL CLINIC   | O             | o        | C          | o                                       | 0             | 88. 04             |
| 88. 05   08805   ARGOS   MEDICAL CLINIC                                     | O             | O        | C          | o                                       | 0             | 88. 05             |
| 91. 00 09100 EMERGENCY  | 4, 670        | 0        | 6, 103     | 8, 113                                  | 0             | 91.00              |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                             |               |          |            |   |               | 92.00              |
| 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS                                  | 1, 354        | 0        | 4, 756     | 0                                       | 0             | 93.00              |
| 93. 01 04951 SHAFER MEDICAL CENTER  | 1, 643        | 0        | C          | 0                                       | 0             | 93. 01             |
| SPECIAL PURPOSE COST CENTERS  |               |          |            |   |               |                    |
| 113. 00 11300 I NTEREST EXPENSE   |               |          |            |   |               | 113.00             |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                               | 35, 933       | 56, 530  | 83, 500    | 71, 310                                 | 0             | 118. 00            |
| NONREI MBURSABLE COST CENTERS   |               |          |            |   |               |                    |
| 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN                              | 37            | 0        | C          | 0                                       |               | 190.00             |
| 192. 00 19200 PHYSICIANS PRIVATE OFFICES                                    | 0             | 0        | C          | 0                                       |               | 192.00             |
| 192. 01 19201 FCMC  | 0             | 0        | C          |   |               | 192.01             |
| 192. 02 19202 ARGOS MEDICAL CENTER  | 0             | 0        | C          | 1                                       |               | 192.02             |
| 192. 03 19203 AKRON MEDICAL CENTER  | 0             | 0        | C          | 1                                       |               | 192.03             |
| 193. 00 19300  NONPALD WORKERS<br>194. 00 07950  ADVERTLSLING               |               | 0        | 250        | 1                                       |               | 193. 00<br>194. 00 |
| 200.00 Cross Foot Adjustments   | ١             | U        | 358        |   |               | 200.00             |
| 201.00   Cross Foot Adjustments<br>201.00   Negative Cost Centers           |               | _        |            |   |               | 200.00             |
| 202.00 TOTAL (sum lines 118 through 201)                                    | 35, 970       | 56, 530  | 83, 858    | 71, 310                                 |               | 201.00             |
| 202.00   TOTAL (Suil TITIES TTO THE OUGH 201)                               | 33, 710       | 50, 550  | 03, 030    | , | U             | 1202. UU           |

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1313 Peri od: Worksheet B From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/29/2021 4:15 pm Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Total RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00102 AKRON BULLDING 1.02 1 02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 61, 962 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 92, 949 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 3, 460 481, 660 481,660 30.00 03100 INTENSIVE CARE UNIT 0 o 79, 751 31.00 756 79, 751 31.00 6,742 04300 NURSERY 0 6,742 43.00 43.00 168 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 11, 415 248, 491 0 248, 491 50.00 05100 RECOVERY ROOM 0 51.00 1, 255 135, 786 0 135, 786 51.00 0 64, 100 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 268 64, 100 52 00 05300 ANESTHESI OLOGY 53.00 1, 422 5, 198 5, 198 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 20, 694 354, 481 0 354, 481 54.00 06000 LABORATORY 60.00 0 0 17, 941 110, 257 0 0 110, 257 60.00 06500 RESPIRATORY THERAPY 5, 970 65 00 124 109 124, 109 65 00 66.00 06600 PHYSI CAL THERAPY 1,670 87, 158 87, 158 66.00 3, 713 06700 OCCUPATI ONAL THERAPY 0 637 3, 713 0 67.00 67.00 0 1, 738 0 68.00 06800 SPEECH PATHOLOGY 333 1,738 68.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 0 o 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 647 8, 375 8, 375 72.00 07300 DRUGS CHARGED TO PATIENTS 61, 962 0 73.00 14,046 76,008 76, 008 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 SHAFER MEDICAL CENTER 50, 562 0 50, 562 88 00 0 464 08801 WOODLAWN MEDICAL PROFESSIONALS 0 2, 136 162, 899 0 162, 899 88.01 88.01 88 02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA 0 1, 155 13,811 0 13,811 88 02 0 0 08803 FULTON COUNTY MEDICAL CENTER - 100 E 2.362 88.03 244 2.362 88.03 08804 AKRON MEDICAL CLINIC 88 04 364 37,682 37, 682 88 04 88.05 08805 ARGOS MEDICAL CLINIC 0 1, 362 89, 822 0 89, 822 88.05 0 09100 EMERGENCY 0 91.00 4,054 194, 951 194, 951 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 524 210, 531 0 210, 531 93.00 93. 01 04951 SHAFER MEDICAL CENTER 0 964 87, 567 0 87, 567 93.01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 61, 962 92, 949 2, 637, 754 2, 637, 754 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 37 190, 00 37 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 Ω 12, 949 0 12, 949 192. 00 192. 01 19201 FCMC 0 0 4,812 0 4, 812 192. 01 0 192. 02 19202 ARGOS MEDICAL CENTER 30, 787 0 0 30, 787 192. 02 0 0 12, 859 192. 03 192. 03 19203 AKRON MEDICAL CENTER 0 12,859 193. 00 19300 NONPALD WORKERS 0 C 0 193.00 C 194. 00 07950 ADVERTI SI NG 0 10, 682 194. 00 10,682 0 0 0 200.00 0 200.00 Cross Foot Adjustments 0

0

92, 949

61, 962

 $\cap$ 

2, 709, 880

0 201.00

2, 709, 880 202. 00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-1313

|                  |       |   |                  |               | T             | o 12/31/2020  | Date/Time Pre<br>7/29/2021 4:1          |                    |
|------------------|-------|---|------------------|---------------|---------------|---------------|---|--------------------|
|                  |       |   |                  | CAPITAL REI   | _ATED COSTS   |               | , | , p                |
|                  |       | Cost Center Description   | BLDG & FIXT      | AKRON         | ARGOS         | CLAYS         | EMPLOYEE                                |                    |
|                  |       | cost center bescription   | (SQUARE FEET)    | BUI LDI NG    | BUI LDI NG    | BUI LDI NG    | BENEFITS                                |                    |
|                  |       |   |                  | (SQUARE FEET) | (SQUARE FEET) | (SQUARE FEET) | DEPARTMENT                              |                    |
|                  |       |   |                  |               |               |               | (GROSS<br>SALARI ES)                    |                    |
|                  |       |   | 1. 00            | 1. 02         | 1. 03         | 1. 04         | 4. 00                                   |                    |
| 1 00             |       | AL SERVICE COST CENTERS   | 100 701          |               |               |               |   | 1 00               |
| 1. 00<br>1. 02   | 1     | CAP REL COSTS-BLDG & FIXT AKRON BUILDING                            | 108, 701         | 3, 500        |               |               |   | 1. 00<br>1. 02     |
| 1. 03            | 00103 | ARGOS BUILDING  | 0                | 0             |               |               |   | 1. 03              |
| 1.04             | 1     | CLAYS BUILDING  | 0                | 0             |               | 20, 414       | 04 004 057                              | 1.04               |
| 4. 00<br>5. 00   | 1     | EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL               | 11, 966          | 0<br>400      |               | 0<br>16       | 21, 984, 256<br>3, 205, 300             |                    |
| 7. 00            |       | OPERATION OF PLANT  | 10, 592          | 240           |               | 4, 657        | 379, 067                                | 7. 00              |
| 8. 00            |       | LAUNDRY & LINEN SERVICE   | 321              | 0             | 0             | 0             | 18, 135                                 |                    |
| 9. 00<br>10. 00  |       | HOUSEKEEPI NG<br>DI ETARY   | 1, 213<br>2, 181 | 0             | 0             | 43            | 381, 576<br>163, 059                    | 1                  |
| 11. 00           | 1     | CAFETERI A  | 3, 243           |               | 0             | 0             | 242, 536                                | 1                  |
| 13. 00           | 01300 | NURSING ADMINISTRATION  | 2, 555           |               | 0             | o             | 551, 619                                | 1                  |
| 14.00            |       | CENTRAL SERVICES & SUPPLY   | 1 20/            | 0             |               | 0             | 0                                       |                    |
| 15. 00<br>16. 00 |       | PHARMACY MEDICAL RECORDS & LIBRARY                                  | 1, 386<br>1, 320 | l e           |               | 0<br>4, 249   | 393, 171<br>446, 779                    | 15. 00<br>16. 00   |
| 10.00            |       | I ENT ROUTI NE SERVI CE COST CENTERS                                | 1,020            |               |               | 1, 217        | 110,777                                 | 10.00              |
| 30.00            | 1     | ADULTS & PEDIATRICS   | 13, 589          | l             |               | 0             | 1, 726, 920                             | 1                  |
| 31. 00<br>43. 00 |       | INTENSIVE CARE UNIT<br>NURSERY                                      | 2, 058<br>187    | 0             |               | 0             | 412, 817<br>134, 999                    |                    |
| 43.00            |       | LARY SERVICE COST CENTERS   | 107              |               | 0             | <u> </u>      | 134, 777                                | 43.00              |
| 50.00            | 05000 | OPERATING ROOM  | 8, 242           | 0             |               | · ·           | 828, 651                                | 50.00              |
| 51.00            | 1     | RECOVERY ROOM   | 4, 937           | 0             |               | l .           | 384, 462                                |                    |
| 52. 00<br>53. 00 |       | DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY                           | 2, 379<br>137    | 0             |               | 0             | 314, 324<br>0                           | 1                  |
| 54.00            |       | RADI OLOGY-DI AGNOSTI C   | 12, 035          | Ö             |               | o             | 1, 546, 012                             | 1                  |
| 60.00            |       | LABORATORY  | 2, 623           | 0             | 0             | o             | 873, 808                                | 1                  |
| 65. 00<br>66. 00 |       | RESPI RATORY THERAPY PHYSI CAL THERAPY                              | 4, 159<br>2, 996 | ł             | 0             | 0             | 913, 470<br>695, 407                    |                    |
| 67. 00           |       | OCCUPATIONAL THERAPY  | 2, 440           |               | 0             | o             | 232, 377                                |                    |
| 68. 00           | 1     | SPEECH PATHOLOGY  | 0                | 0             | 0             | o             | 107, 046                                | 68. 00             |
| 71.00            |       | MEDICAL SUPPLIES CHARGED TO PATIENT                                 | 0                | 0             |               | 0             | 0                                       | 1                  |
| 72. 00<br>73. 00 |       | IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS            | 0                | 0             |               | 0             | 0                                       | 72. 00<br>73. 00   |
| 70.00            |       | TIENT SERVICE COST CENTERS  |                  |               |               | 9             | <u> </u>                                | 70.00              |
| 88. 00           |       | SHAFER MEDICAL CENTER   | 0<br>5. 438      | ı             |               | 4, 113        | 234, 066                                |                    |
| 88. 01<br>88. 02 |       | WOODLAWN MEDICAL PROFESSIONALS FULTON COUNTY MEDICAL CENTER- 700 MA | 0, 430           | 0             | 0             | 0             | 1, 828, 458<br>1, 069, 526              |                    |
| 88. 03           |       | FULTON COUNTY MEDICAL CENTER - 100 E                                | Ö                | Ö             | Ö             | Ö             | 183, 839                                | 1                  |
| 88. 04           |       | AKRON MEDICAL CLINIC  | 0                | 2, 026        |               | 0             | 399, 108                                | 1                  |
| 88. 05<br>91. 00 | 1     | ARGOS MEDICAL CLINIC EMERGENCY                                      | 6, 258           | 0             | .,            | 0             | 1, 164, 595<br>1, 215, 061              |                    |
|                  |       | OBSERVATION BEDS (NON-DISTINCT PART                                 | 0, 230           | Ĭ             |               | Ĭ             | 1, 213, 001                             | 92.00              |
| 93. 00           | 04950 | WOODLAWN MEDICAL PROFESSIONALS                                      | 7, 962           | l             |               | l .           | 344, 034                                | 93. 00             |
| 93. 01           |       | SHAFER MEDICAL CENTER AL PURPOSE COST CENTERS                       | 0                | 0             | 0             | 7, 336        | 482, 108                                | 93. 01             |
| 113.00           |       | INTEREST EXPENSE  |                  |               |               |               |   | 113. 00            |
| 118.00           |       | SUBTOTALS (SUM OF LINES 1 through 117)                              | 107, 777         | 2, 666        | 5, 687        | 20, 414       | 20, 872, 330                            | 118.00             |
| 100 00           |       | IMBURSABLE COST CENTERS GIFT FLOWER COFFEE SHOP & CANTEEN           | 0                |               |               | ام            | 0                                       | 190. 00            |
|                  |       | PHYSICIANS PRIVATE OFFICES  | 585              |               |               |               |   | 190.00             |
| 192. 01          | 19201 | FCMC  | 0                | 0             |               | o             | 423, 008                                |                    |
|                  |       | ARGOS MEDICAL CENTER  | 0                | 0             |               | 0             | 459, 625                                |                    |
|                  |       | AKRON MEDICAL CENTER NONPALD WORKERS                                | 0                | 834<br>0      |               | 0             | 159, 142<br>0                           | 192.03             |
|                  | 1     | ADVERTI SI NG   | 339              | 1             | Ö             | Ö             | 70, 151                                 |                    |
| 200.00           |       | Cross Foot Adjustments  |                  |               |               |               |   | 200.00             |
| 201.00<br>202.00 |       | Negative Cost Centers<br>Cost to be allocated (per Wkst. B,         | 2, 390, 818      | 47, 411       | 109, 342      | 162, 309      | 3, 120, 758                             | 201. 00<br>202. 00 |
| 202.00           |       | Part I)   | 2,070,010        | .,,           | 107, 012      | 102,007       | 0, 120, 700                             | 202.00             |
| 203.00           | 1     | Unit cost multiplier (Wkst. B, Part I)                              | 21. 994443       | 13. 546000    | 14. 578933    | 7. 950867     | 0. 141954                               |                    |
| 204.00           | '     | Cost to be allocated (per Wkst. B, Part II)                         |                  |               |               |               | 0                                       | 204. 00            |
| 205.00           |       | Unit cost multiplier (Wkst. B, Part                                 |                  |               |               |               | 0.000000                                | 205. 00            |
| 206.00           | )     | NAHE adjustment amount to be allocated                              |                  |               |               |               |   | 206. 00            |
|                  |       | (per Wkst. B-2)   |                  |               |               |               |   |                    |
| 207.00           |       | NAHE unit cost multiplier (Wkst. D, Parts III and IV)               |                  |               |               |               |   | 207. 00            |
|                  |       | ·   | 1                | '             | 1             | ·             |   | ·                  |

|                  |  |               |                              |                        | o 12/31/2020                | Date/Time Pre<br>7/29/2021 4:1 |                    |
|------------------|--|---------------|------------------------------|------------------------|-----------------------------|--------------------------------|--------------------|
|                  | Cost Center Description  | Reconciliatio | ADMI NI STRATI V             | OPERATION OF           | LAUNDRY &                   | HOUSEKEEPI NG                  | 5 pili             |
|                  |  | n             | E & GENERAL<br>(ACCUM. COST) | PLANT<br>(SQUARE FEET) | LINEN SERVICE<br>(POUNDS OF | (HOURS OF S<br>ERVIC)          |                    |
|                  |  |               | (ACCOM. COST)                | (SQUARE FEET)          | LAUNDR)                     | ERVIC)                         |                    |
|                  |  | 5A            | 5. 00                        | 7. 00                  | 8. 00                       | 9. 00                          |                    |
| 1. 00            | GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT                             |               | Ι                            | I                      |                             |                                | 1.00               |
| 1. 00            | 00102 AKRON BUILDING   |               |                              |                        |                             |                                | 1.00               |
| 1. 03            | 00103 ARGOS BUILDING   |               |                              |                        |                             |                                | 1. 03              |
| 1. 04            | 00101 CLAYS BUILDING   |               |                              |                        |                             |                                | 1. 04              |
| 4. 00<br>5. 00   | 00400 EMPLOYEE BENEFITS DEPARTMENT<br>00500 ADMINISTRATIVE & GENERAL                     | -6, 977, 077  | 43, 495, 114                 |                        |                             |                                | 4. 00<br>5. 00     |
| 7. 00            | 00700 OPERATION OF PLANT   | -0, 977, 077  |                              | 1                      | ,                           |                                | 7.00               |
| 8. 00            | 00800 LAUNDRY & LINEN SERVICE  | Ö             |                              | 1                      |                             |                                | 8. 00              |
| 9. 00            | 00900 HOUSEKEEPI NG  | 0             | 657, 519                     |                        |                             | 87, 655                        | 9. 00              |
| 10.00            | 01000 DI ETARY   | 0             | 339, 974                     |                        |                             | 125                            | 10.00              |
| 11. 00<br>13. 00 | 01100   CAFETERI A<br>  01300   NURSI NG   ADMI NI STRATI ON                             | 0             | 429, 918<br>794, 990         |                        |                             | 1, 450<br>100                  | 11. 00<br>13. 00   |
| 14. 00           | 01400 CENTRAL SERVICES & SUPPLY  | 0             | 0                            | 2, 333                 |                             | 0                              | 14.00              |
| 15.00            | 01500 PHARMACY   | 0             |                              | 1, 386                 | 0                           | 1, 010                         | 15. 00             |
| 16. 00           | 01600 MEDI CAL RECORDS & LI BRARY  | 0             | 1, 225, 737                  | 5, 569                 | 0                           | 540                            | 16. 00             |
| 30. 00           | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS                         | 0             | 3, 014, 675                  | 13, 589                | 275                         | 20, 350                        | 30.00              |
| 31. 00           | 03100 INTENSIVE CARE UNIT  | 0             |                              |                        |                             | 4, 175                         | 31.00              |
| 43.00            | 04300 NURSERY  | 0             |                              |                        |                             | 0                              | 43.00              |
|                  | ANCILLARY SERVICE COST CENTERS   | _             |                              | 1                      |                             |                                |                    |
| 50. 00<br>51. 00 | 05000   OPERATI NG ROOM   05100   RECOVERY ROOM  | 0             |                              |                        |                             | 11, 115<br>8, 110              | 50. 00<br>51. 00   |
| 52. 00           | 05200 DELIVERY ROOM & LABOR ROOM   | 0             | , -                          |                        |                             | 0, 110                         | 52.00              |
| 53. 00           | 05300 ANESTHESI OLOGY  | 0             | ,                            |                        |                             | 0                              | 53.00              |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C  | 0             | , ,                          |                        |                             | 8, 390                         | 54.00              |
| 60.00            | 06000 LABORATORY   | 0             |                              |                        |                             | 2, 820                         | 60.00              |
| 65. 00<br>66. 00 | 06500 RESPI RATORY THERAPY<br>06600 PHYSI CAL THERAPY                                    | 0             | 1, 372, 865<br>997, 075      |                        |                             | 2, 920<br>1, 865               | 65. 00<br>66. 00   |
| 67. 00           | 06700 OCCUPATI ONAL THERAPY  |               | 312, 715                     |                        | 0                           | 1, 803                         | 67.00              |
| 68. 00           | 06800 SPEECH PATHOLOGY   | 0             | 143, 197                     | 1                      | o                           | 0                              | 68. 00             |
| 71. 00           | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0             |                              | C                      | 1                           | 0                              | 71. 00             |
| 72. 00<br>73. 00 | 07200   IMPL. DEV. CHARGED TO PATIENTS<br>  07300   DRUGS CHARGED TO PATIENTS            | 0 0           |                              | 1                      | _                           | 0                              | 72. 00<br>73. 00   |
| 73.00            | OUTPATIENT SERVICE COST CENTERS  | 0             |                              |                        | )  U                        | 0                              | 73.00              |
| 88. 00           | 08800 SHAFER MEDICAL CENTER  | 0             | 762, 841                     | 4, 113                 | 0                           | 2, 125                         | 88. 00             |
| 88. 01           | 08801 WOODLAWN MEDICAL PROFESSIONALS   | 0             | _, _,                        |                        |                             | 3, 786                         |                    |
| 88. 02<br>88. 03 | 08802 FULTON COUNTY MEDICAL CENTER- 700 MA<br>08803 FULTON COUNTY MEDICAL CENTER - 100 E | 0             | 1, 954, 041<br>323, 410      |                        |                             | 0                              | 88. 02<br>88. 03   |
| 88. 04           | 08804 AKRON MEDICAL CLINIC   | 0             | 638, 818                     | 1                      | 1                           | 0                              | 88. 04             |
| 88. 05           | 08805 ARGOS MEDICAL CLINIC   | Ö             |                              | 1                      |                             | 0                              | 88. 05             |
| 91.00            | 09100 EMERGENCY  | 0             | 2, 465, 674                  | 6, 258                 | 148                         | 11, 380                        | 91.00              |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART  |               | 072 204                      | 7.040                  |                             | 2 200                          | 92. 00<br>93. 00   |
| 93. 00<br>93. 01 | 04950   WOODLAWN MEDICAL PROFESSIONALS<br>  04951   SHAFER MEDICAL CENTER                | 0             |                              |                        |                             | 3, 299<br>4, 005               |                    |
| 70.01            | SPECIAL PURPOSE COST CENTERS   |               | 710, 100                     | 7,000                  | ,                           | 1,000                          | 70.01              |
|                  | 11300 I NTEREST EXPENSE  |               |                              |                        |                             |                                | 113. 00            |
| 118.00           | SUBTOTALS (SUM OF LINES 1 through 117)<br>  NONREIMBURSABLE COST CENTERS                 | -6, 977, 077  | 41, 351, 092                 | 107, 389               | 1, 473                      | 87, 565                        | 118. 00            |
| 190 00           | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN  | 0             |                              | C                      | ol                          | 90                             | 190. 00            |
|                  | 19200 PHYSI CI ANS PRI VATE OFFI CES   | 0             |                              | l .                    |                             |                                | 192.00             |
|                  | 19201 FCMC   | 0             | 754, 253                     | C                      | O                           |                                | 192. 01            |
|                  | 19202 ARGOS MEDICAL CENTER   | 0             |                              | 1                      | 0                           |                                | 192. 02            |
|                  | 19203 AKRON MEDICAL CENTER<br> 19300 NONPAID WORKERS                                     | 0             | 244, 776                     |                        |                             |                                | 192. 03<br>193. 00 |
|                  | 07950 ADVERTI SI NG  |               | 449, 452                     | 1                      |                             |                                | 194. 00            |
| 200.00           |  |               | ,                            |                        |                             |                                | 200. 00            |
| 201.00           |  |               |                              |                        |                             |                                | 201. 00            |
| 202.00           | Cost to be allocated (per Wkst. B, Part I)   |               | 6, 977, 077                  | 3, 848, 009            | 194, 072                    | 833, 822                       | 202. 00            |
| 203.00           |  |               | 0. 160411                    | 35. 832432             | 131. 752885                 | 9. 512543                      | 203 00             |
| 204.00           |  | 1             | 277, 478                     | 1                      |                             | 35, 970                        |                    |
|                  | Part II)   |               |                              |                        |                             |                                |                    |
| 205.00           |  |               | 0. 006380                    | 2. 834294              | 6. 092329                   | 0. 410359                      | 205. 00            |
| 206.00           |  |               |                              |                        |                             |                                | 206. 00            |
| 200.00           | (per Wkst. B-2)  |               |                              |                        |                             |                                |                    |
| 207.00           |  |               |                              |                        |                             |                                | 207. 00            |
|                  | Parts III and IV)  | I             | I                            | I                      | 1                           |                                | I                  |

| Heal th                              | Financial Systems  | WOODLAWN H                      | OSPI TAL                             |   | In Lie                                      | u of Form CMS-                            | 2552-10            |
|--------------------------------------|--|---------------------------------|--------------------------------------|---|---|---|--------------------|
| COST A                               | LLOCATION - STATISTICAL BASIS  |                                 | Provi der Co                         |   | Period:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet B-1 Date/Time Pre 7/29/2021 4:1 | pared:             |
|                                      | Cost Center Description  | DI ETARY<br>(PATI ENT DA<br>YS) | CAFETERI A<br>(FTES)                 | NURSI NG<br>ADMI NI STRATI (<br>N<br>(DI RECT NRS | SUPPLY<br>(COSTED                           | PHARMACY<br>(COSTED<br>REQUIS.)           | J pili             |
|                                      |  | 10.00                           | 11. 00                               | 1 NG HR)<br>13. 00                                | REQUIS.)<br>14.00                           | 15. 00                                    |                    |
|                                      | GENERAL SERVICE COST CENTERS   | 10.00                           |                                      | 10.00   |   | 10.00                                     |                    |
| 14. 00<br>15. 00                     | 00100 CAP REL COSTS-BLDG & FIXT 00102 AKRON BUILDING 00103 ARGOS BUILDING 00101 CLAYS BUILDING 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY | 2, 716<br>0<br>0<br>0<br>0<br>0 | 22, 038<br>725<br>0<br>693<br>1, 267 | 52, 56  | 0 0   | 100                                       | 1                  |
| 20.00                                | I NPATI ENT ROUTI NE SERVI CE COST CENTERS   | 2 225                           | 2 022                                | 20.70   |   | _   | 20.00              |
| 30. 00<br>31. 00<br>43. 00           | 03000 ADULTS & PEDIATRICS<br>03100 INTENSIVE CARE UNIT<br>04300 NURSERY  | 2, 325<br>391<br>0              | 2, 833<br>1, 077<br><u>172</u>       | 6, 88   |   | 0   | 31.00              |
| 50. 00                               | ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM   | 0                               | 2, 275                               |   | 0 0   | 0   | 50.00              |
| 51. 00<br>52. 00<br>53. 00<br>54. 00 | 05100 RECOVERY ROOM<br>05200 DELIVERY ROOM & LABOR ROOM<br>05300 ANESTHESIOLOGY<br>05400 RADIOLOGY-DIAGNOSTIC  | 0<br>0<br>0<br>0                | 785<br>399<br>0<br>2, 791            |   | 0<br>0<br>0<br>0<br>0<br>0                  | 0   | 52.00              |
| 60.00                                | 06000 LABORATORY   | 0                               | 1, 784                               | 1   | 0   | 0   | 60.00              |
| 65. 00<br>66. 00                     | 06500 RESPI RATORY THERAPY<br>06600 PHYSI CAL THERAPY  | 0                               | 1, 211<br>1, 003                     | 1   | 0 0   | 0   | 65. 00<br>66. 00   |
| 67. 00                               | 06700 OCCUPATI ONAL THERAPY  | 0                               | 284                                  |   | 0   |   | 67.00              |
| 68. 00<br>71. 00                     | 06800 SPEECH PATHOLOGY<br>07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0                               | 129<br>0                             | 1   | 0 0   | 0   | 68. 00<br>71. 00   |
| 72.00                                | 07200 IMPL. DEV. CHARGED TO PATIENTS   | o                               | 0                                    |   | 0 0   | 0   | 72.00              |
| 73. 00                               | 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS  | 0                               | 0                                    |   | 0 0   | 100                                       | 73.00              |
|                                      | 08800 SHAFER MEDICAL CENTER  | 0                               | 0                                    | l .   | 0 0   | l .                                       |                    |
| 88. 01<br>88. 02                     | 08801 WOODLAWN MEDICAL PROFESSIONALS<br>08802 FULTON COUNTY MEDICAL CENTER- 700 MA   | 0                               | 1, 662<br>0                          |   | 0 0   | 0   |                    |
| 88. 03                               | 08803 FULTON COUNTY MEDICAL CENTER - 100 E   | o                               | 0                                    |   | 0 0   | ő   | 88. 03             |
| 88. 04<br>88. 05                     | 08804 AKRON MEDICAL CLINIC<br>08805 ARGOS MEDICAL CLINIC   | 0                               | 0                                    |   | 0 0   | 0   | 88. 04<br>88. 05   |
|                                      | 09100 EMERGENCY  | 0                               | 1, 604                               | 5, 98   |   |   | 1                  |
|                                      | 09200 OBSERVATION BEDS (NON-DISTINCT PART  |                                 | 1 250                                |   |   |   | 92.00              |
|                                      | 04950 WOODLAWN MEDICAL PROFESSIONALS<br>04951 SHAFER MEDICAL CENTER  | 0                               | 1, 250<br>0                          |   | 0 0   | l e                                       |                    |
| 440.00                               | SPECIAL PURPOSE COST CENTERS   |                                 |                                      |   |   |   | 112 00             |
| 113.00                               | 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS   | 2, 716                          | 21, 944                              | 52, 56  | 1 0   | 100                                       | 113. 00<br>118. 00 |
|                                      | 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES   | 0                               | 0                                    | 1   | 0 0   |   | 190. 00<br>192. 00 |
| 192. 01                              | 19201 FCMC   | ő                               | 0                                    | 1   | 0 0   | 0   | 192. 01            |
|                                      | 19202 ARGOS MEDI CAL CENTER<br>19203 AKRON MEDI CAL CENTER   | 0                               | 0                                    |   | 0   |   | 192. 02<br>192. 03 |
|                                      | 19300 NONPALD WORKERS  | 0                               | 0                                    |   | 0 0   | 0   | 193.00             |
| 194. 00<br>200. 00                   | 07950 ADVERTISING  | 0                               | 94                                   |   | 0   | 0   | 194.00             |
| 200.00                               | ,  |                                 |                                      |   |   |   | 200. 00<br>201. 00 |
| 202. 00                              | Part I)  | 477, 276                        | 628, 880                             |   |   | 4, 538, 825                               |                    |
| 203. 00<br>204. 00                   | Cost to be allocated (per Wkst. B, Part II)  | 175. 727541<br>56, 530          | 28. 536165<br>83, 858                | 71, 31  | 0   |   | 204. 00            |
| 205. 00                              | Unit cost multiplier (Wkst. B, Part  | 20. 813697                      | 3. 805155                            | 1. 35670  | 9 0.000000                                  | 619. 620000                               | 205. 00            |
| 206.00                               |  |                                 |                                      |   |   |   | 206. 00            |
| 207. 00                              |  |                                 |                                      |   |   |   | 207. 00            |

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1313 Period: Worksheet B-1

From 01/01/2020 12/31/2020 Date/Time Prepared: 7/29/2021 4:15 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00102 AKRON BULLDING 1.02 1 02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 136, 129, 766 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 065, 836 30.00 03100 INTENSIVE CARE UNIT 1, 107, 510 31.00 31.00 04300 NURSERY 246, 128 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16, 713, 085 50.00 05100 RECOVERY ROOM 51.00 1, 837, 314 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 392, 712 52.00 05300 ANESTHESI OLOGY 53.00 2, 082, 685 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 30, 337, 521 54.00 06000 LABORATORY 60.00 26, 267, 461 60.00 06500 RESPIRATORY THERAPY 65 00 8, 741, 223 65 00 66.00 06600 PHYSI CAL THERAPY 2, 445, 711 66.00 06700 OCCUPATI ONAL THERAPY 932, 473 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 487, 489 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 411, 291 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 20, 565, 557 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 678, 860 08800 SHAFER MEDICAL CENTER 88 00 88. 01 08801 WOODLAWN MEDICAL PROFESSIONALS 3, 127, 818 88.01 88 02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA 1, 691, 309 88 02 08803 FULTON COUNTY MEDICAL CENTER - 100 E 356, 605 88.03 88.03 08804 AKRON MEDICAL CLINIC 88.04 533, 009 88 04 88.05 08805 ARGOS MEDICAL CLINIC 1, 994, 267 88.05 09100 EMERGENCY 5, 935, 607 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 767, 409 93.00 93.01 04951 SHAFER MEDICAL CENTER 1, 410, 886 93.01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 136, 129, 766 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 0 192. 01 19201 FCMC 192.01 192. 02 19202 ARGOS MEDICAL CENTER 192.02 0 192. 03 19203 AKRON MEDICAL CENTER 192.03 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 ADVERTI SI NG 194. 00 0 200.00 200. 00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 684, 779 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.012376 203.00 Cost to be allocated (per Wkst. B, 204.00 204.00 92, 949 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000683 205.00 II) NAHE adjustment amount to be allocated 206. 00 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

| Peri od: | Worksheet C | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared:

|   |                 | 10       | 12/31/2020     | 7/29/2021 4:1 | pared:<br>5 pm |
|---|-----------------|----------|----------------|---------------|----------------|
|   | Title XVIII     |          | Hospi tal      | Cost          |                |
|   |                 |          | Costs          |               |                |
| Cost Center Description Total Cost Thera                          | apy Limit Total | Costs    | RCE            | Total Costs   |                |
| (from Wkst.   | Adj .           | Di       | i sal I owance |               |                |
| B, Part I,  |                 |          |                |               |                |
| col. 26)  |                 |          |                |               |                |
| 1.00  | 2.00 3.0        | 00       | 4. 00          | 5. 00         |                |
| INPATIENT ROUTINE SERVICE COST CENTERS                            |                 |          |                |               |                |
| 30. 00   03000   ADULTS & PEDI ATRI CS 5, 527, 712                | 5, !            | 527, 712 | 0              | 0             |                |
| 31. 00   03100   I NTENSI VE CARE UNI T 1, 187, 403               | 1, 1            | 187, 403 | 0              | 0             |                |
| 43. 00 04300 NURSERY 246, 941                                     |                 | 246, 941 | 0              | 0             | 43.00          |
| ANCILLARY SERVICE COST CENTERS                                    |                 |          |                |               |                |
| 50. 00   05000   OPERATING ROOM 4, 007, 644                       |                 | 007, 644 | 0              | 0             |                |
| 51. 00   05100   RECOVERY ROOM                                    |                 | 160, 091 | 0              | 0             |                |
| 52.00   05200   DELIVERY ROOM & LABOR ROOM 691, 938               |                 | 691, 938 | 0              | 0             | 02.00          |
| 53. 00   05300   ANESTHESI OLOGY 98, 820                          |                 | 98, 820  | 0              | 0             | 53.00          |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C 4, 442, 343              |                 | 442, 343 | 0              | 0             |                |
| 60. 00   06000   LABORATORY 3, 997, 274                           | 3,              | 997, 274 | 0              | 0             |                |
| 65. 00   06500   RESPI RATORY THERAPY 1, 919, 349                 | 0 1,            | 919, 349 | 0              | 0             | 65.00          |
| 66. 00   06600   PHYSI CAL THERAPY 1, 344, 428                    | 0 1, 3          | 344, 428 | 0              | 0             | 66.00          |
| 67. 00   06700   0CCUPATI ONAL THERAPY 382, 522                   | 0               | 382, 522 | 0              | 0             | 67.00          |
| 68. 00   06800   SPEECH PATHOLOGY   175, 881                      | 0               | 175, 881 | 0              | 0             | 68.00          |
| 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0           |                 | 0        | 0              | 0             | 71.00          |
| 72. 00   07200   I MPL. DEV. CHARGED TO PATIENTS 1, 253, 593      | 1, 3            | 253, 593 | 0              | 0             | 72.00          |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 793, 344                | 4,              | 793, 344 | 0              | 0             | 73.00          |
| OUTPATIENT SERVICE COST CENTERS                                   |                 |          |                |               |                |
| 88. 00   08800   SHAFER   MEDI CAL   CENTER   1, 061, 204         | 1, (            | 061, 204 | 0              | 0             |                |
| 88. 01   08801   WOODLAWN MEDICAL PROFESSIONALS 3, 566, 525       | 3, !            | 566, 525 | 0              | 0             | 88. 01         |
| 88. 02   08802   FULTON COUNTY MEDICAL CENTER- 700 MA 2, 292, 507 | 2, 2            | 292, 507 | 0              | 0             |                |
| 88. 03   08803   FULTON COUNTY MEDICAL CENTER - 100 E 380, 888    | ;               | 380, 888 | 0              | 0             | 88. 03         |
| 88. 04   08804   AKRON MEDICAL CLINIC 821, 671                    |                 | 821, 671 | 0              | 0             | 88. 04         |
| 88. 05   08805   ARGOS   MEDI CAL   CLI NI C   2, 306, 329        | 2,              | 306, 329 | 0              | 0             | 88. 05         |
| 91. 00   09100   EMERGENCY 3, 450, 252                            | 3,              | 450, 252 | 0              | 0             | 91.00          |
| 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   1,411,539  | 1,              | 411, 539 |                | 0             | 92.00          |
| 93. 00   04950   WOODLAWN MEDICAL PROFESSIONALS   1, 491, 375     | 1,              | 491, 375 | 0              | 0             | 93.00          |
| 93. 01 04951 SHAFER MEDICAL CENTER 1, 380, 673                    | 1, 3            | 380, 673 | 0              | 0             | 93. 01         |
| SPECIAL PURPOSE COST CENTERS                                      |                 |          |                |               |                |
| 113. 00 11300   I NTEREST EXPENSE                                 |                 |          |                |               | 113. 00        |
| 200. 00 Subtotal (see instructions) 49, 392, 246                  |                 | 392, 246 | 0              |               | 200. 00        |
| 201.00 Less Observation Beds 1,411,539                            |                 | 411, 539 |                |               | 201. 00        |
| 202.00   Total (see instructions)   47,980,707                    | 0 47,           | 980, 707 | o              | 0             | 202. 00        |

| Peri od: | Worksheet C | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared:

|        |  |              |               |              | 10 12/31/2020 | 7/29/2021 4: 1 |         |
|--------|--|--------------|---------------|--------------|---------------|----------------|---------|
|        |  |              | Title         | XVIII        | Hospi tal     | Cost           |         |
|        |  |              | Charges       |              |               |                |         |
|        | Cost Center Description                    | I npati ent  | Outpati ent   | Total (col.  | Cost or Other | TEFRA          |         |
|        |  |              |               | + col. 7)    | Ratio         | I npati ent    |         |
|        |  |              |               |              |               | Ratio          |         |
|        |  | 6. 00        | 7.00          | 8. 00        | 9. 00         | 10.00          |         |
|        | INPATIENT ROUTINE SERVICE COST CENTERS     |              |               |              |               |                |         |
|        | 03000 ADULTS & PEDIATRICS                  | 3, 092, 297  |               | 3, 092, 29   | 7             |                | 30.00   |
|        | 03100 INTENSIVE CARE UNIT                  | 1, 107, 510  |               | 1, 107, 51   |               |                | 31.00   |
|        | 04300 NURSERY                              | 246, 128     |               | 246, 12      | 8             |                | 43.00   |
|        | ANCILLARY SERVICE COST CENTERS             |              |               |              |               |                |         |
|        | 05000 OPERATING ROOM                       | 4, 147, 548  | 12, 565, 537  |              |               | 0.000000       | 50.00   |
|        | 05100 RECOVERY ROOM                        | 382, 284     | 1, 455, 030   |              |               | 0.000000       |         |
|        | 05200 DELIVERY ROOM & LABOR ROOM           | 250, 880     | 141, 832      |              |               |                |         |
|        | 05300 ANESTHESI OLOGY                      | 291, 897     | 1, 790, 788   | 2, 082, 68   | 0. 047448     | 0.000000       | 53.00   |
|        | 05400 RADI OLOGY-DI AGNOSTI C              | 1, 164, 845  | 29, 172, 676  | 30, 337, 52  |               | 0.000000       |         |
| 60.00  | 06000 LABORATORY                           | 2, 549, 711  | 23, 717, 750  | 26, 267, 46  | 0. 152176     | 0.000000       | 60.00   |
| 65.00  | 06500 RESPI RATORY THERAPY                 | 2, 667, 675  | 6, 073, 548   | 8, 741, 22   | 3 0. 219574   | 0.000000       | 65.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                    | 305, 863     | 2, 139, 848   | 2, 445, 71   | 0. 549708     | 0.000000       | 66.00   |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 115, 754     | 816, 719      | 932, 47      | 3 0. 410223   | 0.000000       | 67.00   |
| 68. 00 | 06800 SPEECH PATHOLOGY                     | 21, 390      | 466, 099      | 487, 48      | 9 0. 360790   | 0.000000       | 68.00   |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0            | 0             |              | 0. 000000     | 0.000000       | 71.00   |
|        | 07200 IMPL. DEV. CHARGED TO PATIENTS       | 1, 595, 028  | 816, 263      | 2, 411, 29   | 1 0. 519885   | 0.000000       | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 3, 891, 861  | 16, 673, 696  | 20, 565, 55  | 7 0. 233076   | 0.000000       | 73.00   |
|        | OUTPATIENT SERVICE COST CENTERS            |              |               |              |               |                |         |
| 88. 00 | 08800 SHAFER MEDICAL CENTER                | 16           | 678, 844      | 678, 86      | 0             |                | 88. 00  |
| 88. 01 | 08801 WOODLAWN MEDICAL PROFESSIONALS       | 1, 165       | 3, 126, 653   | 3, 127, 81   | 8             |                | 88. 01  |
| 88. 02 | 08802 FULTON COUNTY MEDICAL CENTER- 700 MA | 0            | 1, 691, 309   | 1, 691, 30   | 9             |                | 88. 02  |
| 88. 03 | 08803 FULTON COUNTY MEDICAL CENTER - 100 E | 0            | 356, 605      | 356, 60      | 5             |                | 88. 03  |
| 88. 04 | 08804 AKRON MEDICAL CLINIC                 | 0            | 533, 009      | 533, 00      | 9             |                | 88. 04  |
| 88. 05 | 08805 ARGOS MEDICAL CLINIC                 | 0            | 1, 994, 267   | 1, 994, 26   | 7             |                | 88. 05  |
| 91.00  | 09100 EMERGENCY                            | 152, 103     | 5, 783, 504   | 5, 935, 60   | 7 0. 581280   | 0.000000       | 91.00   |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 281, 480     | 1, 692, 059   | 1, 973, 53   | 9 0. 715232   | 0.000000       | 92.00   |
| 93.00  | 04950 WOODLAWN MEDICAL PROFESSIONALS       | 0            | 767, 409      | 767, 40      | 9 1. 943390   | 0.000000       | 93.00   |
| 93. 01 | 04951 SHAFER MEDICAL CENTER                | 0            | 1, 410, 886   | 1, 410, 88   | 6 0. 978586   | 0.000000       | 93. 01  |
|        | SPECIAL PURPOSE COST CENTERS               |              |               |              |               |                | ]       |
| 113.00 | 11300 I NTEREST EXPENSE                    |              |               |              |               |                | 113. 00 |
| 200.00 | Subtotal (see instructions)                | 22, 265, 435 | 113, 864, 331 | 136, 129, 76 | 6             |                | 200.00  |
| 201.00 | Less Observation Beds                      |              |               |              |               |                | 201.00  |
| 202.00 | Total (see instructions)                   | 22, 265, 435 | 113, 864, 331 | 136, 129, 76 | 6             |                | 202.00  |
|        |  | ,            |               |              |               |                |         |

| Health Financial Systems                 | WOODLAWN HOSPITAL      | In Lieu of Form CMS-2552-10                  |   |  |
|--|------------------------|--|---|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1313 | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet C<br>Part I<br>Date/Time Prepared:<br>7/29/2021 4:15 pm |  |

|          |   |               |             | 10 12/01/2020 | 7/29/2021 4: 1 |         |
|----------|---|---------------|-------------|---------------|----------------|---------|
|          |   |               | Title XVIII | Hospi tal     | Cost           | •       |
|          | Cost Center Description                   | PPS Inpatient |             |               |                |         |
|          |   | Ratio         |             |               |                |         |
|          |   | 11. 00        |             |               |                |         |
| 1.1      | NPATIENT ROUTINE SERVICE COST CENTERS     |               |             |               |                |         |
| 30.00 0  | 3000 ADULTS & PEDIATRICS                  |               |             |               |                | 30.00   |
| 31.00 0  | 3100 INTENSIVE CARE UNIT                  |               |             |               |                | 31.00   |
| 43.00 04 | 4300 NURSERY                              |               |             |               |                | 43.00   |
|          | NCILLARY SERVICE COST CENTERS             |               |             |               |                |         |
|          | 5000 OPERATING ROOM                       | 0. 000000     |             |               |                | 50.00   |
|          | 5100 RECOVERY ROOM                        | 0. 000000     |             |               |                | 51.00   |
|          | 5200 DELIVERY ROOM & LABOR ROOM           | 0. 000000     |             |               |                | 52.00   |
|          | 5300 ANESTHESI OLOGY                      | 0. 000000     |             |               |                | 53.00   |
|          | 5400 RADI OLOGY-DI AGNOSTI C              | 0. 000000     |             |               |                | 54.00   |
|          | 6000 LABORATORY                           | 0. 000000     |             |               |                | 60.00   |
|          | 6500 RESPI RATORY THERAPY                 | 0. 000000     |             |               |                | 65.00   |
|          | 6600 PHYSI CAL THERAPY                    | 0. 000000     |             |               |                | 66.00   |
|          | 6700 OCCUPATI ONAL THERAPY                | 0. 000000     |             |               |                | 67.00   |
|          | 6800 SPEECH PATHOLOGY                     | 0. 000000     |             |               |                | 68.00   |
|          | 7100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0. 000000     |             |               |                | 71.00   |
|          | 7200 IMPL. DEV. CHARGED TO PATIENTS       | 0. 000000     |             |               |                | 72.00   |
|          | 7300 DRUGS CHARGED TO PATIENTS            | 0. 000000     |             |               |                | 73.00   |
|          | UTPATIENT SERVICE COST CENTERS            |               |             |               |                |         |
|          | 8800 SHAFER MEDICAL CENTER                |               |             |               |                | 88. 00  |
|          | 8801 WOODLAWN MEDICAL PROFESSIONALS       |               |             |               |                | 88. 01  |
|          | 8802 FULTON COUNTY MEDICAL CENTER- 700 MA |               |             |               |                | 88. 02  |
|          | 8803 FULTON COUNTY MEDICAL CENTER - 100 E |               |             |               |                | 88. 03  |
|          | 8804 AKRON MEDICAL CLINIC                 |               |             |               |                | 88. 04  |
|          | 8805 ARGOS MEDICAL CLINIC                 |               |             |               |                | 88. 05  |
|          | 9100 EMERGENCY                            | 0. 000000     |             |               |                | 91.00   |
|          | 9200 OBSERVATION BEDS (NON-DISTINCT PART  | 0. 000000     |             |               |                | 92.00   |
|          | 4950 WOODLAWN MEDICAL PROFESSIONALS       | 0. 000000     |             |               |                | 93. 00  |
|          | 4951 SHAFER MEDICAL CENTER                | 0. 000000     |             |               |                | 93. 01  |
|          | PECIAL PURPOSE COST CENTERS               |               |             |               |                | 1       |
|          | 1300 INTEREST EXPENSE                     |               |             |               |                | 113.00  |
| 200. 00  | Subtotal (see instructions)               |               |             |               |                | 200. 00 |
| 201. 00  | Less Observation Beds                     |               |             |               |                | 201. 00 |
| 202. 00  | Total (see instructions)                  |               |             |               |                | 202. 00 |

| Health Financial Systems                 | WOODLAWN HOSPITAL      | In Lieu of Form CMS-2552-10 |
|--|------------------------|-----------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-1313 | Period: Worksheet C         |

To 12/31/2020 Date/Time Prepared: 7/29/2021 4:15 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 527, 712 5, 527, 712 5, 527, 712 30.00 03100 INTENSIVE CARE UNIT 1, 187, 403 1, 187, 403 0 1, 187, 403 31.00 31.00 246, 941 43.00 04300 NURSERY 246, 941 0 246, 941 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4,007,644 4,007,644 4, 007, 644 50.00 51.00 05100 RECOVERY ROOM 1, 160, 091 1, 160, 091 0 1, 160, 091 51.00 05200 DELIVERY ROOM & LABOR ROOM 691, 938 691, 938 0 691, 938 52.00 52.00 05300 ANESTHESI OLOGY 98, 820 53.00 98, 820 98, 820 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 442, 343 4, 442, 343 0 4, 442, 343 54.00 60.00 06000 LABORATORY 3, 997, 274 3, 997, 274 0 0 3, 997, 274 60.00 06500 RESPIRATORY THERAPY 1, 919, 349 1, 919, 349 1, 919, 349 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 1, 344, 428 C 1, 344, 428 1, 344, 428 66.00 67.00 06700 OCCUPATIONAL THERAPY 382, 522 382, 522 0 382, 522 67.00 0 68.00 06800 SPEECH PATHOLOGY 175, 881 175, 881 175, 881 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 253, 593 1, 253, 593 0 1, 253, 593 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 793, 344 4, 793, 344 0 4, 793, 344 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 08800 SHAFER MEDICAL CENTER 88.00 1, 061, 204 1, 061, 204 0 1, 061, 204 88.00 88.01 08801 WOODLAWN MEDICAL PROFESSIONALS 3, 566, 525 3, 566, 525 0 3, 566, 525 88.01 08802 FULTON COUNTY MEDICAL CENTER- 700 MA 2, 292, 507 o 88.02 2, 292, 507 2, 292, 507 88.02 0 88 03 08803 FULTON COUNTY MEDICAL CENTER - 100 E 380, 888 380 888 380, 888 88 03 08804 AKRON MEDICAL CLINIC 88.04 821, 671 821, 671 821, 671 88.04 88.05 08805 ARGOS MEDICAL CLINIC 2, 306, 329 2, 306, 329 0 2, 306, 329 88.05 91.00 09100 EMERGENCY 3, 450, 252 3, 450, 252 ol 3, 450, 252 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 1, 411, 539 1, 411, 539 1, 411, 539 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 1, 491, 375 1, 491, 375 1, 491, 375 93.00 04951 SHAFER MEDICAL CENTER 93.01 1, 380, 673 1, 380, 673 1, 380, 673 93.01 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 49, 392, 246 0 49, 392, 246 0 49, 392, 246 200. 00 1, 411, 539 201. 00 201.00 Less Observation Beds 1, 411, 539 1, 411, 539 47, 980, 707 0 47, 980, 707 0 47, 980, 707 202. 00 202.00 Total (see instructions)

From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/29/2021 4:15 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 092, 297 30.00 03000 ADULTS & PEDIATRICS 3, 092, 297 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 107, 510 1, 107, 510 31.00 04300 NURSERY 246, 128 246, 128 43.00 43.00 ANCILLARY SERVICE COST CENTERS 4, 147, 548 0.000000 50.00 12, 565, 537 16, 713, 085 0 239791 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 382, 284 1, 455, 030 1,837,314 0.631406 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 250,880 141, 832 392, 712 1. 761948 0.000000 52.00 05300 ANESTHESI OLOGY 1, 790, 788 0.047448 291.897 2.082.685 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 1, 164, 845 29, 172, 676 30, 337, 521 0. 146431 54 00 60.00 06000 LABORATORY 2, 549, 711 23, 717, 750 26, 267, 461 0. 152176 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 2, 667, 675 6, 073, 548 8, 741, 223 0. 219574 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 2, 445, 711 305, 863 2, 139, 848 0.549708 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 115, 754 816, 719 932, 473 0.410223 0.000000 67.00 06800 SPEECH PATHOLOGY 487, 489 0.360790 68.00 21, 390 466, 099 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 0.000000 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 595, 028 72.00 816, 263 2, 411, 291 0.519885 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 3, 891, 861 20, 565, 557 0.233076 73.00 16, 673, 696 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 08800 SHAFER MEDICAL CENTER 0.000000 88.00 16 678, 844 678,860 1.563215 88.00 88.01 08801 WOODLAWN MEDICAL PROFESSIONALS 1, 165 3, 126, 653 3, 127, 818 1. 140260 0.000000 88.01 88.02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA 0 1, 691, 309 1, 691, 309 1.355463 0.000000 88.02 08803 FULTON COUNTY MEDICAL CENTER - 100 E 0 356, 605 1.068095 0.000000 88.03 356, 605 88.03 08804 AKRON MEDICAL CLINIC 1. 541571 88 04 0 533,009 533,009 0.000000 88 04 88.05 08805 ARGOS MEDICAL CLINIC 0 1, 994, 267 1, 994, 267 1.156480 0.000000 88.05 09100 EMERGENCY 5, 783, 504 5, 935, 607 91.00 152, 103 0.581280 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 973, 539 0.000000 92.00 281, 480 1, 692, 059 0.715232 04950 WOODLAWN MEDICAL PROFESSIONALS 93.00 93.00 767, 409 767.409 1.943390 0.000000 93.01 04951 SHAFER MEDICAL CENTER 1, 410, 886 1, 410, 886 0.978586 0.000000 93.01 SPECIAL PURPOSE COST CENTERS 113 00 11300 LNTEREST EXPENSE 113 00 200.00 Subtotal (see instructions) 22, 265, 435 113, 864, 331 136, 129, 766 200.00 201.00 Less Observation Beds 201.00

22, 265, 435

113, 864, 331

136, 129, 766

202.00

202.00

Total (see instructions)

| Health Financial Systems                 | OSPI TAL      | In Lieu of Form CMS-2552-1 |                 |   |  |
|--|---------------|----------------------------|-----------------|---|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES |               | Provider CCN: 15-1313      | From 01/01/2020 | Worksheet C<br>Part I<br>Date/Time Pre<br>7/29/2021 4:1 |  |
|  |               | Title XIX                  | Hospi tal       | Cost  |  |
| Cost Center Description                  | PPS Inpatient |                            |                 |   |  |

|  |               |           |           | 7/29/2021 4: 15 pill |
|--|---------------|-----------|-----------|----------------------|
|  |               | Title XIX | Hospi tal | Cost                 |
| Cost Center Description                          | PPS Inpatient |           |           |                      |
|  | Ratio         |           |           |                      |
|  | 11. 00        |           |           |                      |
| INPATIENT ROUTINE SERVICE COST CENTERS           |               |           |           |                      |
| 30. 00   03000   ADULTS & PEDI ATRI CS           |               |           |           | 30.00                |
| 31.00 03100 INTENSIVE CARE UNIT                  |               |           |           | 31.00                |
| 43. 00   04300 NURSERY                           |               |           |           | 43.00                |
| ANCILLARY SERVICE COST CENTERS                   |               |           |           |                      |
| 50. 00 05000 OPERATING ROOM                      | 0. 000000     |           |           | 50.00                |
| 51.00   05100   RECOVERY ROOM                    | 0. 000000     |           |           | 51.00                |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM           | 0. 000000     |           |           | 52.00                |
| 53. 00   05300   ANESTHESI OLOGY                 | 0. 000000     |           |           | 53.00                |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 0. 000000     |           |           | 54.00                |
| 60. 00   06000   LABORATORY                      | 0. 000000     |           |           | 60.00                |
| 65. 00 06500 RESPIRATORY THERAPY                 | 0. 000000     |           |           | 65.00                |
| 66. 00 06600 PHYSI CAL THERAPY                   | 0. 000000     |           |           | 66.00                |
| 67. 00 06700 OCCUPATI ONAL THERAPY               | 0. 000000     |           |           | 67. 00               |
| 68. 00 06800 SPEECH PATHOLOGY                    | 0. 000000     |           |           | 68.00                |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0. 000000     |           |           | 71.00                |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 0. 000000     |           |           | 72.00                |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 0. 000000     |           |           | 73.00                |
| OUTPATIENT SERVICE COST CENTERS                  |               |           |           |                      |
| 88. 00 08800 SHAFER MEDICAL CENTER               | 0. 000000     |           |           | 88.00                |
| 88. 01 08801 WOODLAWN MEDICAL PROFESSIONALS      | 0. 000000     |           |           | 88. 01               |
| 88.02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA | 0. 000000     |           |           | 88. 02               |
| 88.03 08803 FULTON COUNTY MEDICAL CENTER - 100 E | 0. 000000     |           |           | 88. 03               |
| 88. 04   08804   AKRON MEDICAL CLINIC            | 0. 000000     |           |           | 88.04                |
| 88. 05 08805 ARGOS MEDICAL CLINIC                | 0. 000000     |           |           | 88. 05               |
| 91. 00   09100   EMERGENCY                       | 0. 000000     |           |           | 91.00                |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0. 000000     |           |           | 92.00                |
| 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS      | 0. 000000     |           |           | 93.00                |
| 93. 01 04951 SHAFER MEDICAL CENTER               | 0. 000000     |           |           | 93. 01               |
| SPECIAL PURPOSE COST CENTERS                     | 0.000000      |           |           | 75.01                |
| 113. 00 11300   NTEREST EXPENSE                  |               |           |           | 113. 00              |
| 200.00 Subtotal (see instructions)               |               |           |           | 200.00               |
| 201.00 Less Observation Beds                     |               |           |           | 201.00               |
| 202.00 Total (see instructions)                  |               |           |           | 202. 00              |
| 202. 00   10 tal (300 1113 ti dott 0113)         | 1             |           |           | 1202.00              |

| Health Financial Systems                              | WOODLAWN I   | HOSPI TAL     |              | In Lie                                      | u of Form CMS-2 | 2552-10 |
|---|--------------|---------------|--------------|---|-----------------|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT    | TAL COSTS    | Provi der C   |              | Period:<br>From 01/01/2020<br>To 12/31/2020 |                 |         |
|   |              |               | XVIII        | Hospi tal                                   | Cost            |         |
| 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                        |              | ,             |              |   |                 |         |
| 50. 00   05000   OPERATING ROOM                       | 248, 491     |               |              |   |                 |         |
| 51.00   05100   RECOVERY ROOM                         | 135, 786     |               | l .          |   |                 |         |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM                | 64, 100      |               |              |   |                 |         |
| 53. 00   05300   ANESTHESI OLOGY                      | 5, 198       |               |              |   |                 |         |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C              | 354, 481     |               |              |   | 4, 184          |         |
| 60. 00  06000   LABORATORY                            | 110, 257     |               |              |   | 3, 984          |         |
| 65. 00   06500   RESPI RATORY THERAPY                 | 124, 109     |               |              |   |                 |         |
| 66. 00   06600 PHYSI CAL THERAPY                      | 87, 158      |               |              |   | 4, 307          |         |
| 67. 00 06700 OCCUPATI ONAL THERAPY                    | 3, 713       |               |              |   |                 |         |
| 68. 00 06800 SPEECH PATHOLOGY                         | 1, 738       | 487, 489      | 0. 00356     | 5 12, 186                                   | 43              | 68.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT       | 0            |               |              |   | 0               |         |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS            | 8, 375       |               |              |   | 2, 294          |         |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                | 76, 008      | 20, 565, 557  | 0. 00369     | 6 1, 283, 471                               | 4, 744          | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                       |              |               |              |   |                 |         |
| 88. 00   08800   SHAFER MEDICAL CENTER                | 50, 562      |               |              |   | 0               |         |
| 88. 01   08801   WOODLAWN MEDICAL PROFESSIONALS       | 162, 899     | 3, 127, 818   | 0. 05208     | 1 0   | 0               | 88. 01  |
| 88. 02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA     | 13, 811      | 1, 691, 309   | 0. 00816     | 6 0   | 0               | 88. 02  |
| 88. 03   08803   FULTON COUNTY MEDICAL CENTER - 100 E | 2, 362       | 356, 605      | 0. 00662     | 4 0   | 0               | 88. 03  |
| 88. 04   08804 AKRON MEDICAL CLINIC                   | 37, 682      | 533, 009      | 0. 07069     | 7 0   | 0               | 88. 04  |
| 88. 05   08805   ARGOS MEDICAL CLINIC                 | 89, 822      | 1, 994, 267   | 0. 04504     | .0  | 0               | 88. 05  |
| 91. 00   09100   EMERGENCY                            | 194, 951     | 5, 935, 607   | 0. 03284     | 4 8, 313                                    | 273             | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART       | 122, 996     | 1, 973, 539   | 0. 06232     | 3 21, 625                                   | 1, 348          | 92.00   |
| 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS            | 210, 531     | 767, 409      | 0. 27434     | 0   | 0               | 93.00   |
| 93.01 04951 SHAFER MEDICAL CENTER                     | 87, 567      | 1, 410, 886   | 0. 06206     | 5 0   | 0               | 93. 01  |
| 200.00 Total (lines 50 through 199)                   | 2, 192, 597  | 131, 683, 831 |              | 6, 137, 817                                 | 66, 194         | 200.00  |

| Health Financial Systems |   | WOODLAWN HOSPITAL                                     | In Lieu of Form CMS-2552-10 |
|--------------------------|---|---|-----------------------------|
|                          | ADDODTI ONMENT OF INDATIENT /OUTDATIENT | ANCILLADY SERVICE OTHER DASS   Drovi dor CCN: 15 1212 | Pori od: Workshoot D        |

Peri od: Worksheet D Part IV Date/Time Prepared: 7/20/2001 4:15 pm THROUGH COSTS

|        |  |               |               |          |               | 7/29/2021 4:1 | 5 pm    |
|--------|--|---------------|---------------|----------|---------------|---------------|---------|
|        |  |               | Title         | XVIII    | Hospi tal     | Cost          |         |
|        | 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             |               |               |          |               |               |         |
| 50.00  | 05000 OPERATING ROOM                       | 0             | 0             | (        | 0             | 0             |         |
| 51.00  | 05100  RECOVERY ROOM                       | 0             | 0             | (        | 0             | 0             | 51.00   |
| 52.00  | 05200 DELIVERY ROOM & LABOR ROOM           | 0             | 0             | (        | 0             | 0             | 52.00   |
| 53.00  | 05300  ANESTHESI OLOGY                     | 0             | 0             | (        | 0             | 0             | 53.00   |
| 54.00  | 05400  RADI OLOGY-DI AGNOSTI C             | 0             | 0             | (        | 0             | 0             | 54.00   |
| 60.00  | 06000 LABORATORY                           | 0             | 0             | (        | 0             | 0             | 60.00   |
| 65.00  | 06500 RESPI RATORY THERAPY                 | 0             | 0             | (        | 0             | 0             | 65. 00  |
| 66.00  | 06600 PHYSI CAL THERAPY                    | 0             | 0             | (        | 0             | 0             | 66. 00  |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                | 0             | 0             | (        | 0             | 0             | 67.00   |
| 68. 00 | 06800 SPEECH PATHOLOGY                     | 0             | 0             | (        | 0             | 0             | 68. 00  |
|        | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0             | 0             | (        | 0             | 0             | 71.00   |
| 72.00  | 07200 I MPL. DEV. CHARGED TO PATIENTS      | 0             | 0             | (        | 0             | 0             | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            | 0             | 0             | (        | 0             | 0             | 73. 00  |
|        | OUTPATIENT SERVICE COST CENTERS            | ı             |               |          |               |               |         |
| 88. 00 | 08800 SHAFER MEDICAL CENTER                | 0             | 0             | (        | 0             | 0             | 88. 00  |
| 88. 01 | 08801 WOODLAWN MEDICAL PROFESSIONALS       | 0             | 0             | (        | 0             | 0             | 88. 01  |
| 88. 02 | 08802 FULTON COUNTY MEDICAL CENTER- 700 MA | 0             | 0             | (        | 0             | 0             | 88. 02  |
| 88. 03 | 08803 FULTON COUNTY MEDICAL CENTER - 100 E | 0             | 0             | (        | 0             | 0             | 88. 03  |
| 88. 04 | 08804 AKRON MEDICAL CLINIC                 | 0             | 0             | (        | 0             | 0             | 88. 04  |
| 88. 05 | 08805 ARGOS MEDICAL CLINIC                 | 0             | 0             | (        | 0             | 0             | 88. 05  |
| 91. 00 | 09100 EMERGENCY                            | 0             | 0             | (        | 0             | 0             | 91.00   |
|        | 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 0             |               | (        |               | 0             | 92.00   |
|        | 04950 WOODLAWN MEDICAL PROFESSIONALS       | 0             | 0             | (        | 0             | 0             | 93. 00  |
|        | 04951 SHAFER MEDICAL CENTER                | 0             | 0             | (        | 0             | 0             |         |
| 200.00 | Total (lines 50 through 199)               | 0             | 0             |          | 0             | 0             | 200. 00 |

| Health Financial Systems |                                       | WOODLAWN HOSPITAL |            |                        | In Lieu of Form CMS-2552-10 |             |
|--------------------------|---------------------------------------|-------------------|------------|------------------------|-----------------------------|-------------|
|                          | ADDODELONMENT OF INDATIENT/OUTDATIENT | ANCLLLADV SEDVICE | OTHED DACC | Drovi don CCN, 1E 1212 | Dori od:                    | Workshoot D |

Period: | Workshee From 01/01/2020 | Part IV To 12/31/2020 | Date/Tim THROUGH COSTS Date/Time Prepared: 7/29/2021 4:15 pm Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost 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 50.00 05000 OPERATING ROOM 0 16, 713, 085 0.000000 50.00 05100 RECOVERY ROOM 0 0 1, 837, 314 0.000000 51.00 51.00 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 392, 712 52.00 0 52.00 05300 ANESTHESI OLOGY 0 0 2, 082, 685 53.00 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 30, 337, 521 0.000000 54.00 60.00 06000 LABORATORY 0 26, 267, 461 0.000000 60.00 06500 RESPIRATORY THERAPY 65.00 0 0 8, 741, 223 0.000000 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 2, 445, 711 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 932, 473 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 487, 489 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0.000000 71.00 C 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2, 411, 291 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 20, 565, 557 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 SHAFER MEDICAL CENTER 0 678, 860 0.000000 88.00 88.01 08801 WOODLAWN MEDICAL PROFESSIONALS 0 0 0 3, 127, 818 0.000000 88.01 08802 FULTON COUNTY MEDICAL CENTER- 700 MA 88.02 00000000 0 0 1, 691, 309 0.000000 88.02 08803 FULTON COUNTY MEDICAL CENTER - 100 E 0 0 0.000000 88 03 88 03 356, 605 0 88.04 08804 AKRON MEDICAL CLINIC 0 533,009 0.000000 88.04 08805 ARGOS MEDICAL CLINIC 1, 994, 267 0.000000 88.05

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5, 935, 607

1, 973, 539

1, 410, 886

131, 683, 831

767, 409

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0.000000

0.000000

91.00

92.00

93.00

93.01

200.00

09100 EMERGENCY

93. 01 04951 SHAFER MEDICAL CENTER

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS

91.00

| Health Financial Systems |                                       | WOODLAWN HOSPITAL |            |                        | In Lieu of Form CMS-2552-10 |             |
|--------------------------|---------------------------------------|-------------------|------------|------------------------|-----------------------------|-------------|
|                          | ADDODELONMENT OF INDATIENT/OUTDATIENT | ANCLLLADV SEDVICE | OTHED DACC | Drovi don CCN, 1E 1212 | Dori od:                    | Workshoot D |

Period: From 01/01/2020 To 12/31/2020 Worksheet Part IV THROUGH COSTS Date/Time Prepared: 7/29/2021 4:15 pm Title XVIII Hospi tal Cost Cost Center Description I npati ent Outpati ent Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Charges Pass-Through Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 1, 388, 825 50 00 05000 OPERATING ROOM 0 51.00 05100 RECOVERY ROOM 0.000000 111,832 0 51.00 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 1, 548 0 05300 ANESTHESI OLOGY 0.000000 90, 905 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 358, 074 54.00 0.000000 0 54.00 60.00 06000 LABORATORY 0.000000 949, 351 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 1, 088, 700 0 0 65.00 06600 PHYSI CAL THERAPY 120, 854 0 66.00 0.000000 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 41, 568 0 67.00 06800 SPEECH PATHOLOGY 0.000000 12, 186 0 0 68.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 660, 565 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1, 283, 471 0 73.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0 88.00 08800 SHAFER MEDICAL CENTER 0 0 0 88.00 88. 01 08801 WOODLAWN MEDICAL PROFESSIONALS 0.000000 0 0 88.01 08802 FULTON COUNTY MEDICAL CENTER- 700 MA 0.000000 0 0 88.02 88.02 0 0 0 0 0 0 08803 FULTON COUNTY MEDICAL CENTER - 100 E 0 0.000000 88.03 88.03 0 0 08804 AKRON MEDICAL CLINIC 0 88.04 0.000000 0 0 88.04 88.05 08805 ARGOS MEDICAL CLINIC 0.000000 C 0 88.05 09100 EMERGENCY 8, 313 0 91.00 91.00 0.000000 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 21, 625 Ω 92.00 0 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.00 0.000000 0

0.000000

6, 137, 817

0 93.01 0 200.00

93. 01 04951 SHAFER MEDICAL CENTER

Total (lines 50 through 199)

In Lieu of Form CMS-2552-10 Health Financial Systems WOODLAWN HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1313 Peri od: Worksheet D From 01/01/2020 Part V 12/31/2020 Date/Time Prepared: 7/29/2021 4:15 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 096, 599 0. 239791 50.00 05100 RECOVERY ROOM 0 51.00 0.631406 0 206, 172 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 1. 761948 0 3, 106 0 52.00 53.00 05300 ANESTHESI OLOGY 0.047448 358, 975 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.146431 7, 461, 675 0 54.00 06000 LABORATORY 60.00 0.152176 5, 739, 855 0 60.00 06500 RESPIRATORY THERAPY 65.00 0. 219574 0 1, 697, 357 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.549708 535, 302 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 410223 0 240, 717 0 67.00 06800 SPEECH PATHOLOGY 0.360790 0 68.00 68.00 9, 916 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 519885 0 0 72.00 184, 707 72.00 07300 DRUGS CHARGED TO PATIENTS 6, 510, 490 1, 230 73.00 73 00 0.233076 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 SHAFER MEDICAL CENTER 88.00 08801 WOODLAWN MEDICAL PROFESSIONALS 88. 01 88.01 08802 FULTON COUNTY MEDICAL CENTER- 700 MA 88 02 88 02 08803 FULTON COUNTY MEDICAL CENTER - 100 E 88.03 88.03 08804 AKRON MEDICAL CLINIC 88.04 88.05 08805 ARGOS MEDICAL CLINIC 88.05 09100 EMERGENCY 0.581280 1, 159, 315 0 91.00 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.715232 305, 991 0 0 92.00 176 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 1.943390 5, 788 0 93.00 93. 01 04951 SHAFER MEDICAL CENTER 0. 978586 20, 657 93.01 0 0

26, 536, 622

26, 536, 622

1.406

1, 406

0 200.00

0 202.00

201.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

200.00

201.00

| Health Financial Systems    | WOODLAWN HOS                           | In Lieu                | of Form CMS-2552-10         |                       |
|-----------------------------|--|------------------------|-----------------------------|-----------------------|
| APPORTI ONMENT OF MEDI CAL, | OTHER HEALTH SERVICES AND VACCINE COST | Provi der CCN: 15-1313 | Peri od:<br>From 01/01/2020 | Worksheet D<br>Part V |
|                             |  |                        |                             | Data/Time Dropared    |

|  |             |               |       | To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |         |
|--|-------------|---------------|-------|---------------|--------------------------------|---------|
|  |             | Title         | XVIII | Hospi tal     | Cost                           |         |
|  | Cos         | sts           |       |               |                                |         |
| Cost Center Description                          | Cost        | Cost          |       |               |                                |         |
|  | Rei mbursed | Rei mbursed   |       |               |                                |         |
|  | Servi ces   | Services Not  |       |               |                                |         |
|  | Subject To  | Subject To    |       |               |                                |         |
|  |             | Ded. & Coins. |       |               |                                |         |
|  | (see inst.) | (see inst.)   |       |               |                                |         |
|  | 6. 00       | 7. 00         |       |               |                                |         |
| ANCILLARY SERVICE COST CENTERS                   |             |               |       |               |                                |         |
| 50. 00 05000 OPERATING ROOM                      | 502, 746    |               |       |               |                                | 50.00   |
| 51.00   05100   RECOVERY ROOM                    | 130, 178    |               |       |               |                                | 51.00   |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM           | 5, 473      |               |       |               |                                | 52.00   |
| 53. 00   05300   ANESTHESI OLOGY                 | 17, 033     |               |       |               |                                | 53.00   |
| 54. 00   05400   RADI OLOGY-DI AGNOSTI C         | 1, 092, 621 |               |       |               |                                | 54.00   |
| 60. 00   06000   LABORATORY                      | 873, 468    | 0             |       |               |                                | 60.00   |
| 65. 00   06500   RESPI RATORY THERAPY            | 372, 695    |               |       |               |                                | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                   | 294, 260    | 0             |       |               |                                | 66.00   |
| 67. 00 06700 OCCUPATI ONAL THERAPY               | 98, 748     | 0             |       |               |                                | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                     | 3, 578      | 0             |       |               |                                | 68. 00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 0           | 0             |       |               |                                | 71.00   |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS       | 96, 026     | 0             |       |               |                                | 72.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS            | 1, 517, 439 | 287           |       |               |                                | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                  |             |               |       |               |                                |         |
| 88.00 08800 SHAFER MEDICAL CENTER                |             |               |       |               |                                | 88. 00  |
| 88. 01   08801   WOODLAWN MEDICAL PROFESSIONALS  |             |               |       |               |                                | 88. 01  |
| 88.02 08802 FULTON COUNTY MEDICAL CENTER- 700 MA |             |               |       |               |                                | 88. 02  |
| 88.03 08803 FULTON COUNTY MEDICAL CENTER - 100 E |             |               |       |               |                                | 88. 03  |
| 88.04 08804 AKRON MEDICAL CLINIC                 |             |               |       |               |                                | 88. 04  |
| 88. 05 08805 ARGOS MEDICAL CLINIC                |             |               |       |               |                                | 88. 05  |
| 91. 00   09100   EMERGENCY                       | 673, 887    | l ol          |       |               |                                | 91.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART  | 218, 855    | o             |       |               |                                | 92.00   |
| 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS      | 11, 248     | 342           |       |               |                                | 93.00   |
| 93. 01 04951 SHAFER MEDICAL CENTER               | 20, 215     |               |       |               |                                | 93. 01  |
| 200.00 Subtotal (see instructions)               | 5, 928, 470 | 629           |       |               |                                | 200.00  |
| 201.00 Less PBP Clinic Lab. Services-Program     | 0           |               |       |               |                                | 201.00  |
| Only Charges                                     |             |               |       |               |                                |         |
| 202.00   Net Charges (line 200 - line 201)       | 5, 928, 470 | 629           |       |               |                                | 202. 00 |

| Health Financial Systems                    | WOODLAWN HOSPITAL                          | In Lie                                       | u of Form CMS-2             | 2552-10 |
|---|--|--|-----------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     | Provi der CCN: 15-1313                     | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet D-1 Date/Time Pre | pared:  |
|   | Title XVIII                                | Hospi tal                                    | 7/29/2021 4:1<br>Cost       | 5 piii  |
| Cost Center Description                     |  |  |                             |         |
|   |  |  | 1. 00                       |         |
| PART I - ALL PROVIDER COMPONENTS            |  |  |                             |         |
| I NPATI ENT DAYS                            |  |  |                             | 1       |
| 1 00 Inpatient days (including private room | days and swing-bed days excluding newborn) |  | 3 100                       | 1 1 00  |

|                  | Title XVIII Hospital  | Cost             |                   |
|------------------|---|------------------|-------------------|
|                  | 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)  | 3, 100           | 1.00              |
| 2.00             | Inpatient days (including private room days, excluding swing-bed and newborn days)  | 2, 934           | 2.00              |
| 3. 00            | Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.                              | 0                | 3. 00             |
| 4. 00            | Semi-private room days (excluding swing-bed and observation bed days)   | 2, 159           | 4.00              |
| 5. 00            | Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost   | 96               |                   |
|                  | 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)   | 70               | 7 00              |
| 7. 00            | Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period   | 70               | 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   | 890              | 9. 00             |
| 10. 00           | newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)                               | 96               | 10.00             |
| 10.00            | through December 31 of the cost reporting period (see instructions)   | 70               | 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)   | 0                | 12.00             |
| 13. 00           | through December 31 of the cost reporting period  Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)           | 0                | 13. 00            |
| 13.00            | after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   | O                | 13.00             |
| 14.00            | Medically necessary private room days applicable to the Program (excluding swing-bed days)  | 0                | 14.00             |
| 15.00            | Total nursery days (title V or XIX only)  | 0                | 15.00             |
| 16. 00           | Nursery days (title V or XIX only)  | 0                | 16.00             |
| 17. 00           | SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost   |                  | 17. 00            |
| 17.00            | reporting period  |                  | 17.00             |
| 18.00            | Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost   |                  | 18.00             |
|                  | reporting period  |                  |                   |
| 19. 00           | Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost  | 129. 14          | 19. 00            |
| 20. 00           | reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost   | 129. 14          | 20. 00            |
| 20.00            | reporting period  | 127. 14          | 20.00             |
| 21.00            | Total general inpatient routine service cost (see instructions)   | 5, 527, 712      | 21.00             |
| 22. 00           | Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line   | 0                | 22.00             |
| 22 00            | 5 x line 17) Swing had cost applicable to SNE type corvices after December 21 of the cost reporting period (Line 4)   | 0                | 23. 00            |
| 23. 00           | Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6   x line 18)  | U                | 23.00             |
| 24.00            | Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line  | 9, 040           | 24.00             |
|                  | 7 x line 19)  |                  |                   |
| 25. 00           | Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8  | 0                | 25. 00            |
| 26. 00           | x line 20)<br>  Total swing-bed cost (see instructions)   | 183, 889         | 26. 00            |
| 27. 00           | General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  | 5, 343, 823      |                   |
|                  | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  | 5,5.5,525        |                   |
|                  | General inpatient routine service charges (excluding swing-bed and observation bed charges)   | 0                |                   |
| 29.00            | Private room charges (excluding swing-bed charges)  | 0                |                   |
| 30. 00<br>31. 00 | Semi-private room charges (excluding swing-bed charges)<br>  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)                          | 0. 000000        | 30. 00<br>31. 00  |
| 32.00            | Average private room per diem charge (line 29 ÷ line 3)   | 0.00000          |                   |
| 33.00            | Average semi-private room per diem charge (line 30 ÷ line 4)  | 0. 00            |                   |
| 34.00            | Average per diem private room charge differential (line 32 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             |                   |
| 36.00            | Private room cost differential adjustment (line 3 x line 35)  | E 242 922        | 36.00             |
| 37. 00           | General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)                                       | 5, 343, 823      | 37. 00            |
|                  | PART II - HOSPITAL AND SUBPROVIDERS ONLY  |                  |                   |
|                  | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   |                  |                   |
| 38.00            | Adjusted general inpatient routine service cost per diem (see instructions)   | 1, 821. 34       |                   |
| 39.00            | Program general inpatient routine service cost (line 9 x line 38)   | 1, 620, 993      |                   |
| 40. 00<br>41. 00 | Medically necessary private room cost applicable to the Program (line 14 x line 35)  Total Program general inpatient routine service cost (line 39 + line 40) | 0<br>1, 620, 993 | 40. 00<br>41. 00  |
| 41.00            | Total Trogram general impatient foutthe service cost (Tine 37 + Tine 40)  | 1, 020, 793      | <del>+</del> 1.00 |

| Heal th          | n Financial Systems WOODLAWN HOSPITAL In   | Lieu of Form CMS-2        | 2552-10          |
|------------------|--|---------------------------|------------------|
| COMPUT           | TATION OF INPATIENT OPERATING COST Provider CCN: 15-1313 Period: From 01/01/2  | Worksheet D-1             |                  |
|                  | To 12/31/2   | 020 Date/Time Pre         |                  |
|                  | Title XVIII Hospital   | 7/29/2021 4:1<br>Cost     | 5 piii           |
|                  | Cost Center Description Total Total Average Per Program Da   | <i>y</i>   <i>y</i>       |                  |
|                  | Inpatient   Inpatient   Diem (col. 1   Cost   Days + col. 2)   | (col. 3 x col. 4)         |                  |
| 10.00            | 1.00 2.00 3.00 4.00  | 5. 00                     | 10.00            |
| 42.00            | NURSERY (title V & XIX only) 0 0 0.00 Intensive Care Type Inpatient Hospital Units   | 0 0                       | 42.00            |
| 43.00            | INTENSIVE CARE UNIT 1, 187, 403 391 3, 036. 84   | 160 485, 894              | 43.00            |
| 44.00            | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT  |                           | 44. 00<br>45. 00 |
| 46. 00           |  |                           | 46.00            |
| 47. 00           | OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  |                           | 47.00            |
|                  | COST Center Description  | 1.00                      |                  |
| 48.00            |  | 1, 597, 376               | 1                |
| 49.00            | Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS   | 3, 704, 263               | 49. 00           |
| 50.00            |  | and 0                     | 50. 00           |
| 51. 00           | Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts  | 11 0                      | 51.00            |
|                  | and IV)  |                           |                  |
| 52. 00<br>53. 00 | Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and              | 0                         | 52. 00<br>53. 00 |
| 00.00            | medical education costs (line 49 minus line 52)  |                           | 00.00            |
| 54.00            | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges   | 0                         | 54.00            |
| 55. 00           |  | 0.00                      |                  |
| 56. 00<br>57. 00 |  | 0                         | 56. 00<br>57. 00 |
| 58. 00           |  | 0                         | 58.00            |
| 59. 00           |  | the 0.00                  | 59. 00           |
| 60.00            | market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  | 0.00                      | 60.00            |
| 61. 00           |  | by 0                      | 61. 00           |
|                  | which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)          |                           |                  |
| 62.00            |  | 0                         |                  |
| 63. 00           | Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST   | 0                         | 63.00            |
| 64. 00           | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (  | See 174, 849              | 64. 00           |
| 65. 00           | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See                                   | 9 0                       | 65. 00           |
| 66. 00           | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For                                   | 174, 849                  | 66.00            |
|                  | CAH (see instructions)   |                           |                  |
| 67. 00           | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting peri (line 12 x line 19)   | od 0                      | 67.00            |
| 68. 00           | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)   | 0                         | 68. 00           |
| 69. 00           | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  | 0                         | 69. 00           |
| 70.00            | PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) |                           | 70.00            |
| 71. 00<br>72. 00 |  |                           | 71. 00<br>72. 00 |
| 73. 00           |  |                           | 73.00            |
| 74. 00<br>75. 00 |  | ımp                       | 74.00            |
| 75.00            | Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, colu 26, line 45)  | 111111                    | 75. 00           |
| 76.00            |  |                           | 76.00            |
| 77. 00<br>78. 00 | , ,  |                           | 77. 00<br>78. 00 |
| 79.00            |  |                           | 79.00            |
| 80. 00<br>81. 00 |  |                           | 80. 00<br>81. 00 |
| 82.00            | Inpatient routine service cost limitation (line 9 x line 81)   |                           | 82.00            |
| 83. 00<br>84. 00 |  | -                         | 83. 00<br>84. 00 |
| 85.00            | Utilization review - physician compensation (see instructions)   |                           | 85.00            |
| 86. 00           | Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST                                      |                           | 86. 00           |
| 87. 00           | Total observation bed days (see instructions)  |                           | 87.00            |
| 88. 00<br>89. 00 | Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)                                      | 1, 821. 34<br>1, 411, 539 | 1                |
| _ /. 00          | 1  | 1 ., , , , . , . , . , .  | , 55             |

| Health Financial Systems                    | WOODLAWN H | IOSPI TAL    |            | In Lie                           | u of Form CMS-2 | 2552-10 |
|---|------------|--------------|------------|----------------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |            | Provi der CO |            | Peri od:                         | Worksheet D-1   |         |
|   |            |              |            | From 01/01/2020<br>To 12/31/2020 |                 |         |
|   |            |              | XVIII      | 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                 | 481, 660   | 5, 527, 712  | 0. 08713   | 1, 411, 539                      | 122, 996        | 90.00   |
| 91.00 Nursing School cost                   | 0          | 5, 527, 712  | 0.00000    | 0 1, 411, 539                    | 0               | 91.00   |
| 92.00 Allied health cost                    | 0          | 5, 527, 712  | 0.00000    | 0 1, 411, 539                    | 0               | 92.00   |
| 93.00 All other Medical Education           | o          | 5, 527, 712  | 0. 00000   | 1, 411, 539                      | 0               | 93. 00  |

| Health Financial Systems                       | WOODLAWN HOSPITAL      | In lie                      | u of Form CMS-2             | 0552_10 |
|--|------------------------|-----------------------------|-----------------------------|---------|
|  |                        |                             |                             |         |
| COMPUTATION OF INPATIENT OPERATING COST        | Provi der CCN: 15-1313 | Peri od:<br>From 01/01/2020 | Worksheet D-1               |         |
|  |                        | To 12/31/2020               | Date/Time Pre 7/29/2021 4:1 |         |
|  | Title XIX              | Hospi tal                   | Cost                        |         |
| Cost Center Description                        |                        |                             |                             |         |
|  |                        |                             | 1. 00                       |         |
| PART I - ALL PROVIDER COMPONENTS               |                        |                             |                             |         |
| I NPATI ENT DAYS                               |                        |                             |                             |         |
| 1.00 Inpatient days (including private room of | 3, 100                 | 1.00                        |                             |         |
| 2.00 Inputiont days (including private room of | 2 024                  | 2 00                        |                             |         |

| PART I - ALL PROVIDER COMPONENTS   |        | Cost Costor Decembries  | LOST      |        |
|--|--------|---|-----------|--------|
| PART 1 - ALL PROVIDER COMPONENTS   |        | Cost Center Description   | 1 00      |        |
| Impattent days (Including private room days and swing-bed days, excluding neroborn)   3,100   1,000   1,000   1,000   2,944   2,000   1,000   2,000    |        | PART I - ALL PROVIDER COMPONENTS  | 11.00     |        |
| Inpatient days (Including private room days, excluding swing-bed and newborn days)   2,934   2,000     |        |   |           |        |
| Private room days (excluding sking-bed and observation bed days). If you have only private room days.  do do not complete this Time.  2 159  4 00 Semi-private room days (excluding swing-bed and observation bed days).  Total swing-bed SWF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this Line).  Total swing-bed SWF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this Line).  Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this Line).  Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if cal endary year, enter 0 on this Line).  Total swing-bed NF type inpattent days (including private room days) after December 31 of the cost reporting period (if called the private room days) after December 31 of the cost reporting period (including private room days).  Total swing-bed NF type inpattent days applicable to title XVIII only (including private room days).  Total problems 31 of the cost reporting period (it called to the Program (excluding private room days) after December 31 of the cost reporting period (it called to the problems and private room days).  Total problems 31 of the cost reporting period (if called year, enter 0 on this Line).  December 31 of the cost reporting period (if called year, enter 0 on this Line).  Well and the problems 31 of the cost reporting period (if called year) are, enter 0 on this Line).  Well and the problems 31 of the cost reporting period (if called year) are, enter 0 on this Line).  Well and the problems 31 of the cost reporting period (if called year) are, enter 0 on this Line).  Well and the problems 31 of the cost reporting period (if called year) are, enter 0 on this Line).  Well and the problems 31 of the cost reporting period (in called year) are year |        |   |           | 1.00   |
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| 5.00 Total swin,p-bed SRF type inpatient days (including private room days) through becember 31 of the cost reporting period of the claim of the cost reporting period of the claim of the cost of the cost reporting period of the claim of the cost reporting period of the cost repo | 3.00   |   | ٥         | 3.00   |
| reporting period (1r calendar year, enter 0 on this line)  7. 00 Total saving-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (1r calendar year, enter 0 on this line)  8. 00 Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (1r calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days) after December 31 of the cost reporting period (1r calendar year, enter 0 on this line)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) set of through December 31 of the cost reporting period (1r calendar year)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after SNF type inpatient days applicable to title XVIII only (including private room days) after SNF type inpatient days applicable to title XVIII only (including private room days) after SNF type inpatient days applicable to title XVIII only (including private room days) after SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (1 titles V or XIX only (including private room days) after December 31 of the cost reporting period (1 titles V or XIX only (including private room days) after December 31 of the cost reporting period (1 titles V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days (title V or XIX only) 321 lis. 00 (1 total nurser) days ( | 4.00   |   | 2, 159    | 4.00   |
| 6.00 Total swing-bed SMF 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 Total swing-bed NF type inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Into a 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)  8.00 Total inpatient days including private room days after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (see instructions)  10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 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 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 VVIII XX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Farlar December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessaary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Total nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days)  18.00 Medicare rate for swing-bed NF services applicable to services | 5. 00  |   | 96        | 5. 00  |
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| 70 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) reporting period (if Calendar year, enter 0 on this line) reporting period (if Calendar year, enter 0 on this line) reporting period (if Calendar year, enter 0 on this line) reporting period (if Calendar year, enter 0 on the cost reporting period (if Calendar year) reporting period (if Calendar year, enter 0 on this line) reporting period (if Calendar year, enter 0 on this li | 7.00   |   | 70        | 7. 00  |
| reporting period (if Calendar year, enter 0 on this line)  10 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10 Os wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) and through December 31 of the cost reporting period (see instructions)  12 Os 3 ing-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)  13 OS 3 ing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14 ON Medically necessary private room days applicable to XIX only (including private room days)  15 ON Total nursery days (title V or XIX only)  16 ON Mursery days (title V or XIX only)  17 ON Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18 ON Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  19 ON Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  19 ON Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  19 ON Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (line of the cost reporting period (li | 0.00   |   |           | 0.00   |
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| through December 31 of the cost reporting period (see Instructions)  11.00 Single bd SNF type inpatient days applicable to title V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Single bd NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Single bd NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Modically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Norsery 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  18.00 Modicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Modicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Modicard rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Swing-bed cost swing-bed cost (see instructions)  20.00 Single December 31 of SNF type services after December 31 of the cost reporting period (line Swing-bed c |        |   |           |        |
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| 17.00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18.00   18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   19.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   19.00    | 16.00  |   | 0         | 16.00  |
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| reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 129. 14 19.00 Nedicaid rate for swing-bed NF services applicable to services after December 31 of the cost 129. 14 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 129. 14 20.00 Negroring period Total general inpatient routine service cost (see instructions) 5.527,712 21.00 Negroring period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 24.00 Negroring Negror |        | reporting period  |           |        |
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| reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 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 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 3x line 31)  35.00 Average per diem private room cost differential (line 3x line 31)  36.00 Private room cost differential dijustment (line 3 x line 35)  37.00 Program general inpatient routine service cost (line 9x line 38)  38.00 Adjusted general inpatient routine service cost (line 9x line 38)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9x line 38)  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  | . ,    |   |           | .,,,,, |
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| 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)  24.00 X line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line y 9,040 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line y 9,040 24.00 7 x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average perivate room per diem charge (line 29 + line 3)  33.00 Average perivate room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823 7)  37.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x lin | 21 00  |   | 5 527 712 | 21 00  |
| 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 9,040 24.00 7 x line 19)  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)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service charges (excluding swing-bed sand observation bed charges)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average perivate room per diem charge (line 29 + line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823)  37.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Adjusted 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)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)   |        |   |           | 22.00  |
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| 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823) 38.00 Adjusted 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) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 45.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)   | 24 00  | , ,   | 9 040     | 24 00  |
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| 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 36)  30.00 Average per diem private room cost differential (line 3 x line 36)  30.00 Average per diem private room cost differential (line 3 x line 36)  30.00 Average per diem private room cost differential (line 3 x line 36)  30.00 Average per diem pri | 25. 00 |   | 0         | 25. 00 |
| 27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average private room per diem charge (line 29 + line 3)  33. 00 Average semi-private room per diem charge (line 30 + line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  1,821.34 38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  1,821.34 38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,821.34 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  27. 00 Adverage per diem private room cost applicable to the Program (line 14 x line 35)  | 24 00  |   | 102 000   | 24 00  |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  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)  40.00 Variable charges  40.00 Variable charg |        |   |           |        |
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| 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823) 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 (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00 30.00 31.00 0.00 32.00 0.00 32.00 0.00 34.00 0.00 0.00 0.00 0.00 0.00   |        | General inpatient routine service charges (excluding swing-bed and observation bed charges) | 0         | 28. 00 |
| 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823)  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)  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)  0.00 0.00 32.00  32.00 0.00 33.00  0.00 33.00  0.00 33.00  0.00 33.00  0.00 33.00  0.00 34.00  37.00 0.00  37.00 0.00  37.00 0.00  38.00 0.00  38.00 0.00  38.00 0.00  39.00 Program general inpatient routine service cost per diem (see instructions)  1,821.34 0.00  40.00  |        |   |           |        |
| 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  1,821.34 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 34.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 40.00   |        |   |           |        |
| 33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  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 .00 33.00  34.00 34.00  35.00 36.00  37.00 26.00  36.00 37.00  37.00 36.00  37.00 |        |   |           | •      |
| 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823 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)  37.00 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)  0.00 34.00 35.00 35.00 36.00 36.00 37.00 36.0 |        |   |           | •      |
| 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 5, 343, 823 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 821. 34 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 127, 494 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00   |        |   |           | •      |
| 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 5, 343, 823 and  |        |   |           | •      |
| 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  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)  37.00  5, 343, 823  37.00  40.00   |        | , , ,   |           |        |
| 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  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)  0 40.00   |        | i i i i i i i i i i i i i i i i i i i   | - 1       |        |
| PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  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)  7.821.34 38.00 127,494 39.00 127,4 |        | 27 minus line 36)   |           |        |
| 38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,821.34 38.00  Program general inpatient routine service cost (line 9 x line 38)  127,494 39.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00  |        |   |           |        |
| 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)  127,494 39.00 40.00   | 20. 20 |   | 1 004 01  | 20.00  |
| 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00  |        |   |           |        |
|  |        |   |           |        |
|  |        |   |           |        |

|  | Financial Systems   | WOODLAWN H           |                      | ON 45 4040 B                |  | u of Form CMS-2           |                            |
|--|---|----------------------|----------------------|-----------------------------|--|---------------------------|----------------------------|
| COMPUT   | ATION OF INPATIENT OPERATING COST   |                      | Provi der C          | F                           | eriod:<br>rom 01/01/2020<br>o 12/31/2020 | Date/Time Pre             | pared:                     |
|  |   |                      | Ti +I                | e XIX                       | Hospi tal                                | 7/29/2021 4:1<br>Cost     | 5 pm                       |
|  | Cost Center Description   | Total<br>I npati ent | Total<br>I npati ent | Average Per<br>Diem (col. 1 | Program Days                             | Program Cost<br>(col. 3 x |                            |
|  |   | Cost                 | Days                 | ÷ col . 2)                  | 4.00                                     | col . 4)                  |                            |
| 42 00  | NURSERY (title V & XIX only)  | 1. 00<br>246, 941    | 2. 00                | 3. 00<br>769. 29            | 4.00                                     | 5. 00                     | 42. 00                     |
|  | Intensive Care Type Inpatient Hospital Units  |                      | <u></u> :            |                             | 1  |                           | 1                          |
| 43. 00<br>44. 00<br>45. 00   | INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT   | 1, 187, 403          | 391                  | 3, 036. 84                  | 0  | 0                         | 43. 00<br>44. 00<br>45. 00 |
|  | SURGICAL INTENSIVE CARE UNIT  |                      |                      |                             |  |                           | 46. 00                     |
| 47. 00   | OTHER SPECIAL CARE (SPECIFY)  Cost Center Description   |                      |                      |                             |  |                           | 47. 00                     |
|  | cost center bescription   |                      |                      |                             |  | 1. 00                     |                            |
| 48. 00   | Program inpatient ancillary service cost (Wk  | st. D-3, col. 3      | B, line 200)         |                             |  | 60, 611                   | 48. 00                     |
| 49. 00   | Total Program inpatient costs (sum of lines   | 41 through 48)(      | see instructi        | ons)                        |  | 188, 105                  | 49. 00                     |
| F0 00  | PASS THROUGH COST ADJUSTMENTS   |                      |                      | WI+ D                       | -6 Dt- 1                                 |                           | <br>                       |
| 50. 00   | Pass through costs applicable to Program inp  | attent routine       | services (Tro        | m WKSt. D, SUM              | or Parts I and                           | 0                         | 50.00                      |
| 51. 00   | Pass through costs applicable to Program inp and IV)  | atient ancillar      | ry services (f       | rom Wkst. D, sı             | um of Parts II                           | 0                         | 51.00                      |
| 52.00  | Total Program excludable cost (sum of lines   |                      |                      |                             |  | 0                         |                            |
| 53. 00   | Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION   |                      | elated, non-phy      | ysician anesth              | etist, and                               | 0                         | 53.00                      |
|  | Program di scharges   |                      |                      |                             |  | 0                         | 54.00                      |
|  | Target amount per discharge   |                      |                      |                             |  | 0.00                      | 1                          |
| 56.00  | Target amount (line 54 x line 55)   | ing cost and to      | rast smount (        | lino E/ minuo l             | lino E2)                                 | 0                         |                            |
| 58.00  | Difference between adjusted inpatient operat<br>Bonus payment (see instructions)  | ing cost and ta      | irget alliount (     | illie so illilius i         | 111le 53)                                | 0                         |                            |
| 59. 00   | Lesser of lines 53/54 or 55 from the cost re  | porting period       | endi na 1996.        | updated and cor             | mpounded by the                          |                           |                            |
|  | market basket   | per orrig per rea    |                      |                             |  |                           |                            |
| 60.00  |   |                      |                      |                             |  | 0.00                      | 1                          |
| 61. 00   | 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) |                      |                      |                             |  | 0                         | 61.00                      |
| 62.00  | 1   | ,                    |                      |                             |  | 0                         | 62.00                      |
| 63.00 Allowable Inpatient cost plus incentive payment (see instructions) |   |                      |                      |                             | 0  | 63.00                     |                            |
| 64. 00   | PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos   | ts through Dece      | ember 31 of the      | e cost reporti              | ng period (See                           | 0                         | 64.00                      |
| 65. 00   | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos  | ts after Decemb      | er 31 of the         | cost reporting              | period (See                              | 0                         | 65. 00                     |
| 66. 00   | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi  | ne costs (line       | 64 plus line         | 65)(title XVII              | l only). For                             | 0                         | 66. 00                     |
| 67. 00   | CAH (see instructions) Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)   | e costs through      | December 31          | of the cost re              | porting period                           | 0                         | 67. 00                     |
| 68. 00   | Title V or XIX swing-bed NF inpatient routin<br>((line 13 x line 20)  | e costs after D      | ecember 31 of        | the cost repor              | rting period                             | 0                         | 68. 00                     |
| 69. 00   | 1 7   |                      |                      |                             |  | 0                         | 69. 00                     |
| 70.00  | Skilled nursing facility/other nursing facil  |                      |                      |                             |  |                           | 70.00                      |
| 71. 00   | Adjusted general inpatient routine service c  |                      | ine 70 ÷ line        | 2)                          |  |                           | 71.00                      |
| 72.00  | Program routine service cost (line 9 x line   | •                    | . (line 14 v li      | ino 25)                     |  |                           | 72.00                      |
| 73. 00<br>74. 00   | Medically necessary private room cost applic<br>Total Program general inpatient routine serv  |                      |                      |                             |  |                           | 73. 00<br>74. 00           |
| 75. 00   | Capital -related cost allocated to inpatient 26, line 45)   | •                    |                      | •                           | art II, column                           |                           | 75. 00                     |
| 76. 00   | Per diem capital-related costs (line 75 ÷ li  |                      |                      |                             |  |                           | 76. 00                     |
| 77.00  | Program capital -related costs (line 9 x line   | •                    |                      |                             |  |                           | 77.00                      |
| 78. 00<br>79. 00   | Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces   | ,                    | rovider recor        | 46)                         |  |                           | 78. 00<br>79. 00           |
| 80.00  | Total Program routine service costs for comp  | , ,                  |                      | •                           | us line 79)                              |                           | 80.00                      |
| 81. 00   | Inpatient routine service cost per diem limi  | tati on              |                      | •                           | ŕ  |                           | 81.00                      |
| 82.00  | Inpatient routine service cost limitation (I  |                      | * .                  |                             |  |                           | 82.00                      |
| 83. 00<br>84. 00   | Reasonable inpatient routine service costs (<br>Program inpatient ancillary services (see in  |                      | 15)                  |                             |  |                           | 83. 00<br>84. 00           |
| 85. 00   | Utilization review - physician compensation   |                      | ons)                 |                             |  |                           | 85.00                      |
| 86. 00   | Total Program inpatient operating costs (sum  | •                    |                      |                             |  |                           | 86.00                      |
| 07   | PART IV - COMPUTATION OF OBSERVATION BED PASS   |                      |                      |                             |  | =                         |                            |
| 87. 00<br>88. 00   | Total observation bed days (see instructions Adjusted general inpatient routine cost per  | •                    | line 2)              |                             |  | 775<br>1, 821. 34         | 1                          |
|  | Observation bed cost (line 87 x line 88) (se  |                      |                      |                             |  | 1, 411, 539               |                            |
|  | ,   |                      |                      |                             |  | ,                         |                            |

| Health Financial Systems                    | WOODLAWN H | HOSPI TAL    |            | In Lie                           | u of Form CMS-2 | 2552-10 |
|---|------------|--------------|------------|----------------------------------|-----------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST     |            | Provi der CO |            | Peri od:                         | Worksheet D-1   |         |
|   |            |              |            | From 01/01/2020<br>To 12/31/2020 |                 |         |
|   |            |              | 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                 | 481, 660   | 5, 527, 712  | 0. 08713   | 6 1, 411, 539                    | 122, 996        | 90.00   |
| 91.00 Nursing School cost                   | 0          | 5, 527, 712  | 0.00000    | 0 1, 411, 539                    | 0               | 91.00   |
| 92.00 Allied health cost                    | 0          | 5, 527, 712  | 0.00000    | 0 1, 411, 539                    | 0               | 92.00   |
| 93.00 All other Medical Education           | 0          | 5, 527, 712  | 0. 00000   | 1, 411, 539                      | 0               | 93. 00  |

|  | HOSPI TAL   |                    |                                  | u of Form CMS-                 |         |
|--|-------------|--------------------|----------------------------------|--------------------------------|---------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT                                   | Provi der C | CN: 15-1313        | Peri od:                         | Worksheet D-3                  | 3       |
|  |             |                    | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |         |
|  | Title       | e XVIII            | Hospi tal                        | Cost                           |         |
| Cost Center Description  |             | Ratio of Cos       |                                  | I npati ent                    |         |
|  |             | To Charges         |                                  | Program Costs                  |         |
|  |             |                    | Charges                          | (col. 1 x                      |         |
|  |             |                    |                                  | col . 2)                       |         |
|  |             | 1.00               | 2. 00                            | 3. 00                          |         |
| INPATIENT ROUTINE SERVICE COST CENTERS   |             |                    | 4 470 047                        |                                |         |
| 30. 00   03000   ADULTS & PEDI ATRI CS   |             |                    | 1, 172, 867                      |                                | 30.00   |
| 31. 00   03100   INTENSI VE CARE UNIT  |             |                    | 441, 440                         |                                | 31.00   |
| 43. 00 04300 NURSERY   |             |                    |                                  |                                | 43.00   |
| ANCILLARY SERVICE COST CENTERS  50. 00   OPERATING ROOM                          |             | 0.0007             | 01 1 200 025                     | 222 020                        |         |
| 50. 00   05000   OPERATING ROOM<br>51. 00   05100   RECOVERY ROOM                |             | 0. 2397<br>0. 6314 | · · ·                            | · ·                            |         |
|  |             |                    |                                  | · ·                            |         |
| 52. 00   05200   DELI VERY ROOM & LABOR ROOM<br>53. 00   05300   ANESTHESI OLOGY |             | 1. 7619<br>0. 0474 |                                  |                                |         |
| 53. 00   05300   ANESTHEST OLOGY<br>54. 00   05400   RADI OLOGY-DI AGNOSTI C     |             | 0. 0474            | · ·                              | 52, 433                        |         |
| 60. 00   06000   LABORATORY  |             | 0. 1464            |                                  | 144, 468                       |         |
| 65. 00   06500   RESPI RATORY THERAPY  |             | 0. 1321            | · ·                              | · ·                            |         |
| 66. 00   06600   PHYSI CAL THERAPY   |             | 0. 5497            |                                  | 66, 434                        |         |
| 67. 00   06700   0CCUPATI ONAL THERAPY   |             | 0. 4102            | · ·                              |                                |         |
| 68. 00 06800 SPEECH PATHOLOGY  |             | 0. 3607            | · ·                              | 4, 397                         |         |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                  |             | 0.0000             |                                  |                                | 1       |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS                                     |             | 0. 5198            |                                  |                                |         |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS   |             | 0. 2330            | ·                                | 299, 146                       |         |
| OUTPATIENT SERVICE COST CENTERS  |             | 0. 2000            | 1,200,171                        | 277, 110                       | 70.00   |
| 88. 00 08800 SHAFER MEDICAL CENTER   |             | 0.0000             | 00                               | 0                              | 88.00   |
| 88. 01 08801 WOODLAWN MEDICAL PROFESSIONALS                                      |             | 0.0000             |                                  | 0                              |         |
| 88. 02   08802 FULTON COUNTY MEDICAL CENTER- 700 MA                              |             | 0.0000             |                                  | Ö                              | 88. 02  |
| 88. 03   08803   FULTON COUNTY   MEDICAL CENTER - 100   E                        |             | 0.0000             |                                  | Ö                              |         |
| 88. 04   08804   AKRON MEDI CAL CLI NI C   |             | 0.0000             |                                  | Ö                              | 1       |
| 88. 05   08805   ARGOS   MEDI CAL   CLI NI C                                     |             | 0.0000             |                                  | Ö                              |         |
| 91. 00   09100   EMERGENCY   |             | 0. 5812            |                                  | 4, 832                         |         |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART                                 |             | 0. 7152            | ·                                | 15, 467                        |         |
| 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS                                      |             | 1. 9433            |                                  | 0                              |         |
| 93. 01 04951 SHAFER MEDICAL CENTER   |             | 0. 9785            |                                  | Ō                              |         |
| 200 00 Total (sum of Lines 50 through 94 and 96 through 98)                      | 1           |                    | 6 137 817                        | 1 597 376                      | lann nn |

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

6, 137, 817

1, 597, 376 200. 00 201. 00 202. 00

200. 00 201. 00 202. 00

|        | <u> </u>                                   | AWN HOSPITAL |               | In Lie           | u of Form CMS-2             | 2552-10 |
|--------|--|--------------|---------------|------------------|-----------------------------|---------|
| INPATI | ENT ANCILLARY SERVICE COST APPORTIONMENT   | Provi der C  |               | Peri od:         | Worksheet D-3               |         |
|        |  |              |               | From 01/01/2020  |                             |         |
|        |  | Component    | CCN: 15-Z313  | To 12/31/2020    | Date/Time Pre 7/29/2021 4:1 |         |
|        |  | Title        | XVIII S       | Swing Beds - SNF |                             | 5 piii  |
|        | Cost Center Description                    | 11110        | Ratio of Cos  |                  | I npati ent                 |         |
|        | oust deliter beset per on                  |              | To Charges    | Program          | Program Costs               |         |
|        |  |              | l ro onar goo | Charges          | (col . 1 x                  |         |
|        |  |              |               | onal goo         | col . 2)                    |         |
|        |  |              | 1, 00         | 2. 00            | 3. 00                       |         |
|        | INPATIENT ROUTINE SERVICE COST CENTERS     |              |               |                  |                             |         |
| 30.00  | 03000 ADULTS & PEDIATRICS                  |              |               | 0                |                             | 30.00   |
| 31.00  | 03100 INTENSIVE CARE UNIT                  |              |               | 0                |                             | 31.00   |
|        | 04300 NURSERY                              |              |               |                  |                             | 43.00   |
|        | ANCILLARY SERVICE COST CENTERS             |              | •             |                  |                             |         |
| 50.00  | 05000 OPERATING ROOM                       |              | 0. 23979      | 1 2, 281         | 547                         | 50.00   |
| 51.00  | 05100 RECOVERY ROOM                        |              | 0. 63140      | 6 42             | 27                          | 51.00   |
| 52.00  | 05200 DELIVERY ROOM & LABOR ROOM           |              | 1. 76194      | 8 0              | 0                           | 52.00   |
| 53.00  | 05300 ANESTHESI OLOGY                      |              | 0.04744       | 8 0              | 0                           | 53.00   |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C              |              | 0. 14643      | 1 13, 416        | 1, 965                      | 54.00   |
| 60.00  | 06000 LABORATORY                           |              | 0. 15217      | 6 10, 949        | 1, 666                      | 60.00   |
| 65.00  | 06500 RESPI RATORY THERAPY                 |              | 0. 21957      | 4 25, 795        | 5, 664                      | 65.00   |
| 66.00  | 06600 PHYSI CAL THERAPY                    |              | 0. 54970      | 8 28, 236        | 15, 522                     | 66.00   |
| 67.00  | 06700 OCCUPATI ONAL THERAPY                |              | 0. 41022      | 3 17, 020        | 6, 982                      | 67.00   |
| 68.00  | 06800 SPEECH PATHOLOGY                     |              | 0. 36079      | 0                | 0                           | 68.00   |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  |              | 0.00000       | 0                | 0                           | 71.00   |
| 72.00  | 07200 IMPL. DEV. CHARGED TO PATIENTS       |              | 0. 51988      | 5 0              | 0                           | 72.00   |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS            |              | 0. 23307      | 6 38, 578        | 8, 992                      | 73.00   |
|        | OUTPATIENT SERVICE COST CENTERS            |              |               |                  |                             |         |
| 88.00  | 08800 SHAFER MEDICAL CENTER                |              | 0.00000       | 0                | 0                           | 88. 00  |
| 88. 01 | 08801 WOODLAWN MEDICAL PROFESSIONALS       |              | 0.00000       | 0                | 0                           | 88. 01  |
| 88. 02 | 08802 FULTON COUNTY MEDICAL CENTER- 700 MA |              | 0.00000       | 0                | 0                           | 88. 02  |
| 88. 03 | 08803 FULTON COUNTY MEDICAL CENTER - 100 E |              | 0.00000       | 0                | 0                           | 88. 03  |
| 88. 04 | 08804 AKRON MEDICAL CLINIC                 |              | 0.00000       | 0                | 0                           | 88. 04  |
| 88. 05 | 08805 ARGOS MEDICAL CLINIC                 |              | 0.00000       | 0                | 0                           | 88. 05  |
| 91.00  | 09100 EMERGENCY                            |              | 0. 58128      | 0 12             | 7                           | 91.00   |
| 02 00  | 00200 OBSERVATION DEDS (NON DISTINCT DART  |              | 0.71500       | 124              | 212                         | 00 00   |

0. 715232 1. 943390

0. 978586

136, 765

92.00

93.00

93.01 0

312

0

41, 684 200. 00 201. 00 202. 00

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 93. 00 | 04950 | WOODLAWN MEDICAL PROFESSIONALS

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

93. 01 04951 SHAFER MEDICAL CENTER

200. 00 201. 00 202. 00

|   | N HOSPITAL  |              |                             | u of Form CMS-             |        |
|---|-------------|--------------|-----------------------------|----------------------------|--------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT        | Provi der C |              | Peri od:<br>From 01/01/2020 | Worksheet D-3              | 3      |
|   |             |              | To 12/31/2020               |                            | pared: |
|   |             |              |                             | 7/29/2021 4:1              | 5 pm   |
| Octob Octob December 111                              | litl        | e XIX        | Hospi tal                   | Cost                       |        |
| Cost Center Description                               |             | Ratio of Cos |                             | Inpatient                  |        |
|   |             | To Charges   | Program<br>Charges          | Program Costs<br>(col. 1 x |        |
|   |             |              | Chai ges                    | col. 2)                    |        |
|   |             | 1.00         | 2. 00                       | 3.00                       |        |
| INPATIENT ROUTINE SERVICE COST CENTERS                |             | 1.00         | 2.00                        | 3.00                       |        |
| 30. 00 03000 ADULTS & PEDI ATRI CS                    |             |              | 99, 806                     |                            | 30.00  |
| 31. 00   03100   I NTENSI VE CARE UNI T               |             |              | 11, 394                     |                            | 31.00  |
| 43. 00   04300   NURSERY                              |             |              | 0                           | l                          | 43.00  |
| ANCILLARY SERVICE COST CENTERS                        |             | •            |                             |                            |        |
| 50. 00 05000 OPERATING ROOM                           |             | 0. 23979     | 76, 015                     | 18, 228                    | 50.00  |
| 51. 00   05100   RECOVERY ROOM                        |             | 0. 63140     | 7, 677                      | 4, 847                     | 51.00  |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM                |             | 1. 76194     | 8                           | 0                          | 52.00  |
| 53. 00   05300   ANESTHESI OLOGY                      |             | 0. 04744     | 5, 361                      | 254                        | 53.00  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                  |             | 0. 14643     | 13, 547                     | 1, 984                     | 54.00  |
| 60. 00   06000   LABORATORY                           |             | 0. 15217     | 40, 284                     | 6, 130                     | 60.00  |
| 65. 00 06500 RESPI RATORY THERAPY                     |             | 0. 21957     | 25, 738                     | 5, 651                     |        |
| 66. 00 06600 PHYSI CAL THERAPY                        |             | 0. 54970     |                             |                            | 66.00  |
| 67. 00   06700 OCCUPATI ONAL THERAPY                  |             | 0. 41022     |                             | 324                        |        |
| 68. 00 06800 SPEECH PATHOLOGY                         |             | 0. 36079     |                             | 0                          | 68.00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT       |             | 0.00000      |                             | 0                          |        |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS            |             | 0. 51988     |                             |                            |        |
| 73. 00 O7300 DRUGS CHARGED TO PATIENTS                |             | 0. 23307     | 48, 631                     | 11, 335                    | 73. 00 |
| OUTPATIENT SERVICE COST CENTERS                       |             |              |                             |                            |        |
| 88. 00 08800 SHAFER MEDICAL CENTER                    |             | 1. 56321     |                             |                            |        |
| 88. 01   08801   WOODLAWN   MEDI CAL   PROFESSI ONALS |             | 1. 14026     |                             | 1                          | 88. 01 |
| 88. 02   08802   FULTON COUNTY MEDICAL CENTER- 700 MA |             | 1. 35546     |                             | 0                          | 88. 02 |
| 88. 03   08803   FULTON COUNTY MEDICAL CENTER - 100 E |             | 1. 06809     |                             | 0                          | 88. 03 |
| 88. 04   08804   AKRON MEDICAL CLINIC                 |             | 1. 54157     |                             | 1                          | 88. 04 |
| 88. 05   08805   ARGOS   MEDI CAL   CLI NI C          |             | 1. 15648     |                             | 0                          |        |
| 91. 00   09100   EMERGENCY                            |             | 0. 58128     | · ·                         | 3, 501                     | 91.00  |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART      |             | 0. 71523     |                             | 0                          |        |
| 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS           |             | 1. 94339     |                             | 0                          | 93.00  |
| 93. 01   04951   SHAFER MEDI CAL CENTER               | 2)          | 0. 97858     | 340 044                     | 0                          |        |

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

60, 611 200. 00 201. 00 202. 00

240, 044

200. 00 201. 00 202. 00

| Health Financial Systems                | WOODLAWN HOSPITAL      | In Lieu                          | ı of Form CMS-2552-10   |
|---|------------------------|----------------------------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-1313 | From 01/01/2020<br>To 12/31/2020 | Worksheet E<br>Part B<br>Date/Time Prepared:<br>7/29/2021 4:15 pm |
|   | Title XVIII            | Hospi tal                        | Cost  |

|                  |  | Title XVIII           | Hospi tal       | 7/29/2021 4:1<br>Cost | 5 pm             |
|------------------|--|-----------------------|-----------------|-----------------------|------------------|
|                  |  |                       | 110001 tai      |                       |                  |
|                  | 1.00   |                       |                 |                       |                  |
| 1. 00            | PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)  |                       |                 | 5, 929, 099           | 1.00             |
| 2. 00            | Medical and other services (see Fristractions)   | ns)                   |                 | 0,727,077             | 1                |
| 3. 00            | OPPS payments  | /                     |                 | 0                     |                  |
| 4.00             | Outlier payment (see instructions)   |                       |                 | 0                     | 4.00             |
| 4. 01            | Outlier reconciliation amount (see instructions)   |                       |                 | 0                     |                  |
| 5.00             | Enter the hospital specific payment to cost ratio (see instruction   | ons)                  |                 | 0.000                 |                  |
| 6.00             | Line 2 times line 5  |                       |                 | 0                     |                  |
| 7. 00<br>8. 00   | Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)                                  |                       |                 | 0.00                  | 1                |
| 9. 00            | Ancillary service other pass through costs from Wkst. D, Pt. IV,   | col. 13. Line 200     |                 | 0                     | 1                |
| 10.00            | Organ acqui si ti ons  |                       |                 | 0                     | 1                |
| 11.00            | Total cost (sum of lines 1 and 10) (see instructions)  |                       |                 | 5, 929, 099           | 11.00            |
|                  | COMPUTATION OF LESSER OF COST OR CHARGES   |                       |                 |                       |                  |
| 10.00            | Reasonable charges   |                       |                 | 0                     | 10.00            |
| 12. 00<br>13. 00 | Ancillary service charges<br>Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line                                    | 60)                   |                 | 0                     |                  |
| 14. 00           | Total reasonable charges (sum of lines 12 and 13)  | 09)                   |                 | 0                     | 1                |
| 11.00            | Customary charges  |                       |                 |                       | 11.00            |
| 15.00            | Aggregate amount actually collected from patients liable for payr  | ment for services on  | a charge basis  | 0                     | 15. 00           |
| 16. 00           | Amounts that would have been realized from patients liable for patients  | ayment for services o | n a chargebasis | 0                     | 16.00            |
| 47.00            | had such payment been made in accordance with 42 CFR §413.13(e)  |                       |                 | 0 000000              | 17.00            |
| 17. 00<br>18. 00 | Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)                                  |                       |                 | 0.000000              |                  |
| 19. 00           | Excess of customary charges over reasonable cost (complete only i  | f line 18 exceeds li  | ne 11) (see     | 0                     | 1                |
| 17.00            | instructions)  |                       | , (555          |                       | .,,,,            |
| 20.00            | Excess of reasonable cost over customary charges (complete only i  | f line 11 exceeds li  | ne 18) (see     | 0                     | 20.00            |
|                  | instructions)  |                       |                 |                       |                  |
| 21. 00           | Lesser of cost or charges (see instructions)   |                       |                 | 5, 988, 390           |                  |
|                  | Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)                  | tions)                |                 | 0                     |                  |
| 24. 00           | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   | 11 0113)              |                 | 0                     | 24.00            |
|                  | COMPUTATION OF REIMBURSEMENT SETTLEMENT  |                       |                 |                       |                  |
| 25.00            | Deductibles and coinsurance amounts (for CAH, see instructions)  |                       |                 | 113, 507              | 25. 00           |
| 26.00            | Deductibles and Coinsurance amounts relating to amount on line 24  |                       |                 | 4, 175, 361           | 1                |
| 27. 00           | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus  | s the sum of lines 22 | ! and 23] (see  | 1, 699, 522           | 27. 00           |
| 28. 00           | instructions) Direct graduate medical education payments (from Wkst. E-4, line   | 50)                   |                 | 0                     | 28. 00           |
|                  | ESRD direct medical education costs (from Wkst. E-4, line 36)  | 30)                   |                 | 0                     |                  |
| 30.00            | Subtotal (sum of lines 27 through 29)  |                       |                 | 1, 699, 522           |                  |
| 31.00            | Primary payer payments   |                       |                 | 790                   | 31.00            |
| 32.00            | Subtotal (line 30 minus line 31)   |                       |                 | 1, 698, 732           | 32.00            |
| 22.00            | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)  |                       |                 | 0                     | 22.00            |
|                  | Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)   |                       |                 | 0<br>820, 149         |                  |
|                  | Adjusted reimbursable bad debts (see instructions)   |                       |                 | 533, 097              |                  |
|                  | Allowable bad debts for dual eligible beneficiaries (see instruc   | tions)                |                 | 419, 495              |                  |
| 37.00            | Subtotal (see instructions)  |                       |                 | 2, 231, 829           |                  |
|                  | MSP-LCC reconciliation amount from PS&R  |                       |                 | 0                     |                  |
| 39. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |                       |                 | 0                     |                  |
| 39. 50<br>39. 97 | Pioneer ACO demonstration payment adjustment (see instructions)  |                       |                 | _                     | 39.50            |
| 39. 97<br>39. 98 | Demonstration payment adjustment amount before sequestration<br>Partial or full credits received from manufacturers for replaced | devices (see instruc  | tions)          | 0                     | ı                |
| 39. 99           | RECOVERY OF ACCELERATED DEPRECIATION   | devices (see mistrae  | . (1 0113)      | Ö                     | 1                |
|                  | Subtotal (see instructions)  |                       |                 | 2, 231, 829           |                  |
| 40. 01           | Sequestration adjustment (see instructions)  |                       |                 | 14, 730               | 40. 01           |
| 40. 02           | Demonstration payment adjustment amount after sequestration  |                       |                 | 0                     |                  |
|                  | Sequestration adjustment-PARHM pass-throughs   |                       |                 | 0 504 050             | 40.03            |
|                  | Interim payments Interim payments-PARHM  |                       |                 | 2, 581, 853           |                  |
| 42.00            | Tentative settlement (for contractors use only)  |                       |                 | 0                     | 41. 01<br>42. 00 |
|                  | Tentative settlement-PARHM (for contractor use only)   |                       |                 |                       | 42.00            |
| 43.00            | Balance due provider/program (see instructions)  |                       |                 | -364, 754             | 43.00            |
| 43. 01           | Balance due provider/program-PARHM (see instructions)  |                       |                 |                       | 43. 01           |
| 44. 00           | Protested amounts (nonallowable cost report items) in accordance   | with CMS Pub. 15-2,   | chapter 1,      | 0                     | 44.00            |
|                  | \$115. 2   |                       |                 |                       | 1                |
| 90 00            | TO BE COMPLETED BY CONTRACTOR  Original outlier amount (see instructions)  |                       |                 | 0                     | 90.00            |
|                  | Outlier reconciliation adjustment amount (see instructions)  |                       |                 | 0                     | 1                |
|                  | The rate used to calculate the Time Value of Money   |                       |                 | 0.00                  |                  |
|                  | Time Value of Money (see instructions)   |                       |                 | 0                     | 1                |
| 94.00            | Total (sum of lines 91 and 93)   |                       |                 | 0                     | 94.00            |
|                  |  |                       |                 |                       |                  |

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2020 | Part | | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-1313

|                |  |            | '           | 0 12/31/2020         | 7/29/2021 4: 1          |                |
|----------------|--|------------|-------------|----------------------|-------------------------|----------------|
|                |  | Title      | : XVIII     | Hospi tal            | Cost                    | •              |
|                |  | I npati en | it Part A   | Par                  | t B                     |                |
|                |  | mm/dd/yyyy | Amount      | mm/dd/yyyy           | Amount                  |                |
|                |  | 1.00       | 2.00        | 3.00                 | 4. 00                   |                |
| 1. 00          | Total interim payments paid to provider  |            | 2, 866, 507 |                      | 2, 581, 853             | 1.00           |
| 2. 00          | Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero                          |            | C           |                      | 0                       | 2. 00          |
| 3.00           | List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) |            |             |                      |                         | 3. 00          |
|                | Program to Provider  |            |             |                      |                         |                |
| 3. 01          | ADJUSTMENTS TO PROVIDER  | 07/15/2020 | 252, 800    |                      | 0                       | 3. 01          |
| 3. 02          |  |            | 0           |                      | 0                       | 3. 02          |
| 3. 03          |  |            | 0           |                      | 0                       | 3. 03          |
| 3. 04          |  |            | 0           |                      | 0                       | 3. 04          |
| 3. 05          |  |            | 0           |                      | 0                       | 3. 05          |
| 0 50           | Provi der to Program   |            | 1           |                      |                         | 0.50           |
| 3.50           | ADJUSTMENTS TO PROGRAM   |            | 0           |                      | 0                       | 3.50           |
| 3. 51<br>3. 52 |  |            |             |                      |                         | 3. 51<br>3. 52 |
| 3. 52<br>3. 53 |  |            |             |                      |                         | 3. 52          |
| 3. 54          |  |            |             |                      |                         | 3. 54          |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines  |            | 252, 800    |                      | 0                       | 3. 99          |
| 3. 77          | 3. 50-3. 98)   |            | 252, 600    |                      |                         | 3. 77          |
| 4. 00          | Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  |            | 3, 119, 307 |                      | 2, 581, 853             | 4.00           |
|                | TO BE COMPLETED BY CONTRACTOR  |            |             |                      |                         |                |
| 5. 00          | List separately each tentative settlement payment after  |            |             |                      |                         | 5. 00          |
| 3.00           | desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  |            |             |                      |                         | 3.00           |
|                | Program to Provider  |            |             |                      |                         |                |
| 5. 01          | TENTATI VE TO PROVI DER  |            | 0           |                      | 0                       | 5. 01          |
| 5. 02          |  |            | 0           |                      | 0                       | 5. 02          |
| 5. 03          |  |            | 0           |                      | 0                       | 5. 03          |
|                | Provi der to Program   | 1          |             | 1                    | _                       |                |
| 5. 50          | TENTATI VE TO PROGRAM  |            | 0           |                      | 0                       | 5. 50          |
| 5. 51          |  |            | 0           |                      | 0                       | 5. 51          |
| 5. 52<br>5. 99 | Cultural (cum of lines F 01 F 40 minus cum of lines  |            | 0           |                      | 0                       | 5. 52<br>5. 99 |
| 5. 99          | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   |            |             |                      | 0                       | 5. 99          |
| 6. 00          | Determined net settlement amount (balance due) based on the cost report. (1)   |            |             |                      |                         | 6.00           |
| 6. 01          | SETTLEMENT TO PROVIDER   |            | 327, 042    |                      | 0                       | 6. 01          |
| 6. 02          | SETTLEMENT TO PROGRAM  |            | 0           |                      | 364, 754                | 6. 02          |
| 7. 00          | Total Medicare program liability (see instructions)  |            | 3, 446, 349 |                      | 2, 217, 099             | 7. 00          |
|                |  |            |             | Contractor<br>Number | NPR Date<br>(Mo/Day/Yr) |                |
|                |  | (          | )           | 1.00                 | 2.00                    |                |
| 8. 00          | Name of Contractor   |            |             |                      |                         | 8. 00          |

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-1313 | Peri od: From 01/01/2020 | Part I | Part I |
Component CCN: 15-Z313 | To 12/31/2020 | Date/Time Prepared: 7/29/2021 4:15 pm

|                |  | '          |           |                 | 7/29/2021 4:1 | 5 pm           |
|----------------|--|------------|-----------|-----------------|---------------|----------------|
|                |  | Title      | XVIII S   | wing Beds - SNF | Cost          |                |
|                |  | Inpatien   | it Part A | Par             | t B           |                |
|                |  | mm/dd/yyyy | Amount    | mm/dd/yyyy      | Amount        |                |
|                |  | 1. 00      | 2.00      | 3. 00           | 4. 00         |                |
| 1. 00          | Total interim payments paid to provider                  |            | 192, 918  |                 | 0             | 1.00           |
| 2.00           | Interim payments payable on individual bills, either     |            |           |                 | 0             | 2.00           |
|                | submitted or to be submitted to the contractor for       |            |           |                 |               |                |
|                | services rendered in the cost reporting period. If none, |            |           |                 |               |                |
|                | write "NONE" or enter a zero                             |            |           |                 |               |                |
| 3.00           | List separately each retroactive lump sum adjustment     |            |           |                 |               | 3.00           |
|                | 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)      |            |           |                 |               | ļ              |
|                | Program to Provider                                      |            | 1         |                 | _             |                |
| 3. 01          | ADJUSTMENTS TO PROVIDER                                  |            | 0         |                 | 0             | 3. 01          |
| 3. 02          |  |            | 0         |                 | 0             | 3. 02          |
| 3. 03          |  |            | 0         |                 | 0             | 3. 03          |
| 3. 04          |  |            | 0         |                 | 0             | 3.04           |
| 3. 05          | Describer to Describe                                    |            | 0         |                 | 0             | 3.05           |
| 3. 50          | Provider to Program ADJUSTMENTS TO PROGRAM               |            |           |                 | 0             | 3. 50          |
| 3. 50          | ADJUSTMENTS TO PROGRAM                                   |            |           |                 |               | 3.50           |
| 3. 52          |  |            |           |                 |               | 3.52           |
| 3. 53          |  |            |           |                 |               | 3.53           |
| 3. 54          |  |            |           |                 |               | 3.54           |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines      |            |           |                 | 0             | 3. 99          |
| 3. 77          | 3. 50-3. 98)   |            |           |                 | Ĭ             | 3. //          |
| 4. 00          | Total interim payments (sum of lines 1, 2, and 3.99)     |            | 192, 918  |                 | 0             | 4.00           |
|                | (transfer to Wkst. E or Wkst. E-3, line and column as    |            |           |                 | _             |                |
|                | appropri ate)  |            |           |                 |               |                |
|                | TO BE COMPLETED BY CONTRACTOR                            |            |           |                 |               |                |
| 5.00           | List separately each tentative settlement payment after  |            |           |                 |               | 5.00           |
|                | desk review. Also show date of each payment. If none,    |            |           |                 |               |                |
|                | write "NONE" or enter a zero. (1)                        |            |           |                 |               |                |
|                | Program to Provider                                      |            |           |                 |               |                |
| 5. 01          | TENTATI VE TO PROVI DER                                  |            | 0         |                 | 0             | 5. 01          |
| 5. 02          |  |            | 0         |                 | 0             | 5. 02          |
| 5. 03          | Decided to December 1                                    |            | 0         |                 | 0             | 5.03           |
| F F0           | Provider to Program TENTATIVE TO PROGRAM                 |            |           | ı               | 0             | 0              |
| 5. 50<br>5. 51 | TENTATIVE TO PROGRAM                                     |            |           |                 | 0             | 5. 50<br>5. 51 |
| 5. 51          |  |            |           |                 | 0             | 5.51           |
| 5. 99          | Subtotal (sum of lines 5.01-5.49 minus sum of lines      |            |           |                 | 0             | 5. 99          |
| J. 77          | 5. 50-5. 98)   |            |           |                 | 0             | 3. 77          |
| 6. 00          | Determined net settlement amount (balance due) based on  |            |           |                 |               | 6.00           |
| 2. 50          | the cost report. (1)                                     |            |           |                 |               | 0.00           |
| 6. 01          | SETTLEMENT TO PROVIDER                                   |            | 24, 337   |                 | 0             | 6. 01          |
| 6. 02          | SETTLEMENT TO PROGRAM                                    |            | 0         |                 | Ō             | 6. 02          |
| 7. 00          | Total Medicare program liability (see instructions)      |            | 217, 255  |                 | 0             | •              |
|                |  |            |           | Contractor      | NPR Date      |                |
|                |  |            |           | Number          | (Mo/Day/Yr)   |                |
|                |  | (          | )         | 1.00            | 2. 00         |                |
| 8.00           | Name of Contractor                                       |            |           |                 |               | 8.00           |

| Heal th | Financial Systems WOODLAWN HO                                | SPI TAL                  | In Lie                           | u of Form CMS- | 2552-10 |
|---------|--|--------------------------|----------------------------------|----------------|---------|
| CALCUL  | ATION OF REIMBURSEMENT SETTLEMENT FOR HIT                    | Provi der CCN: 15-1313   | Peri od:                         | Worksheet E-1  |         |
|         |  |                          | From 01/01/2020<br>To 12/31/2020 |                | nared:  |
|         |  |                          | 10 12/31/2020                    | 7/29/2021 4: 1 |         |
|         |  | Title XVIII              | Hospi tal                        | Cost           |         |
|         |  |                          |                                  |                |         |
|         | TO DE COMPLETED BY CONTRACTOR FOR MONOTANDARD COOT DEPORTS   |                          |                                  | 1. 00          |         |
|         | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS   | N.I.                     |                                  |                | 1       |
| 1 00    | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO |                          | - 14                             |                | 1 00    |
| 1.00    | Total hospital discharges as defined in AARA §4102 from Wkst |                          | e 14                             |                | 1.00    |
| 2.00    | Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,  | 8-12                     |                                  |                | 2.00    |
| 3. 00   | Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2      |                          |                                  |                | 3.00    |
| 4. 00   | Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,  | 8-12                     |                                  |                | 4. 00   |
| 5. 00   | Total hospital charges from Wkst C, Pt. I, col. 8 line 200   |                          |                                  |                | 5. 00   |
| 6. 00   | Total hospital charity care charges from Wkst. S-10, col. 3  | line 20                  |                                  |                | 6. 00   |
| 7.00    | CAH only - The reasonable cost incurred for the purchase of  | certified HIT technology | Wkst. S-2, Pt. I                 |                | 7. 00   |
|         | line 168   |                          |                                  |                |         |
| 8.00    | Calculation of the HIT incentive payment (see instructions)  |                          |                                  |                | 8. 00   |
| 9.00    | Sequestration adjustment amount (see instructions)           |                          |                                  |                | 9. 00   |
| 10.00   | Calculation of the HIT incentive payment after sequestration | (see instructions)       |                                  |                | 10.00   |
|         | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH             |                          |                                  |                |         |
| 30.00   | Initial/interim HIT payment adjustment (see instructions)    |                          |                                  |                | 30.00   |
| 31.00   | Other Adjustment (specify)                                   |                          |                                  |                | 31.00   |
| 32.00   | Balance due provider (line 8 (or line 10) minus line 30 and  | line 31) (see instructio | ns)                              |                | 32.00   |
|         |  |                          | . '                              |                |         |

| Cost   Part A  |        |  | Component CCN: 15-2313   | 10 12/31/2020    | 7/29/2021 4:1 |                  |
|--|--------|--|--|------------------|---------------|------------------|
| 1.00   2.00  |        |  | Title XVIII  | Swing Beds - SNF | Cost          |                  |
| COMPUTATION OF NET COST OF COVERED SERVICES  1.00   Inpatient routine services - swing bed-SNF (see instructions)   176,597   0   1.00   Inpatient routine services - swing bed-SNF (see instructions)   176,597   0   2.00   Anciliary services (from Wist. D. 3, col. 3, line 200, for Part A, and sum of Wist. D, Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and SWing-bed pass-through, see Part V, Cols. 6 and 7, line 202, for Part B) (for CARI and Swing-bed pass-through) (for Cari and   |        |  |  |                  |               |                  |
| 1.00 Inpatient routine services - swing bed-SMF (see instructions) 2.00 Inpatient routine services - swing bed-SMF (see instructions) 3.00 Ancillary services (from West, D-3, cot. 3, line 200, for Part A, and sum or West. D, Act J 100 2.01 Ancillary services (from West, D-3, cot. 3, line 200, for Part A) 3.01 Ancillary services (from West, D-3, cot. 3, line 200, for Part B) 4.02 Part does not be a service of the services of the service of the service of the service of the service of the services of the service of the servic   |        | COMPUTATION OF NET COST OF COVERED SERVICES                          |  | 1.00             | 2.00          |                  |
| Inpatient routine services - swing bed-MF (see Instructions)   10   21   10   22   10   23   24   21   21   22   21   22   23   24   21   21   22   23   24   24   21   24   24   21   24   24   | 1. 00  |  |  | 176, 597         | 0             | 1.00             |
| Part V. Cols. 6 and 7, line 202. for Part B) (For CAH and swing-bed pass-through, see instructions)  Nursing and all lied heal th payment-PARHW (see instructions)  Nursing and all lied heal the payment-PARHW (see instructions)  Drogram days   |        |  |  |                  |               | 2.00             |
| instructions) Per diem cost for interns and residents not in approved teaching program (see instructions) Per diem cost for interns and residents not in approved teaching program (see instructions) Program days Pr   | 3.00   |  | · ·  | 42, 101          | 0             | 3.00             |
| 3.01 Mursing and all led heal th payment-PARHM (see instructions) 5.00 Program days 7.00 Program days 8.00 Program days 9.00 Program days    |        |  | ng-bed pass-through, see   |                  |               |                  |
| 4.00   Per diem cost for interns and residents not in approved teaching program (see instructions)   96   0.00   | 2 01   | · · · · · · · · · · · · · · · · · · ·                                |  |                  |               | 3. 01            |
| instructions)  1. Open days  1. Interns and residents not in approved teaching program (see instructions)  1. Open days  1. Open   |        |  | ing program (see   |                  | 0.00          | 4.00             |
| Interns and residents not in approved teaching program (see instructions)   0  | 1. 00  |  | ring program (see  |                  | 0.00          | 1.00             |
|  | 5. 00  | Program days   |  | 96               | 0             | 5.00             |
| Subtotal (sum of lines 1 through 3 plus lines 6 and 7)   |        |  |  |                  | 0             | 6.00             |
| Primary payer payments (see instructions)  0 Deductible in inus line 9  110.00 Subtotal (line 8 minus line 9)  120.00 Subtotal (line 10 minus line 10)  120.00 Subtotal (line 10 minus line 10)  120.00 Subtotal (line 10 minus line 11)  120.00 Coincarace billed to program patients (from provider records) (exclude coinsurance 6 o  |        |  | thod only  | 0                |               | 7.0              |
| 10.00   Subtota'   (ine 8 minus line 9)   218,698   0   0   0   0   0   0   0   0   0  |        | ,  |  | 218, 698         |               | 8.0              |
| 11.00   Deductible's billed to program patients (exclude amounts applicable to physician professional services)   218,698   0   0   0   0   0   0   0   0   0  |        |  |  | 218 608          |               | 9.0              |
| professional services) 20  |        | · · · · · · · · · · · · · · · · · · ·                                | cable to physician   | 210, 040         |               | 11.0             |
| 218,698   0   0   0   0   0   0   0   0   0  | 11.00  |  | cable to physician   |                  | Ŭ             | ' ' ' '          |
| For physical an professional services  | 12.00  | Subtotal (line 10 minus line 11)                                     |  | 218, 698         | 0             | 12.0             |
| 14.00   80% of Part B costs (Ilne 12 x 80%)   0   0   0   0   16.00   0   0   0   0   0   0   0   0   0  | 13.00  |  | ) (exclude coinsurance   | 0                | 0             | 13.00            |
| 15.00 Subtotal (see Instructions) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.55 Rural community hospital demonstration project (\$410A Demonstration) payment a distribution of adjustment (see Instructions) 16.57 Rural community hospital demonstration project (\$410A Demonstration) payment a distribution of Demonstration payment adjustment adjustment adjustment description of Demonstration payment adjustment (see instructions) 17.01 Adjusted reimbursable bad debts (see instructions) 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.01 Sequestration adjustment (see instructions) 19.02 Demonstration payment adjustment amount after sequestration 19.03 Sequestration adjustment amount after sequestration 19.03 Sequestration adjustment-PARHM pass-throughs 19.03 Sequestration adjustment-PARHM pass-throughs 19.01 Interim payments 192.918 192.918 192.918 192.918 192.918 192.918 192.918 192.918 192.919 192.01 Tentative settlement (for contractor use only) 10.1 Tentative settlement-PARHM (for contractor use only) 10.2 Balance due provider/program-PARHM (see instructions) 10.2 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 192.01 Balance due provider/program-PARHM (see instructions) 192.01 Balance due provider/program-PARHM (see instructions) 192.01 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 193.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 0 193.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 0 193.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 0 193.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, 0 193.00 Protested amounts (nonal lowable cost report items) in accordan |        |  |  |                  |               |                  |
| 0 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Ploneer ACO demonstration payment adjustment (see instructions) 16.55 Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions) 16.99 Demonstration payment adjustment amount before sequestration 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.01 Allowable bad debts (see instructions) 19.01 Total (see instructions) 19.02 Demonstration payment adjustment (see instructions) 19.03 Equestration adjustment (see instructions) 19.04 Individual (see instructions) 19.05 Sequestration adjustment (see instructions) 19.06 Sequestration adjustment (see instructions) 19.07 Demonstration payment adjustment after sequestration) 19.08 Equestration adjustment—PARHM (pass-throughs 19.09 Interim payments—PARHM (see instructions) 19.01 Interim payments—PARHM (for contractor use only) 19.01 Tentative settlement (for contractor use only) 19.01 Tentative settlement (for contractor use only) 19.02 Demonstration payment adjustment—PARHM (see instructions) 19.03 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, and 21) 20.01 Balance due provider/program (line 19 minus lines 19, 01, 20, 20, 20, 20, 20, 20, 20, 20, 20, 20                  |        |  |  | 210 400          |               | 14. 00<br>15. 00 |
| 16.50   Pioneer ACO demonstration payment adjustment (see instructions)  |        |  |  | 218, 098         |               | 16.00            |
| 16.55 Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)   0   0   0   0   0   0   0   0   0  |        |  | 5)   |                  | 0             | 16.5             |
| adjustment (see instructions) 6.99 Demonstration payment adjustment amount before sequestration 7.00 Allowable bad debts (see instructions) 7.01 Adjusted reimbursable bad debts (see instructions) 7.02 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.03 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.04 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.05 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.06 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.07 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.07 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.08 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.09 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.00 Entosetration payments (see instructions) 7.01 Allowable bad debts for dual eligible beneficiaries (see instructions) 7.02 Demonstration payment adjustment -PARHM (processory and the sequential of the sequen   |        | ,                              | •  | 0                |               | 16.5             |
| 17.00  |        | •                              | , , ,  |                  |               |                  |
| Adjusted reimbursable bad debts (see instructions)   0   0   0   0   0   0   0   0   0   |        |  |  | 0                |               | 16. 9            |
| Al owable bad debts for dual eligible beneficiaries (see instructions)  7 Total (see instructions)  9 00 Total (see instructions)  9 01 Sequestration adjustment (see instructions)  9 02 Demonstration payment adjustment amount after sequestration)  9 02 Demonstration payment adjustment-PARHM pass-throughs  10 03 Sequestration adjustment-PARHM pass-throughs  10 01 Interim payments  10 02 Demonstration payments adjustment-PARHM pass-throughs  10 02 Interim payments  10 03 Sequestration adjustment-PARHM pass-throughs  10 05 Sequestration adjustment-PARHM pass-throughs  10 06 Interim payments  10 07 Sequestration adjustment-PARHM pass-throughs  10 07 Sequestration adjustment-PARHM pass-throughs  10 08 Sequestration adjustment payments  10 08 Sequestration adjustment payments  10 09 Sequestration adjustment payments  10 09 Sequestration payments  10 09 Sequestration payments  10 00 Sequestration pay   |        |  |  | 0                |               | 17.0             |
| Total (see instructions)   Sequestration adjustment (see instructions)   Sequestration adjustment (see instructions)   1,443   0   |        | · · · · · · · · · · · · · · · · · · ·                                | rusti spo)   | 0                |               | 17. 0<br>18. 0   |
| Sequestration adjustment (see instructions)   1,443   0   0   0   0   0   0   0   0   0  |        | ·  | ructions)  | 218 608          |               | 19.0             |
| Demonstration payment adjustment amount after sequestration  Sequestration payment adjustment-PARHM pass-throughs  Interim payments  192, 918   O  |        |  |  |                  |               | 19.0             |
| 19.03   Sequestration adjustment-PARHM pass-throughs   192, 918   0  |        | ·  |  | 0                |               | 19.0             |
| Interim payments-PARHM   Tentative settlement (for contractor use only)   0   0   0   0   0   0   0   0   0  | 9. 03  | Sequestration adjustment-PARHM pass-throughs                         |  |                  |               | 19.0             |
| Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor) Tentative settlement-PARHM (see instruction) Tentative settlement-PARHM (see instructions) Tentative settlement-ParkM (see instructions) Tentative settlement-Pa   |        |  |  | 192, 918         | 0             | 20.0             |
| Tentative settlement-PARHM (for contractor use only)  12.00 Bal ance due provider/program (line 19 minus lines 19.01, 20, and 21)  24,337 0  24,337 0  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  10.00 0 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  10.10 0 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  10.00 0 (title XVIII swing-bed SNF))  10.01 0 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  10.02 0 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  10.01 0 Medicare swing-bed SNF target amount  10.02 0 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  10.02 0 Program reimbursement under the §410A Demonstration (see instructions)  10.03 0 Adjustment to Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  10.04 0 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  |        |  |  | _                | _             | 20.0             |
| Balance due provider/program (line 19 minus lines 19.01, 20, and 21)  24, 337  0 Balance due provider/program-PARHM (see instructions)  3.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  100.00 Is this the first year of the current 5-year demonstration period under the 21st century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  101.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  102.00 (title XVIII swing-bed SNF))  103.00 Total (sum of lines 201 and 202)  104.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  105.00 Medicare swing-bed SNF target amount  106.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  107.00 Program reimbursement under the §410A Demonstration (see instructions)  108.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  109.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)   |        |  |  | 0                | 0             | 21.0             |
| Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 0 chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  Doc. 00 1s this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Doc. 00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) Doc. 00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) Doc. 00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  Doc. 00 Medicare swing-bed SNF target amount  Doc. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  Doc. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Doc. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Doc. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Doc. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Doc. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Doc. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Doc. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Doc. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  |        |  | and 21)  | 24 227           | 0             | 21. 0<br>22. 0   |
| Protested amounts (nonal owable cost report items) in accordance with CMS Pub. 15-2, 0 Chapter 1, §115.2  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  Output Contains a contain of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  Output Cost Reimbursement and Cost (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF discharges (see instructions)  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF discharges (see instructions)  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF discharges (see instructions)  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF discharges (see instructions)  Output Cost (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from Wkst. E-2, col. 1, sum of lines 1 200)  Output Cost (from W   |        |  | and 21)  | 24, 337          | U             | 22.0             |
| chapter 1, §115.2  Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment  200.00  Is this the first year of the current 5-year demonstration period under the 21st  Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  201.00  Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  202.00  Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  203.00 Total (sum of lines 201 and 202)  204.00  Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF target amount  206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the §410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)   |        |  | nce with CMS Pub. 15-2.  | 0                | 0             | 23.0             |
| 200.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement  201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 205.00 Medicare swing-bed SNF target amount 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 210.00 Reserved for future use  |        |  |  |                  | -             |                  |
| Century Cures Act? Enter "Y" for yes or "N" for no.  Cost Reimbursement  201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  203.00 Total (sum of lines 201 and 202)  204.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF target amount  206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the §410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  |        |  |  |                  |               |                  |
| Cost Reimbursement  201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))  202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  203.00 Total (sum of lines 201 and 202)  204.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  205.00 Medicare swing-bed SNF target amount  206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  207.00 Program reimbursement under the \$410A Demonstration (see instructions)  208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  | 200.00 |  | riod under the 21st  |                  |               | 200. 0           |
| Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital)) 02.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF)) 03.00 Total (sum of lines 201 and 202) 04.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 05.00 Medicare swing-bed SNF target amount 06.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 07.00 Program reimbursement under the §410A Demonstration (see instructions) 08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  |        |  |  |                  |               |                  |
| 66 (title XVIII hospital))  02.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))  03.00 Total (sum of lines 201 and 202)  04.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  05.00 Medicare swing-bed SNF target amount  06.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  07.00 Program reimbursement under the §410A Demonstration (see instructions)  08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)   | 01 00  |  | Wkst D-1 Pt II line  |                  |               | 201. 0           |
| 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 205.00 Medicare swing-bed SNF target amount 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 210.00 Reserved for future use   | .01.00 |  | with the first transfer of t |                  |               | 201.0            |
| 203.00 Total (sum of lines 201 and 202) 204.00 Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period) 205.00 Medicare swing-bed SNF target amount 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 210.00 Reserved for future use  | 202.00 |  | m Wkst. D-3, col. 3, line  | е                |               | 202.0            |
| Medicare swing-bed SNF discharges (see instructions)  Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  Medicare swing-bed SNF target amount  Medicare swing-bed SNF target amount  Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  POT. 00 Program reimbursement under the \$410A Demonstration (see instructions)  Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  Reserved for future use  |        |  |  |                  |               |                  |
| Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)  Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  Program reimbursement under the \$410A Demonstration (see instructions) Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  Modicare swing-bed SNF PPS payments (see instructions)  Reserved for future use  |        |  |  |                  |               | 203. 0           |
| period)  05. 00 Medicare swing-bed SNF target amount  06. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  07. 00 Program reimbursement under the §410A Demonstration (see instructions)  08. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  09. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  10. 00 Reserved for future use  | 04. 00 |  | C' C II-   | 1.5              | 1 12          | 204. 0           |
| 05. 00 Medicare swing-bed SNF target amount 06. 00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 07. 00 Program reimbursement under the \$410A Demonstration (see instructions) 08. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 09. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10. 00 Reserved for future use  |        | ·  | rirst year or the curren   | it 5-year demons | stration      |                  |
| 06.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)  Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  07.00 Program reimbursement under the §410A Demonstration (see instructions)  Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  10.00 Reserved for future use   | 05 00  |  |  |                  |               | 205. 0           |
| Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement  O7. 00 Program reimbursement under the §410A Demonstration (see instructions)  O8. 00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)  O9. 00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)  10. 00 Reserved for future use  |        |  | imes line 204)   |                  |               | 206. 0           |
| 08.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3) 09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10.00 Reserved for future use   |        |  |  |                  |               |                  |
| and 3) 09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10.00 Reserved for future use  | 07. 00 | Program reimbursement under the §410A Demonstration (see inst        | ructions)  |                  |               | 207. 0           |
| 09.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 10.00 Reserved for future use   | 08. 00 | Medicare swing-bed SNF inpatient service costs (from Wkst. E-        | 2, col. 1, sum of lines 1  | 1                |               | 208. 0           |
| 10.00 Reserved for future use  | 00 0-  | · ·  |  |                  |               | 000 -            |
|  |        | •                              | ctions)  |                  |               | 209. 0           |
| Comparision of DDS varsus Cost Daimbursoment   | 10.00  | Reserved for future use Comparision of PPS versus Cost Reimbursement |  |                  |               | 210. 0           |
|  | 15 00  |  | 209 nlus line 210) (see  |                  |               | 215. 0           |
| instructions)  |        |  |  |                  |               | [ . J. J         |

| Health Financial Systems                 | WOODLAWN HOSPITAL                        | In Lie                                       | u of Form CMS-2   | 2552-10 |
|--|--|--|---|---------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT  | Provi der CCN: 15-1313                   | Peri od:<br>From 01/01/2020<br>To 12/31/2020 | Worksheet E-3<br>Part V<br>Date/Time Pre<br>7/29/2021 4:1 | pared:  |
|  | Title XVIII                              | Hospi tal                                    | Cost  |         |
|  |  |  |   |         |
|  |  |  | 1. 00   |         |
| DADT V CALCULATION OF DEIMPHOSEMENT SETT | TEMENT EOD MEDICADE DADT A SEDVICES COST | T DELMBLIDSEMENT                             |   |         |

|                  | Title XVIII Hospital   | Cost               |        |
|------------------|--|--------------------|--------|
|                  |  | 1. 00              |        |
|                  | PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT                   | 1.00               |        |
| 1. 00            | Inpatient services   | 3, 704, 263        | 1.00   |
| 2. 00            | Nursing and Allied Health Managed Care payment (see instructions)  | 0                  | 2.00   |
| 3.00             | Organ acqui și ti on   | o                  | 3.00   |
| 4.00             | Subtotal (sum of lines 1 through 3)  | 3, 704, 263        | 4.00   |
| 5.00             | Pri mary payer payments  | 0                  | 5.00   |
| 6.00             | Total cost (line 4 less line 5). For CAH (see instructions)  | 3, 741, 306        | 6.00   |
|                  | COMPUTATION OF LESSER OF COST OR CHARGES   |                    |        |
|                  | Reasonabl e charges  |                    |        |
| 7. 00            | Routine service charges  | 0                  | 7. 00  |
| 8. 00            | Ancillary service charges  | 0                  | 8. 00  |
| 9. 00            | Organ acquisition charges, net of revenue  | 0                  | 9. 00  |
| 10.00            | Total reasonable charges   | 0                  | 10.00  |
| 11 00            | Customary charges  | 0                  | 44 00  |
| 11.00            | Aggregate amount actually collected from patients liable for payment for services on a charge basis                  | 0                  | 11.00  |
| 12. 00           | Amounts that would have been realized from patients liable for payment for services on a charge basis                | 0                  | 12.00  |
| 13. 00           | had such payment been made in accordance with 42 CFR 413.13(e) Ratio of line 11 to line 12 (not to exceed 1.000000)  | 0. 000000          | 13. 00 |
| 14. 00           | Total customary charges (see instructions)   | 0.000000           | 14.00  |
| 15. 00           | Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see                      | 0                  | 15.00  |
| 13.00            | instructions)  | J                  | 13.00  |
| 16.00            | Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see                      | 0                  | 16.00  |
|                  | instructions)  |                    |        |
| 17.00            | Cost of physicians' services in a teaching hospital (see instructions)   | 0                  | 17.00  |
|                  | COMPUTATION OF REIMBURSEMENT SETTLEMENT  |                    |        |
| 18. 00           | Direct graduate medical education payments (from Worksheet E-4, line 49)   | 0                  | 18. 00 |
| 19. 00           | Cost of covered services (sum of lines 6, 17 and 18)   | 3, 741, 306        |        |
| 20.00            | Deductibles (exclude professional component)   | 304, 040           |        |
| 21. 00           | Excess reasonable cost (from line 16)  | 0                  | 21.00  |
| 22. 00           | Subtotal (line 19 minus line 20 and 21)  | 3, 437, 266        |        |
| 23.00            | Coinsurance  | 0                  | 23.00  |
| 24. 00           | Subtotal (line 22 minus line 23)   | 3, 437, 266        |        |
| 25. 00           | Allowable bad debts (exclude bad debts for professional services) (see instructions)                                 | 49, 200            |        |
| 26. 00<br>27. 00 | Adjusted reimbursable bad debts (see instructions)   | 31, 980<br>18, 411 |        |
| 28. 00           | Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (sum of lines 24 and 25, or line 26) | 3, 469, 246        |        |
| 29. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   | 3, 409, 240        | 29.00  |
| 29. 50           | Pioneer ACO demonstration payment adjustment (see instructions)  | 0                  | 29.50  |
| 29. 99           | Demonstration payment adjustment amount before sequestration   | Ö                  | 29. 99 |
| 30.00            | Subtotal (see instructions)  | 3, 469, 246        |        |
| 30. 01           | Sequestration adjustment (see instructions)  | 22, 897            |        |
| 30. 02           | Demonstration payment adjustment amount after sequestration  | 0                  |        |
| 30. 03           | Sequestration adjustment-PARHM   |                    | 30. 03 |
| 31.00            | Interim payments   | 3, 119, 307        | 31.00  |
| 31.01            | Interim payments-PARHM   |                    | 31.01  |
| 32.00            | Tentative settlement (for contractor use only)   | 0                  | 32.00  |
| 32. 01           | Tentative settlement-PARHM (for contractor use only)   |                    | 32. 01 |
| 33.00            | Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  | 327, 042           |        |
| 33. 01           | Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)                     |                    | 33. 01 |
| 34.00            | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,                      | 0                  | 34.00  |
|                  | §115. 2  |                    |        |

| Health Financial Systems                | WOODLAWN HOSPITAL      | In Lieu         | of Form CMS-2552-10 |
|---|------------------------|-----------------|---------------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-1313 | Peri od:        | Worksheet E-3       |
|   |                        | From 01/01/2020 |                     |
|   |                        | T- 10/01/0000   | D-+- /T! D          |

|                 |   |                          | From 01/01/2020<br>To 12/31/2020 |             |                  |
|-----------------|---|--------------------------|----------------------------------|-------------|------------------|
|                 |   | Title XIX                | Hospi tal                        | Cost        |                  |
|                 | ·   |                          | Inpatient                        | Outpati ent |                  |
|                 |   |                          | 1. 00                            | 2. 00       |                  |
|                 | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV                               | ICES FOR TITLES V OR XI  | X SERVICES                       |             |                  |
|                 | COMPUTATION OF NET COST OF COVERED SERVICES   |                          |                                  |             |                  |
| 1.00            | Inpatient hospital/SNF/NF services  |                          | 188, 105                         |             | 1.00             |
| 2.00            | Medical and other services  |                          |                                  | 0           | 2.00             |
| 3.00            | Organ acquisition (certified transplant centers only)   |                          | 0                                |             | 3.00             |
| 4. 00           | Subtotal (sum of lines 1, 2 and 3)  |                          | 188, 105                         | 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)   |                          | 188, 105                         | 0           | 7.00             |
|                 | COMPUTATION OF LESSER OF COST OR CHARGES  |                          |                                  |             |                  |
| 0.00            | Reasonable Charges  |                          | 111 200                          |             | 0.00             |
| 8. 00           | Routine service charges   |                          | 111, 200                         | 0           | 8.00             |
| 9. 00<br>10. 00 | Ancillary service charges not of revenue  |                          | 240, 044                         | 0           | 9. 00<br>10. 00  |
|                 | Organ acquisition charges, net of revenue   |                          |                                  |             | 11.00            |
|                 | Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11) |                          | 351, 244                         | 0           | ı                |
| 12.00           | CUSTOMARY CHARGES   |                          | 331, 244                         | 0           | 12.00            |
| 13. 00          | Amount actually collected from patients liable for payment for                                | services on a charge     | O                                | 0           | 13.00            |
| 13.00           | basis   | ser vices on a charge    |                                  | O           | 13.00            |
| 14.00           | Amounts that would have been realized from patients liable for                                | payment for services or  | ol ol                            | 0           | 14.00            |
|                 | a charge basis had such payment been made in accordance with 42                               |                          |                                  | _           |                  |
| 15.00           | Ratio of line 13 to line 14 (not to exceed 1.000000)  | 3 (5)                    | 0. 000000                        | 0.000000    | 15.00            |
| 16.00           | Total customary charges (see instructions)  |                          | 351, 244                         | 0           | 16.00            |
| 17.00           | Excess of customary charges over reasonable cost (complete only                               | /if line 16 exceeds      | 163, 139                         | 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           |                  |
|                 | Cost of physicians' services in a teaching hospital (see instru                               | •                        | 0                                | 0           | 20.00            |
| 21. 00          | Cost of covered services (enter the lesser of line 4 or line 16                               | o)                       | 188, 105                         | 0           | 21. 00           |
|                 | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co                              | completed for PPS provid |                                  |             |                  |
|                 | Other than outlier payments   |                          | 0                                | 0           | 22.00            |
|                 | Outlier payments  |                          | 0                                | 0           | 23.00            |
|                 | Program capital payments  |                          | 0                                |             | 24.00            |
|                 | Capital exception payments (see instructions)   |                          | 0                                | 0           | 25.00            |
|                 | Routine and Ancillary service other pass through costs  |                          | 0                                | 0           |                  |
|                 | Subtotal (sum of lines 22 through 26)   |                          | 0                                | 0           | 27. 00<br>28. 00 |
|                 | Customary charges (title V or XIX PPS covered services only)                                  |                          | 100 105                          | 0           |                  |
| 29.00           | Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT             |                          | 188, 105                         | 0           | 29.00            |
| 30. 00          | Excess of reasonable cost (from line 18)  |                          | 0                                | 0           | 30.00            |
|                 | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)                                |                          | 188, 105                         | 0           | 31.00            |
|                 | Deductibles   |                          | 100, 100                         | 0           | 32.00            |
|                 | Coinsurance   |                          | 0                                | 0           | 33.00            |
|                 | Allowable bad debts (see instructions)  |                          | 0                                | 0           | 34.00            |
|                 | Utilization review  |                          |                                  | ŭ           | 35. 00           |
|                 | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and                                | 33)                      | 188, 105                         | 0           | 1                |
|                 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  |                          | 0                                | 0           |                  |
|                 | Subtotal (line 36 ± line 37)  |                          | 188, 105                         | 0           | 38.00            |
|                 | Direct graduate medical education payments (from Wkst. E-4)                                   |                          | 0                                |             | 39.00            |
|                 | Total amount payable to the provider (sum of lines 38 and 39)                                 |                          | 188, 105                         | 0           | 40.00            |
| 41.00           | Interim payments  |                          | 215, 704                         | 0           | 41.00            |
| 42.00           | Balance due provider/program (line 40 minus line 41)  |                          | -27, 599                         | 0           | 42.00            |
| 43.00           | Protested amounts (nonallowable cost report items) in accordanc                               | ce with CMS Pub 15-2,    | 0                                | 0           | 43.00            |
|                 | chapter 1, §115.2   |                          |                                  |             |                  |
|                 |   |                          |                                  |             |                  |

WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10

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

Provider CCN: 15-1313

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 4:15 pm

| —————————————————————————————————————— |   |                          |              |           | 7/29/2021 4:1 | 5 pm   |
|--|---|--------------------------|--------------|-----------|---------------|--------|
|  |   | General Fund             | Speci fi c   | Endowment | Plant Fund    |        |
|  |   | 1 00                     | Purpose Fund | Fund      | 4.00          |        |
|  | CURRENT ASSETS  | 1.00                     | 2.00         | 3. 00     | 4. 00         |        |
| 1. 00                                  | Cash on hand in banks   | 20, 076, 606             | O            | o         | 0             | 1.00   |
| 2. 00                                  | Temporary investments   | 20,070,000               | Ö            | ő         | 0             | 2.00   |
| 3. 00                                  | Notes recei vabl e  | 0                        |              | o         | 0             | 3.00   |
| 4.00                                   | Accounts recei vable  | 20, 032, 506             | 0            | o         | 0             | 4.00   |
| 5.00                                   | Other recei vable   | 862, 720                 | 0            | o         | 0             | 5.00   |
| 6.00                                   | Allowances for uncollectible notes and accounts receivable                    | -11, 561, 321            | 0            | o         | 0             | 6. 00  |
| 7.00                                   | Inventory   | 1, 066, 528              | 0            | 0         | 0             | 7. 00  |
| 8. 00                                  | Prepai d expenses   | 166, 841                 | 1            | 0         | 0             | 8. 00  |
| 9. 00                                  | Other current assets  | 0                        | 0            | 0         | 0             | 9. 00  |
| 10.00                                  | Due from other funds  | 0                        | 0            | 0         | 0             | 10.00  |
| 11. 00                                 | Total current assets (sum of lines 1-10)                                      | 30, 643, 880             | 0            | 0         | 0             | 11. 00 |
| 12. 00                                 | FIXED ASSETS Land   | 596, 216                 | O            | o         | 0             | 12.00  |
| 13. 00                                 | Land improvements   | 508, 687                 |              | 0         | 0             | 13.00  |
| 14. 00                                 | Accumulated depreciation  | -424, 785                | 1            | ol<br>Ol  | 0             | 14.00  |
| 15. 00                                 | Bui I di ngs  | 27, 445, 913             | 1            | Ö         | 0             | 15.00  |
| 16. 00                                 | Accumulated depreciation  | -14, 358, 749            | 1            | ol        | 0             | 16.00  |
| 17. 00                                 | Leasehold improvements  | 0                        | o            | ō         | 0             | 17. 00 |
| 18.00                                  | Accumul ated depreciation   | 0                        | o            | o         | 0             | 18.00  |
| 19.00                                  | Fi xed equipment  | 0                        | o            | o         | 0             | 19.00  |
| 20.00                                  | Accumulated depreciation  | 0                        | 0            | o         | 0             | 20.00  |
| 21.00                                  | Automobiles and trucks  | 0                        | 0            | o         | 0             | 21.00  |
| 22.00                                  | Accumulated depreciation  | 0                        | 0            | 0         | 0             | 22.00  |
| 23.00                                  | Major movable equipment   | 10, 868, 623             | 0            | 0         | 0             | 23.00  |
| 24.00                                  | Accumulated depreciation  | -8, 468, 465             | 0            | 0         | 0             | 24.00  |
| 25.00                                  | Mi nor equi pment depreci abl e   | 0                        | 0            | 0         | 0             | 25.00  |
| 26.00                                  | Accumulated depreciation  | 0                        | 0            | 0         | 0             | 26. 00 |
| 27. 00                                 | HIT designated Assets   | 0                        | 0            | 0         | 0             | 27. 00 |
| 28. 00                                 | Accumulated depreciation  | 0                        | 0            | 0         | 0             | 28. 00 |
| 29. 00                                 | Mi nor equi pment-nondepreci abl e  | 0                        | 0            | 0         | 0             | 29.00  |
| 30. 00                                 | Total fixed assets (sum of lines 12-29)                                       | 16, 167, 440             | 0            | 0         | 0             | 30.00  |
| 31. 00                                 | OTHER ASSETS Investments  | 5, 642, 529              | 0            | ol        | 0             | 31.00  |
| 32. 00                                 | Deposits on Leases  | 3,042,329                |              | 0         | 0             | 32.00  |
| 33. 00                                 | Due from owners/officers  |                          | 0            | ol<br>Ol  | 0             | 33.00  |
| 34. 00                                 | Other assets  | 462, 907                 |              | ol        | 0             | 34.00  |
| 35. 00                                 | Total other assets (sum of lines 31-34)                                       | 6, 105, 436              |              | ol        | 0             | 35. 00 |
| 36.00                                  | Total assets (sum of lines 11, 30, and 35)                                    | 52, 916, 756             | 1            | o         | 0             | 36.00  |
|  | CURRENT LIABILITIES   |                          |              | •         |               |        |
| 37.00                                  | Accounts payable  | 10, 578, 930             | 0            | 0         | 0             | 37.00  |
| 38. 00                                 | Salaries, wages, and fees payable   | 2, 834, 826              | 0            | 0         | 0             | 38. 00 |
| 39. 00                                 | Payroll taxes payable   | 0                        | 0            | 0         | 0             | 39. 00 |
| 40.00                                  | Notes and Loans payable (short term)  | 1, 058, 138              |              | 0         | 0             | 40.00  |
| 41.00                                  | Deferred income   | 0                        | 0            | O         | 0             | 41.00  |
| 42.00                                  | Accel erated payments   | 0                        |              |           | 0             | 42.00  |
| 43.00                                  | Due to other funds  | 05 170                   | 0            | U         | 0             | 43.00  |
| 44. 00<br>45. 00                       | Other current liabilities Total current liabilities (sum of lines 37 thru 44) | -95, 170<br>14, 376, 724 | 1            | 0         | 0             |        |
| 43.00                                  | LONG TERM LIABILITIES   | 14, 370, 724             | 0            | 0         | 0             | 45.00  |
| 46. 00                                 | Mortgage payable  | n                        | O            | o         | 0             | 46. 00 |
| 47. 00                                 | Notes payable   | 8, 097, 795              |              | Ö         | 0             |        |
| 48. 00                                 | Unsecured Loans   | 0,0,7,7,70               |              | ol        | 0             | 48. 00 |
| 49.00                                  | Other long term liabilities   | 0                        | 0            | o         | 0             | 49.00  |
| 50.00                                  | Total long term liabilities (sum of lines 46 thru 49)                         | 8, 097, 795              |              | o         | 0             | 50.00  |
| 51.00                                  | Total liabilities (sum of lines 45 and 50)                                    | 22, 474, 519             | 1            | o         | 0             | 51.00  |
|  | CAPITAL ACCOUNTS  |                          |              |           |               |        |
| 52.00                                  | General fund balance  | 30, 442, 237             |              |           |               | 52.00  |
| 53.00                                  | Specific purpose fund   |                          | 0            |           |               | 53.00  |
| 54.00                                  | Donor created - endowment fund balance - restricted                           |                          |              | 0         |               | 54.00  |
| 55.00                                  | Donor created - endowment fund balance - unrestricted                         |                          |              | 0         |               | 55.00  |
| 56. 00                                 | Governing body created - endowment fund balance                               |                          |              | 0         |               | 56.00  |
| 57. 00                                 | Plant fund balance - invested in plant  |                          |              |           | 0             | 57.00  |
| 58. 00                                 | Plant fund balance - reserve for plant improvement,                           |                          |              |           | 0             | 58. 00 |
| 59. 00                                 | replacement, and expansion Total fund balances (sum of lines 52 thru 58)      | 30, 442, 237             | o            | 0         | 0             | 59. 00 |
| 60.00                                  | Total liabilities and fund balances (sum of lines 51 and                      | 52, 916, 756             | 1            | 0         | 0             | 60.00  |
| 55.00                                  | [59]  | 52, 710, 750             |              | ď         | U             | 55.50  |
|  |   | •                        | . '          | '         |               | •      |

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-1313

| Period: | Worksheet G-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared:

|                |   |           |              | 1          | To 12/31/2020 | Date/Time Pre<br>  7/29/2021 4:1 |                                       |
|----------------|---|-----------|--------------|------------|---------------|----------------------------------|---------------------------------------|
|                |   | General   | Fund         | Special Pu | urpose Fund   | Endowment                        | , , , , , , , , , , , , , , , , , , , |
|                |   |           |              | •          |               | Fund                             |                                       |
|                |   |           |              |            |               |                                  |                                       |
|                |   | 1. 00     | 2. 00        | 3. 00      | 4. 00         | 5. 00                            |                                       |
| 1. 00          | Fund balances at beginning of period                                    |           | 23, 300, 945 |            | 0             |                                  | 1.00                                  |
| 2.00           | Net income (loss) (from Wkst. G-3, line 29)                             |           | 7, 141, 292  |            |               |                                  | 2.00                                  |
| 3.00           | Total (sum of line 1 and line 2)  |           | 30, 442, 237 |            | 0             | 0                                | 3.00                                  |
| 4. 00<br>5. 00 | Additions (credit adjustments) (specify)                                | 0         |              |            |               | 0                                |                                       |
| 6.00           |   | 0         |              |            |               | 0                                |                                       |
| 7. 00          |   |           |              |            | 1             | 0                                |                                       |
| 8. 00          |   |           |              |            |               | 0                                |                                       |
| 9. 00          |   |           |              |            |               | 0                                |                                       |
| 10.00          | Total additions (sum of line 4-9)                                       |           | o            |            | ol ol         | O                                | 10.00                                 |
| 11. 00         | Subtotal (line 3 plus line 10)  |           | 30, 442, 237 |            | o             |                                  | 11.00                                 |
| 12.00          | Deductions (debit adjustments) (specify)                                | o         |              | (          |               | 0                                | 12.00                                 |
| 13.00          |   | o         |              |            |               | 0                                | 13.00                                 |
| 14.00          |   | O         |              | (          |               | 0                                | 14.00                                 |
| 15.00          |   | 0         |              | (          |               | 0                                |                                       |
| 16.00          |   | 0         |              | (          |               | 0                                |                                       |
| 17. 00         |   | 0         |              | (          |               | 0                                |                                       |
| 18. 00         | Total deductions (sum of lines 12-17)                                   |           | 0            |            | 0             |                                  | 18. 00                                |
| 19. 00         | Fund balance at end of period per balance                               |           | 30, 442, 237 |            | 0             |                                  | 19. 00                                |
|                | sheet (line 11 minus line 18)   | Endowment | <br>PI ant   | Fund       |               |                                  |                                       |
|                |   | Fund      | Frant        | i unu      |               |                                  |                                       |
|                |   | Turiu     |              |            |               |                                  |                                       |
|                |   | 6. 00     | 7. 00        | 8. 00      |               |                                  |                                       |
| 1.00           | Fund balances at beginning of period                                    | 0         |              | (          |               |                                  | 1.00                                  |
| 2. 00          | Net income (loss) (from Wkst. G-3, line 29)                             | _         |              | _          |               |                                  | 2.00                                  |
| 3.00           | Total (sum of line 1 and line 2)  | 0         |              | (          |               |                                  | 3.00                                  |
| 4.00           | Additions (credit adjustments) (specify)                                |           | 0            |            |               |                                  | 4.00                                  |
| 5.00           |   |           | 0            |            |               |                                  | 5. 00<br>6. 00                        |
| 6. 00<br>7. 00 |   |           | 0            |            |               |                                  | 7.00                                  |
| 8. 00          |   |           | 0            |            |               |                                  | 8.00                                  |
| 9. 00          |   |           | 0            |            |               |                                  | 9.00                                  |
| 10.00          | Total additions (sum of line 4-9)                                       | 0         | Ğ            |            |               |                                  | 10.00                                 |
| 11. 00         | Subtotal (line 3 plus line 10)  |           |              |            |               |                                  | 11.00                                 |
| 12. 00         | Deductions (debit adjustments) (specify)                                |           | o            |            |               |                                  | 12.00                                 |
| 13.00          |   |           | o            |            |               |                                  | 13.00                                 |
| 14.00          |   |           | o            |            |               |                                  | 14.00                                 |
| 15.00          |   |           | 0            |            |               |                                  | 15.00                                 |
| 16.00          |   |           | 0            |            |               |                                  | 16.00                                 |
| 17. 00         |   |           | 0            |            |               |                                  | 17. 00                                |
| 18. 00         | Total deductions (sum of lines 12-17)                                   | 0         |              | (          | )             |                                  | 18. 00                                |
|                |   |           |              |            |               |                                  |                                       |
| 19. 00         | Fund balance at end of period per balance sheet (line 11 minus line 18) | 0         |              | (          | P             |                                  | 19. 00                                |

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1313

|                  |  |             | To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |                  |
|------------------|--|-------------|---------------|--------------------------------|------------------|
|                  | 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   | 0.000.5     | · -           | 0 000 545                      | 1 00             |
| 1.00             | Hospi tal  | 3, 338, 54  | 15            | 3, 338, 545                    | 1.00             |
| 2. 00<br>3. 00   | SUBPROVI DER - I PF<br>SUBPROVI DER - I RF   |             |               |                                | 2.00<br>3.00     |
| 4. 00            | SUBPROVIDER - TRF  |             |               |                                | 4.00             |
| 5. 00            | Swing bed - SNF  |             | 0             | 0                              | 5.00             |
| 6. 00            | Swing bed - NF   |             | 0             | 0                              | 6. 00            |
| 7. 00            | SKILLED NURSING FACILITY   |             |               |                                | 7. 00            |
| 8.00             | NURSING FACILITY   |             |               |                                | 8. 00            |
| 9.00             | OTHER LONG TERM CARE   |             |               |                                | 9.00             |
| 10.00            | Total general inpatient care services (sum of lines 1-9)   | 3, 338, 54  | 15            | 3, 338, 545                    | 10.00            |
|                  | Intensive Care Type Inpatient Hospital Services  |             |               |                                |                  |
| 11. 00           | INTENSIVE CARE UNIT  | 1, 107, 51  | 10            | 1, 107, 510                    |                  |
| 12. 00           | CORONARY CARE UNIT   |             |               |                                | 12.00            |
| 13.00            | BURN INTENSIVE CARE UNIT   |             |               |                                | 13.00            |
| 14.00            | SURGICAL INTENSIVE CARE UNIT   |             |               |                                | 14.00            |
| 15. 00<br>16. 00 | OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of lines | 1, 107, 51  | 10            | 1, 107, 510                    | 15. 00<br>16. 00 |
| 16.00            | 11-15)   | 1, 107, 51  | 10            | 1, 107, 310                    | 10.00            |
| 17. 00           | Total inpatient routine care services (sum of lines 10 and 16)                                   | 4, 446, 05  | 55            | 4, 446, 055                    | 17. 00           |
| 18. 00           | Ancillary services   | 17, 343, 29 |               |                                | 1                |
| 19. 00           | Outpatient services  | 475, 02     |               |                                |                  |
| 20.00            | SHAFER MEDICAL CENTER  |             | 678, 844      |                                | 20.00            |
| 20. 01           | WOODLAWN MEDICAL PROFESSIONALS   | 1, 16       | 3, 126, 653   | 3, 127, 818                    | 20. 01           |
| 20. 02           | FULTON COUNTY MEDICAL CENTER- 700 MA   |             | 0 1, 691, 309 | 1, 691, 309                    | 20. 02           |
| 20. 03           | FULTON COUNTY MEDICAL CENTER - 100 E   |             | 0 356, 605    |                                | 1                |
| 20. 04           | AKRON MEDICAL CLINIC   |             | 0 533, 009    |                                | 1                |
| 20. 05           | ARGOS MEDICAL CLINIC   |             | 0 1, 994, 267 |                                | 20. 05           |
| 21. 00           | FEDERALLY QUALIFIED HEALTH CENTER  |             | 0             | 0                              | 21.00            |
| 22. 00           | HOME HEALTH AGENCY   |             |               |                                | 22.00            |
| 23. 00<br>24. 00 | AMBULANCE SERVICES CMHC  |             |               |                                | 23. 00<br>24. 00 |
| 25. 00           | AMBULATORY SURGICAL CENTER (D. P. )  |             |               |                                | 25.00            |
| 26. 00           | HOSPI CE   |             |               |                                | 26.00            |
| 27. 00           | FCMC CLINIC  |             | 0 696, 422    | 696, 422                       | •                |
| 27. 01           | ARGOS CLINIC   |             | 0 821, 169    |                                | 1                |
| 27. 02           | AKRON CLINIC   |             | 0 219, 475    |                                | ı                |
| 27.03            | PROFESSI ONAL FEES   | 96, 87      | 7, 841, 715   | 7, 938, 591                    | 27. 03           |
| 27. 04           | DI ETARY   |             | 0 15, 868     | 15, 868                        | 27. 04           |
| 28. 00           | Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.                           | 22, 362, 43 | 123, 458, 860 | 145, 821, 291                  | 28. 00           |
|                  | G-3, line 1)   |             |               |                                |                  |
| 20.00            | PART II - OPERATING EXPENSES   | T           | 40 474 00E    | I                              | 20.00            |
| 29. 00<br>30. 00 | Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)                               |             | 60, 476, 985  |                                | 29. 00<br>30. 00 |
| 31.00            | ADD (SPECIFI)  |             | 0             |                                | 31.00            |
| 32. 00           |  |             | 0             |                                | 32.00            |
| 33. 00           |  |             | 0             | •                              | 33.00            |
| 34.00            |  |             | 0             |                                | 34.00            |
| 35. 00           |  |             | O             |                                | 35. 00           |
| 36.00            | Total additions (sum of lines 30-35)   |             | 0             |                                | 36.00            |
| 37.00            | DEDUCT (SPECIFY)   |             | 0             |                                | 37.00            |
| 38. 00           |  |             | 0             |                                | 38. 00           |
| 39. 00           |  |             | 0             |                                | 39. 00           |
| 40.00            |  |             | 0             |                                | 40.00            |
| 41.00            | Total (1) 1 (1) (1) (2) (2) (3) (4)  |             | 0             |                                | 41.00            |
| 42.00            | Total deductions (sum of lines 37-41)  |             | 0 474 005     |                                | 42.00            |
| 43. 00           | Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)   |             | 60, 476, 985  |                                | 43. 00           |
|                  | TO MASE. O J. TITIC 4)   | 1           | T             | I                              | I                |

| TATE   | Financial Systems WOODLAWN FINANCIAL FOR THE WOODLAWN FINANCIAL FOR THE FORM OF THE PROPERTY OF REVENUES AND EXPENSES  | Provi der CCN: 15-1313 | Peri od:        | u of Form CMS-2<br>Worksheet G-3 |       |
|--------|--|------------------------|-----------------|----------------------------------|-------|
| DIAIEN | IENT OF REVENUES AND EXPENSES  | Provider CCN. 15-1313  | From 01/01/2020 | WOLKSHEEL G-3                    |       |
|        |  |                        | To 12/31/2020   |                                  |       |
|        |  |                        | 1               | 7/29/2021 4:1                    | 5 pm  |
|        |  |                        |                 |                                  |       |
|        | Table 1 and  | 11                     |                 | 1.00                             | 1.0   |
| . 00   | Total patient revenues (from Wkst. G-2, Part I, column 3,  |                        |                 | 145, 821, 291                    | 1.0   |
| 2.00   | Less contractual allowances and discounts on patients' accounts and patients accounts accounts and patients accounts account and patients accounts account acc | ounts                  |                 | 90, 657, 785                     |       |
| 3. 00  | Net patient revenues (line 1 minus line 2) Less total operating expenses (from Wkst. G-2, Part II, li  | no 42)                 |                 | 55, 163, 506                     | 1     |
| i. 00  |  | ne 43)                 |                 | 60, 476, 985                     |       |
| . 00   | Net income from service to patients (line 3 minus line 4) OTHER INCOME   |                        |                 | -5, 313, 479                     | 5.0   |
| . 00   | Contributions, donations, bequests, etc  |                        |                 | 0                                | 6.0   |
| . 00   | Income from investments  |                        |                 | 113, 253                         |       |
| . 00   | Revenues from telephone and other miscellaneous communicat   | ion sorvices           |                 | 113, 233                         | 1     |
| 0. 00  | Revenue from television and radio service  | Ton Services           |                 | 0                                |       |
| 0.00   | Purchase di scounts  |                        |                 | 0                                | 1     |
|        | Rebates and refunds of expenses  |                        |                 | 0                                | 1     |
|        | Parking lot receipts   |                        |                 | 0                                |       |
|        | Revenue from Laundry and Linen service   |                        |                 | 0                                |       |
|        | Revenue from meals sold to employees and guests  |                        |                 | 132, 065                         |       |
|        | Revenue from rental of living quarters   |                        |                 | 132, 003                         | 1     |
|        | Revenue from sale of medical and surgical supplies to other  | r than natients        |                 | 0                                |       |
|        | Revenue from sale of drugs to other than patients  | trian patronts         |                 | 0                                |       |
|        | Revenue from sale of medical records and abstracts   |                        |                 | 0                                |       |
|        | Tuition (fees, sale of textbooks, uniforms, etc.)  |                        |                 | 0                                |       |
|        | Revenue from gifts, flowers, coffee shops, and canteen   |                        |                 | 0                                | 1     |
|        | Rental of vending machines   |                        |                 | 13                               |       |
| 2. 00  | Rental of hospital space   |                        |                 | 2, 230                           |       |
|        | Governmental appropriations  |                        |                 | 0                                | 1     |
|        | OTHER REVENUE  |                        |                 | 1, 350, 427                      | 24.0  |
| 4. 01  | LTC REVENUE  |                        |                 | 3, 666, 260                      |       |
|        | GAIN/LOSS DISP ASSET-MISC  |                        |                 | -71, 894                         |       |
|        | OTHER (SPECIFY)  |                        |                 | 0                                | 1     |
| 4. 04  | OTHER (SPECIFY)  |                        |                 | 0                                | 1     |
|        | COVI D-19 PHE Fundi ng   |                        |                 | 7, 262, 417                      | 24.5  |
| 5. 00  | Total other income (sum of lines 6-24)   |                        |                 | 12, 454, 771                     | 25. C |
|        | Total (line 5 plus line 25)  |                        |                 | 7, 141, 292                      |       |
|        | OTHER EXPENSES (SPECIFY)   |                        |                 | 0                                |       |
| 8. 00  | Total other expenses (sum of line 27 and subscripts)   |                        |                 | 0                                | 28.0  |
| 9. 00  | Net income (or loss) for the period (line 26 minus line 28   | )                      |                 | 7, 141, 292                      | 29 0  |

|        | Financial Systems  | WOODLAWN H   |              |              |                                  | eu of Form CMS- |                |
|--------|--|--------------|--------------|--------------|----------------------------------|-----------------|----------------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS                     |              | Provi der Co | CN: 15-1313  | Peri od:                         | Worksheet M-1   |                |
|        |  |              | Component    | CCN: 15-8551 | From 01/01/2020<br>To 12/31/2020 |                 | pared:<br>5 pm |
|        |  |              |              |              | RHC I                            | Cost            |                |
|        |  | Compensation | Other Costs  |              | 1 Reclassi fi cat                |                 |                |
|        |  |              |              | + col. 2)    | i ons                            | Tri al Balance  |                |
|        |  |              |              |              |                                  | (col. 3 +       |                |
|        |  | 4.00         | 0.00         | 2.00         | 4.00                             | col . 4)        |                |
|        | FACILITY HEALTH CARE STAFF COSTS                         | 1. 00        | 2. 00        | 3. 00        | 4. 00                            | 5. 00           |                |
| 1. 00  | Physician  | 0            | 0            |              | 0 (                              | 0               | 1.00           |
| 2. 00  | Physician Assistant                                      | 0            | 0            |              | 0 0                              |                 |                |
| 3.00   | Nurse Practitioner                                       | 149, 874     | 0            | 149, 8       | 7                                | 149, 874        | 1              |
| 4. 00  | Vi si ti ng Nurse  | 147, 074     | 0            | 147,0        | 74                               | 0               | 1              |
| 5. 00  | Other Nurse  | 38, 304      | 0            | 38, 3        | 04 -11, 172                      | -               |                |
| 6. 00  | Clinical Psychologist                                    | 00, 00 1     | 0            | 00, 0        | 0 11, 172                        | 0               |                |
| 7. 00  | Clinical Social Worker                                   | 0            | 0            |              |                                  | ol o            |                |
| 8. 00  | Laboratory Techni ci an                                  | 0            | 0            |              | 0                                |                 |                |
| 9. 00  | Other Facility Health Care Staff Costs                   | 83, 510      | 0            | 83, 5        | 10 -24, 357                      | 59, 153         |                |
| 10.00  | Subtotal (sum of lines 1 through 9)                      | 271, 688     | 0            | 271, 6       |                                  |                 | 1              |
| 11.00  | Physician Services Under Agreement                       | 0            | 461, 271     | 461, 2       | 71 -178, 251                     | 283, 020        | 11.00          |
| 12.00  | Physician Supervision Under Agreement                    | 0            | 0            |              | 0                                | 0               | 12.00          |
| 13.00  | Other Costs Under Agreement                              | 0            | 0            |              | 0 0                              | 0               | 13.00          |
| 14.00  | Subtotal (sum of lines 11 through 13)                    | 0            | 461, 271     | 461, 2       | 71 -178, 251                     | 283, 020        | 14.00          |
| 15. 00 | Medical Supplies   | 0            | 20, 878      | 20, 8        | 78 -6, 089                       | 14, 789         | 15. 00         |
| 16.00  | Transportation (Health Care Staff)                       | 0            | 0            |              | 0                                | 0               | 16. 00         |
| 17. 00 | Depreciation-Medical Equipment                           | 0            | 0            |              | 0 0                              | 0               |                |
| 18. 00 | Professional Liability Insurance                         | 0            | 0            |              | 0                                | 0               | 18. 00         |
|        | Other Health Care Costs                                  | 0            | 0            |              | 0                                | 0               | 19.00          |
| 20. 00 | Allowable GME Costs                                      | _            |              |              |                                  |                 | 20.00          |
| 21.00  | Subtotal (sum of lines 15 through 20)                    | 0            | 20, 878      |              |                                  |                 |                |
| 22. 00 | Total Cost of Health Care Services (sum of               | 271, 688     | 482, 149     | 753, 8       | -219, 869                        | 533, 968        | 22. 00         |
|        | lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES |              |              |              |                                  |                 | 1              |
| 23. 00 | Pharmacy   | 0            | 0            |              | 0                                | 0               | 23. 00         |
| 24. 00 | Dental   | 0            | 0            |              |                                  | 1               | 24.00          |
| 25. 00 | Optometry  | 0            | 0            |              | 0                                | ol o            |                |
| 25. 01 | Tel eheal th   | 0            | 0            |              | o c                              | ol o            | 25. 01         |
| 25. 02 | Chronic Care Management                                  | 0            | 0            |              | 0 0                              | 0               | 25. 02         |
| 26. 00 | All other nonreimbursable costs                          | 0            | 0            |              | 0                                | 0               | 26.00          |
| 27.00  | Nonallowable GME costs                                   |              |              |              |                                  |                 | 27.00          |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23             | 0            | 0            |              | 0 0                              | 0               | 28. 00         |
|        | through 27)  |              |              |              |                                  |                 | ]              |
|        | FACILITY OVERHEAD  | -            |              |              |                                  |                 | ļ              |
|        | Facility Costs   | 0            | 5, 116       |              |                                  |                 |                |
| 30 00  | Administrative Costs                                     | 33 274       | 106 682      | 139. 9       | 56 -22.769                       | d 117 187       | 1 30 00        |

33, 274

304, 962

45, 757 117, 187 162, 944

696, 912

30.00

31.00

32.00

5, 116 139, 956

145, 072

898, 909

40, 641 -22, 769

17, 872

-201, 997

5, 116 106, 682

111, 798

593, 947

30.00 Administrative Costs

31.00

Total Facility Overhead (sum of lines 29 and

| Health Financial Systems WOODLAWN HOSE    |             |    |             |              | In Lieu of Form CMS-2552-10 |            |                             |                |
|---|-------------|----|-------------|--------------|-----------------------------|------------|-----------------------------|----------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |             |    | Provi der ( | CCN: 15-1313 | Peri<br>From                | 01/01/2020 | Worksheet M-1               |                |
|   |             |    | Component   | CCN: 15-8551 | То                          | 12/31/2020 | Date/Time Pre 7/29/2021 4:1 | pared:<br>5 pm |
|   |             |    |             |              |                             | RHC I      | Cost                        |                |
|   | Adjustments | Ne | t Expenses  |              |                             |            |                             |                |
|   |             |    | for         |              |                             |            |                             |                |
|   |             | Al | llocation   |              |                             |            |                             |                |
|   |             | (  | (col. 5 +   |              |                             |            |                             |                |
|   |             |    | col. 6)     |              |                             |            |                             |                |
|   | 6.00        |    | 7 00        |              |                             |            |                             |                |

|   |        |  | Auj us tillerits | INEL EXPENSES |  |        |
|---|--------|--|------------------|---------------|--|--------|
|   |        |  |                  | for           |  |        |
|   |        |  |                  | Allocation    |  |        |
|   |        |  |                  | (col. 5 +     |  |        |
|   |        |  |                  | col. 6)       |  |        |
|   |        |  | 6. 00            | 7. 00         |  |        |
|   |        | FACILITY HEALTH CARE STAFF COSTS             |                  |               |  | 1      |
| 1 | 1.00   | Physi ci an                                  | 0                | 0             |  | 1.00   |
| 2 | 2. 00  | Physician Assistant                          | 0                | 0             |  | 2.00   |
| 3 | 3. 00  | Nurse Practitioner                           | 0                | 149, 874      |  | 3.00   |
| 4 | 4. 00  | Visiting Nurse                               | 0                | 0             |  | 4.00   |
| Ę | 5. 00  | Other Nurse                                  | 0                | 27, 132       |  | 5.00   |
| é | 5. 00  | Clinical Psychologist                        | 0                | 0             |  | 6.00   |
|   | 7. 00  | Clinical Social Worker                       | 0                | 0             |  | 7.00   |
|   | 3. 00  | Laboratory Techni ci an                      | n                | 0             | l .  | 8.00   |
|   | 9. 00  | Other Facility Health Care Staff Costs       | l o              | 59, 153       |  | 9.00   |
|   | 10.00  | Subtotal (sum of lines 1 through 9)          | 0                | 236, 159      | 1  | 10.00  |
|   | 11. 00 | Physician Services Under Agreement           | 0                | 283, 020      |  | 11.00  |
|   |        |  | 0                |               |  |        |
|   | 12.00  | Physician Supervision Under Agreement        | 0                | 0             | l control of the cont | 12.00  |
|   |        | Other Costs Under Agreement                  | 0                | 0             | l .  | 13.00  |
|   | 14.00  | `  | 0                | 283, 020      |  | 14.00  |
|   | 15. 00 | Medical Supplies                             | 0                | 14, 789       | 1  | 15. 00 |
|   | 16. 00 | ,  | 0                | 0             |  | 16. 00 |
|   |        | Depreciation-Medical Equipment               | 0                | 0             |  | 17.00  |
| 1 | 18. 00 | Professional Liability Insurance             | 0                | 0             |  | 18.00  |
| 1 | 19. 00 | Other Health Care Costs                      | 0                | 0             |  | 19.00  |
| 2 | 20.00  | Allowable GME Costs                          |                  |               |  | 20.00  |
| 2 | 21. 00 | Subtotal (sum of lines 15 through 20)        | 0                | 14, 789       |  | 21.00  |
| 2 | 22. 00 | Total Cost of Health Care Services (sum of   | 0                | 533, 968      |  | 22.00  |
|   |        | lines 10, 14, and 21)                        |                  |               |  |        |
|   |        | COSTS OTHER THAN RHC/FQHC SERVICES           |                  |               |  | 1      |
| 2 | 23. 00 | Pharmacy                                     | 0                | 0             |  | 23.00  |
| 2 | 24. 00 | Dental                                       | 0                | 0             |  | 24.00  |
| 2 | 25. 00 | Optometry                                    | 0                | 0             |  | 25.00  |
|   | 25. 01 | Tel eheal th                                 | 0                | 0             |  | 25. 01 |
|   | 25. 02 | Chronic Care Management                      | o o              | 0             |  | 25. 02 |
|   | 26. 00 | All other nonreimbursable costs              | n                | l o           |  | 26.00  |
|   | 27. 00 | Nonallowable GME costs                       | Ŭ                | Ĭ             |  | 27. 00 |
|   | 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0                | 0             |  | 28. 00 |
| _ | 20.00  | through 27)                                  | U                | ٥             |  | 20.00  |
|   |        | FACILITY OVERHEAD                            |                  |               |  | +      |
| , | 20 00  | Facility Costs                               | 0                | 45, 757       |  | 29. 00 |
|   |        |  | 0                |               |  | 30.00  |
|   | 30.00  | Administrative Costs                         |                  | 117, 187      | •  |        |
| 3 | 31. 00 | Total Facility Overhead (sum of lines 29 and |                  | 162, 944      |  | 31.00  |
| , | 22 00  | 30)  | _                | /0/ 010       |  | 22.00  |
| 3 | 32. 00 | Total facility costs (sum of lines 22, 28    |                  | 696, 912      |  | 32. 00 |
|   |        | and 31)                                      | I                | I             | I  | I      |
|   |        |  |                  |               |  |        |

|        | Financial Systems                            | WOODLAWN H   |              |               |                                  | eu of Form CMS-2 |         |
|--------|--|--------------|--------------|---------------|----------------------------------|------------------|---------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS         |              | Provi der Co | CN: 15-1313   | Peri od:                         | Worksheet M-1    |         |
|        |  |              | Component (  | CCN: 15-8552  | From 01/01/2020<br>To 12/31/2020 |                  | nared:  |
|        |  |              | Component    | JCIN. 13-0332 | 10 12/31/2020                    | 7/29/2021 4: 1   | 5 pm    |
|        |  |              |              |               | RHC II                           | Cost             | -       |
|        |  | Compensation | Other Costs  | Total (col.   | 1 Reclassi fi cat                | Recl assi fi ed  |         |
|        |  | '            |              | + col . 2)    | i ons                            | Tri al Balance   |         |
|        |  |              |              | ŕ             |                                  | (col. 3 +        |         |
|        |  |              |              |               |                                  | col . 4)         |         |
|        |  | 1. 00        | 2.00         | 3. 00         | 4. 00                            | 5. 00            |         |
|        | FACILITY HEALTH CARE STAFF COSTS             |              |              |               |                                  |                  |         |
| 1.00   | Physi ci an                                  | 1, 892, 077  | 331, 925     | 2, 224, 0     | 02 -935, 490                     | 1, 288, 512      | 1.00    |
| 2.00   | Physician Assistant                          | 0            | 0            |               | 0                                | 0                | 2.00    |
| 3.00   | Nurse Practitioner                           | 0            | 0            |               | 0 286, 823                       | 286, 823         | 3.00    |
| 4.00   | Visiting Nurse                               | 0            | 0            |               | 0                                | 0                | 4.00    |
| 5.00   | Other Nurse                                  | 201, 971     | 0            | 201, 9        | 71 -58, 909                      | 143, 062         | 5.00    |
| 6.00   | Clinical Psychologist                        | 0            | 0            |               | 0                                | 0                | 6.00    |
| 7.00   | Clinical Social Worker                       | 0            | 0            |               | 0                                | 0                | 7.00    |
| 8.00   | Laboratory Techni ci an                      | 0            | 0            |               | 0                                | 0                | 8.00    |
| 9.00   | Other Facility Health Care Staff Costs       | 176, 317     | 0            | 176, 3        | 17 -51, 42 <i>6</i>              | 124, 891         | 9.00    |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 2, 270, 365  | 331, 925     | 2, 602, 2     | 90 -759, 002                     | 1, 843, 288      | 10.00   |
| 11.00  | Physician Services Under Agreement           | 0            | 0            |               | 0                                | 0                | 11.00   |
| 12.00  | Physician Supervision Under Agreement        | o            | 0            |               | 0                                | 0                | 12.00   |
| 13.00  | Other Costs Under Agreement                  | O            | 0            |               | 0                                | 0                | 13.00   |
| 14.00  | Subtotal (sum of lines 11 through 13)        | O            | 0            |               | 0                                | 0                | 14.00   |
| 15.00  | Medical Supplies                             | 0            | 461, 057     | 461, 0        | 57 -134, 475                     | 326, 582         | 15.00   |
| 16.00  | Transportation (Health Care Staff)           | 0            | 0            |               | 0                                | 0                | 16.00   |
| 17.00  | Depreciation-Medical Equipment               | 0            | 0            |               | 0                                | 0                | 17.00   |
| 18.00  | Professional Liability Insurance             | 0            | 0            |               | 0                                | 0                | 18.00   |
| 19.00  | Other Health Care Costs                      | 0            | 0            |               | 0                                | 0                | 19.00   |
| 20.00  | Allowable GME Costs                          |              |              |               |                                  |                  | 20.00   |
| 21.00  | Subtotal (sum of lines 15 through 20)        | 0            | 461, 057     | 461, 0        | 57 -134, 475                     | 326, 582         | 21.00   |
| 22.00  | Total Cost of Health Care Services (sum of   | 2, 270, 365  | 792, 982     | 3, 063, 3     | 47 -893, 477                     | 2, 169, 870      | 22.00   |
|        | lines 10, 14, and 21)                        |              |              |               |                                  |                  | ]       |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |              |              |               |                                  |                  |         |
| 23.00  | Pharmacy                                     | 0            | 0            |               | 0                                | 0                |         |
| 24.00  | Dental                                       | 0            | 0            |               | 0                                | 0                | 24.00   |
| 25.00  | Optometry                                    | 0            | 0            |               | 0                                | 0                | 25.00   |
| 25. 01 | Tel eheal th                                 | 0            | 0            |               | 0                                | 0                |         |
| 25. 02 | Chronic Care Management                      | 0            | 0            |               | 0                                | 0                |         |
| 26. 00 | All other nonreimbursable costs              | 0            | 0            |               | 0                                | 0                | 26.00   |
| 27. 00 | Nonallowable GME costs                       |              |              |               |                                  |                  | 27.00   |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0            | 0            |               | 0                                | 0                | 28.00   |
|        | through 27)                                  |              |              |               |                                  |                  | 1       |
|        | FACILITY OVERHEAD                            |              |              |               |                                  |                  | 4       |
|        | Facility Costs                               | 0            | 444, 481     | 444, 4        |                                  |                  |         |
| 30 00  | Administrative Costs                         | 492 151      | 467 538      | 959 6         | 89 -408 234                      | ll 551 455       | 1 30 00 |

492, 151

2, 762, 516

444, 481 467, 538 912, 019

1, 705, 001

444, 481 959, 689

1, 404, 170

4, 467, 517

-744, 653 -408, 234

-1, 152, 887

-2, 046, 364

-300, 172 551, 455

251, 283

2, 421, 153

30.00

31.00

32.00

30.00 Administrative Costs

31.00

Total Facility Overhead (sum of lines 29 and

| Health Financial Systems WOODLAWN HOSPITAL |             |              |              | In Lie                      | u of Form CMS-2                | 2552-10  |
|--|-------------|--------------|--------------|-----------------------------|--------------------------------|----------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS  |             | Provi der C  | CCN: 15-1313 | Peri od:<br>From 01/01/2020 | Worksheet M-1                  |          |
|  |             | Component    | CCN: 15-8552 | To 12/31/2020               | Date/Time Pre<br>7/29/2021 4:1 |          |
|  |             |              |              | RHC II                      | Cost                           | <u> </u> |
|  | Adjustments | Net Expenses |              |                             |                                |          |

| Adj ustments   |
|--|
| For   All coation   Ccol   5 + col   6   6   6   6   6   6   6   6   6   |
| FACILITY HEALTH CARE STAFF COSTS   |
| Ccol. 5 + col. 6)   Col. 6   Col. 6 |
| FACILITY HEALTH CARE STAFF COSTS   |
| FACILITY HEALTH CARE STAFF COSTS   |
| FACILITY HEALTH CARE STAFF COSTS   1.00   Physician Assistant   0   1, 288, 512   1.00   |
| 1.00       Physician       0       1, 288, 512       1.00         2.00       Physician Assistant       0       0       0       2.00         3.00       Nurse Practitioner       0       286, 823       3.00         4.00       Visiting Nurse       0       0       4.00         5.00       Other Nurse       0       143,062       5.00         6.00       Clinical Psychologist       0       0       7.00         7.00       Clinical Social Worker       0       0       7.00         8.00       Laboratory Technician       0       0       7.00         9.00       Other Facility Health Care Staff Costs       0       124,891       9.00         10.00       Subtotal (sum of lines 1 through 9)       0       1,843,288       10.00         11.00       Physician Services Under Agreement       0       0       11.00         12.00       Physician Supervision Under Agreement       0       0       12.00         13.00       Other Costs Under Agreement       0       0       13.00         14.00       Subtotal (sum of lines 11 through 13)       0       0       14.00         15.00       Medical Supplies       0       326,582   |
| 2. 00       Physician Assistant       0       0       2.00         3. 00       Nurse Practitioner       0       286, 823       3.00         4. 00       Visiting Nurse       0       0       4.00         5. 00       Other Nurse       0       143, 062       5.00         6. 00       Clinical Psychologist       0       0       6.00         7. 00       Clinical Social Worker       0       0       7.00         8. 00       Laboratory Technician       0       0       8.00         9. 00       Other Facility Health Care Staff Costs       0       124,891       9.00         10. 00       Subtotal (sum of lines 1 through 9)       0       1,843,288       10.00         11. 00       Physician Services Under Agreement       0       0       0         12. 00       Physician Supervision Under Agreement       0       0       11.00         14. 00       Subtotal (sum of lines 11 through 13)       0       0       0         15. 00       Medical Supplies       0       326,582       15.00         16. 00       Transportation (Health Care Staff)       0       0       17.00         17. 00       Depreciation-Medical Equipment       0   |
| 3.00       Nurse Practitioner       0       286,823       3.00         4.00       Visiting Nurse       0       0       4.00         5.00       Other Nurse       0       143,062       5.00         6.00       Clinical Psychologist       0       0       6.00         7.00       Clinical Social Worker       0       0       0         8.00       Laboratory Technician       0       0       0         9.00       Other Facility Health Care Staff Costs       0       124,891       9.00         10.00       Subtotal (sum of lines 1 through 9)       0       1,843,288       10.00         11.00       Physician Services Under Agreement       0       0       0         12.00       Physician Services Under Agreement       0       0       11.00         12.00       Physician Supervision Under Agreement       0       0       12.00         13.00       Other Costs Under Agreement       0       0       13.00         14.00       Subtotal (sum of lines 11 through 13)       0       0       0         15.00       Medical Supplies       0       0       326,582       15.00         16.00       Transportation (Health Care Staff)       0  |
| 4. 00       Visiting Nurse       0       0       4.00         5. 00       Other Nurse       0       143,062       5.00         6. 00       Clinical Psychologist       0       0       6.00         7. 00       Clinical Social Worker       0       0       7.00         8. 00       Laboratory Technician       0       0       0         9. 00       Other Facility Health Care Staff Costs       0       124,891       9.00         11. 00       Subtotal (sum of lines 1 through 9)       0       1,843,288       10.00         12. 00       Physician Services Under Agreement       0       0       11.00         12. 00       Physician Supervision Under Agreement       0       0       12.00         13. 00       Other Costs Under Agreement       0       0       13.00         14. 00       Subtotal (sum of lines 11 through 13)       0       0       13.00         15. 00       Medical Supplies       0       326,582       15.00         17. 00       Professional Liability Insurance       0       0       17.00         18. 00       Other Health Care Costs       0       0       19.00         20. 00       Allowable GME Costs       0  |
| 5. 00       Other Nurse       0       143,062       5.00         6. 00       Clinical Psychologist       0       0       6.00         7. 00       Clinical Social Worker       0       0       7.00         8. 00       Laboratory Technician       0       0       8.00         9. 00       Other Facility Health Care Staff Costs       0       124,891       9.00         10. 00       Subtotal (sum of lines 1 through 9)       0       1,843,288       10.00         11. 00       Physician Services Under Agreement       0       0       11.00         12. 00       Physician Supervision Under Agreement       0       0       12.00         13. 00       Other Costs Under Agreement       0       0       13.00         14. 00       Other Costs Under Agreement       0       0       0       13.00         14. 00       Other Costs Under Agreement       0       0       0       13.00         14. 00       Other Costs Under Agreement       0       0       0       13.00         15. 00       Medical Supplies       0       0       0       15.00         16. 00       Transportation (Health Care Staff)       0       0       0       17.00   |
| 6. 00       Clinical Psychologist       0       0       6.00         7. 00       Clinical Social Worker       0       0       7.00         8. 00       Laboratory Technician       0       0       8.00         9. 00       Other Facility Health Care Staff Costs       0       124,891       9.00         10. 00       Subtotal (sum of lines 1 through 9)       0       1,843,288       10.00         11. 00       Physician Services Under Agreement       0       0       0         12. 00       Physician Supervision Under Agreement       0       0       0         13. 00       Other Costs Under Agreement       0       0       0         14. 00       Subtotal (sum of lines 11 through 13)       0       0       0         15. 00       Medical Supplies       0       326,582       15.00         17. 00       Depreciation-Medical Equipment       0       0       16.00         17. 00       Depreciation-Medical Equipment       0       0       18.00         19. 00       Other Health Care Costs       0       0       19.00         20. 00       Allowable GME Costs       0       0       22.00         21. 00       Total Cost of Health Care Services (sum   |
| 7. 00       Clinical Social Worker       0       0       7. 00         8. 00       Laboratory Technician       0       0       8. 00         9. 00       Other Facility Heal th Care Staff Costs       0       124, 891       9. 00         10. 00       Subtotal (sum of lines 1 through 9)       0       1, 843, 288       10. 00         11. 00       Physician Services Under Agreement       0       0       11. 00         12. 00       Physician Supervision Under Agreement       0       0       12. 00         13. 00       Other Costs Under Agreement       0       0       13. 00         14. 00       Subtotal (sum of lines 11 through 13)       0       0       13. 00         15. 00       Medical Supplies       0       326, 582       15. 00         16. 00       Transportation (Health Care Staff)       0       0       16. 00         17. 00       Depreciation-Medical Equipment       0       0       16. 00         18. 00       Professional Liability Insurance       0       0       18. 00         19. 00       Other Health Care Costs       0       0       19. 00         20. 00       Allowable GME Costs       21. 00         22. 00       Total Cost of Health  |
| 8. 00       Laboratory Technician       0       0       8. 00         9. 00       Other Facility Health Care Staff Costs       0       124, 891       9. 00         10. 00       Subtotal (sum of lines 1 through 9)       0       1, 843, 288       10. 00         11. 00       Physician Services Under Agreement       0       0       11. 00         12. 00       Physician Supervision Under Agreement       0       0       12. 00         13. 00       Other Costs Under Agreement       0       0       13. 00         14. 00       Subtotal (sum of lines 11 through 13)       0       0       0         15. 00       Medical Supplies       0       326, 582       15. 00         16. 00       Transportation (Health Care Staff)       0       0       16. 00         17. 00       Depreciation-Medical Equipment       0       0       17. 00         18. 00       Professional Liability Insurance       0       0       18. 00         19. 00       Other Health Care Costs       0       0       19. 00         20. 00       Allowable GME Costs       0       0       20. 00         21. 00       Subtotal (sum of lines 15 through 20)       0       2, 169, 870       22. 00   |
| 9. 00       Other Facility Health Care Staff Costs       0       124,891       9.00         10. 00       Subtotal (sum of lines 1 through 9)       0       1,843,288       10.00         11. 00       Physician Services Under Agreement       0       0       11.00         12. 00       Physician Supervision Under Agreement       0       0       0         13. 00       Other Costs Under Agreement       0       0       0         14. 00       Subtotal (sum of lines 11 through 13)       0       0       0         15. 00       Medical Supplies       0       326,582       15.00         16. 00       Transportation (Health Care Staff)       0       0       16.00         17. 00       Depreciation-Medical Equipment       0       0       17.00         18. 00       Professional Liability Insurance       0       0       18.00         19. 00       Other Health Care Costs       0       0       19.00         20. 00       Allowable GME Costs       0       0       20.00         21. 00       Subtotal (sum of lines 15 through 20)       0       326,582       21.00         22. 00       Total Cost of Health Care Services (sum of 0       2,169,870       22.00   |
| 10.00       Subtotal (sum of lines 1 through 9)       0       1,843,288       10.00         11.00       Physician Services Under Agreement       0       0       11.00         12.00       Physician Supervision Under Agreement       0       0       12.00         13.00       Other Costs Under Agreement       0       0       13.00         14.00       Subtotal (sum of lines 11 through 13)       0       0       0         15.00       Medical Supplies       0       326,582       15.00         16.00       Transportation (Heal th Care Staff)       0       0       16.00         17.00       Depreciation-Medical Equipment       0       0       17.00         18.00       Professional Liability Insurance       0       0       18.00         19.00       Other Health Care Costs       0       0       19.00         20.00       Allowable GME Costs       0       0       20.00         21.00       Subtotal (sum of lines 15 through 20)       0       326,582       21.00         22.00       Total Cost of Health Care Services (sum of       0       2,169,870       22.00   |
| 11. 00       Physician Services Under Agreement       0       0         12. 00       Physician Supervision Under Agreement       0       0         13. 00       Other Costs Under Agreement       0       0         14. 00       Subtotal (sum of lines 11 through 13)       0       0         15. 00       Medical Supplies       0       326,582         16. 00       Transportation (Health Care Staff)       0       0         17. 00       Depreciation-Medical Equipment       0       0         18. 00       Professional Liability Insurance       0       0         19. 00       Other Health Care Costs       0       0         20. 00       Allowable GME Costs       20.00         21. 00       Subtotal (sum of lines 15 through 20)       0       326, 582         22. 00       Total Cost of Health Care Services (sum of       0       2, 169, 870   |
| 12.00       Physician Supervision Under Agreement       0       0         13.00       Other Costs Under Agreement       0       0         14.00       Subtotal (sum of lines 11 through 13)       0       0         15.00       Medical Supplies       0       326,582         16.00       Transportation (Heal th Care Staff)       0       0         17.00       Depreciation-Medical Equipment       0       0         18.00       Professional Liability Insurance       0       0         19.00       Other Heal th Care Costs       0       0         20.00       Allowable GME Costs       20.00         21.00       Subtotal (sum of lines 15 through 20)       0       326,582         22.00       Total Cost of Health Care Services (sum of       0       2,169,870   |
| 13.00       Other Costs Under Agreement       0       0       13.00         14.00       Subtotal (sum of lines 11 through 13)       0       0       14.00         15.00       Medical Supplies       0       326,582       15.00         16.00       Transportation (Heal th Care Staff)       0       0       16.00         17.00       Depreciation-Medical Equipment       0       0       17.00         18.00       Professional Liability Insurance       0       0       18.00         19.00       Other Heal th Care Costs       0       0       19.00         20.00       Allowable GME Costs       20.00       20.00         21.00       Subtotal (sum of lines 15 through 20)       0       326,582       21.00         22.00       Total Cost of Health Care Services (sum of       0       2,169,870       22.00   |
| 14.00       Subtotal (sum of lines 11 through 13)       0       0       14.00         15.00       Medical Supplies       0       326,582       15.00         16.00       Transportation (Heal th Care Staff)       0       0       16.00         17.00       Depreciation-Medical Equipment       0       0       17.00         18.00       Professional Liability Insurance       0       0       18.00         19.00       Other Heal th Care Costs       0       0       19.00         20.00       Allowable GME Costs       20.00       20.00         21.00       Subtotal (sum of lines 15 through 20)       0       326,582       21.00         22.00       Total Cost of Health Care Services (sum of       0       2,169,870       22.00   |
| 15.00     Medical Supplies     0     326, 582     15.00       16.00     Transportation (Heal th Care Staff)     0     0     16.00       17.00     Depreciation-Medical Equipment     0     0     17.00       18.00     Professional Liability Insurance     0     0     18.00       19.00     Other Heal th Care Costs     0     0     19.00       20.00     Allowable GME Costs     20.00     20.00       21.00     Subtotal (sum of lines 15 through 20)     0     326,582     21.00       22.00     Total Cost of Health Care Services (sum of     0     2,169,870     22.00  |
| 16.00       Transportation (Heal th Care Staff)       0       0       16.00         17.00       Depreciation-Medical Equipment       0       0       17.00         18.00       Professional Liability Insurance       0       0       18.00         19.00       Other Heal th Care Costs       0       0       19.00         20.00       Allowable GME Costs       20.00       20.00       20.00       20.00         21.00       Subtotal (sum of lines 15 through 20)       0       326,582       21.00         22.00       Total Cost of Heal th Care Services (sum of 0)       2,169,870       22.00  |
| 17. 00       Depreciation-Medical Equipment       0       0         18. 00       Professional Liability Insurance       0       0         19. 00       Other Health Care Costs       0       0         20. 00       Allowable GME Costs       20. 00         21. 00       Subtotal (sum of lines 15 through 20)       0       326, 582         22. 00       Total Cost of Health Care Services (sum of cost of cost of cost of cos   |
| 18.00     Professional Liability Insurance     0     0       19.00     Other Health Care Costs     0     0       20.00     Allowable GME Costs     20.00       21.00     Subtotal (sum of lines 15 through 20)     0     326,582       22.00     Total Cost of Health Care Services (sum of 22.00  |
| 19.00       Other Health Care Costs       0       0       19.00         20.00       Allowable GME Costs       20.00         21.00       Subtotal (sum of lines 15 through 20)       0       326,582       21.00         22.00       Total Cost of Health Care Services (sum of       0       2,169,870       22.00   |
| 20.00       Allowable GME Costs       20.00         21.00       Subtotal (sum of lines 15 through 20)       0       326,582       21.00         22.00       Total Cost of Health Care Services (sum of       0       2,169,870       22.00   |
| 21. 00       Subtotal (sum of lines 15 through 20)       0       326, 582       21. 00         22. 00       Total Cost of Health Care Services (sum of 22. 00       0       2, 169, 870       22. 00   |
| 22.00 Total Cost of Health Care Services (sum of 0 2, 169, 870 22.00   |
|  |
|  |
| lines 10, 14, and 21)  |
| COSTS OTHER THAN RHC/FQHC SERVICES   |
| 23. 00   Pharmacy   0   0   23. 00   |
| 24. 00   Dental   0   0   24. 00   |
| 25. 00   Optometry   0   0   25. 00  |
| 25. 01   Tel eheal th   0   0   25. 01   |
| 25. 02   Chroni c Care Management   0   0   25. 02   |
| 26.00   All other nonreimbursable costs   0   0   26.00  |
| 27. 00 Nonallowable GME costs 27. 00   |
| 28.00   Total Nonreimbursable Costs (sum of lines 23 0 0 28.00   |
| through 27)  |
| FACILITY OVERHEAD  |
| 29. 00   Facility Costs   0   -300, 172   29. 00   |
| 30. 00   Administrative Costs   0   551, 455   30. 00  |
| 31.00   Total Facility Overhead (sum of lines 29 and 0   251,283   31.00   |
| 30)  |
| 32.00   Total facility costs (sum of lines 22, 28   0   2,421,153   32.00  |
| and 31)  |

|                | Financial Systems  | WOODLAWN H    |             | ON 45 4040   |                             | u of Form CMS-2                |              |
|----------------|--|---------------|-------------|--------------|-----------------------------|--------------------------------|--------------|
| ANALYS         | SIS OF HOSPITAL-BASED RHC/FQHC COSTS                     |               | Provi der C |              | Peri od:<br>From 01/01/2020 | Worksheet M-1                  |              |
|                |  |               | Component   | CCN: 15-8550 | To 12/31/2020               | Date/Time Pre<br>7/29/2021 4:1 |              |
|                |  |               |             |              | RHC III                     | Cost                           |              |
|                |  | Compensation  | Other Costs | ,            | 1 Reclassi fi cat           | Recl assi fi ed                |              |
|                |  |               |             | + col. 2)    | i ons                       | Trial Balance                  |              |
|                |  |               |             |              |                             | (col. 3 +                      |              |
|                |  | 1.00          | 0.00        | 2.00         | 4.00                        | col . 4)                       |              |
|                | FACILITY HEALTH CARE CTAFE COCTO                         | 1. 00         | 2. 00       | 3. 00        | 4. 00                       | 5. 00                          |              |
| 1 00           | FACILITY HEALTH CARE STAFF COSTS                         | 001 105       | F 410       | 00/ 52       | 415 200                     | E01 2EE                        | 1 00         |
| 1. 00<br>2. 00 | Physician Assistant                                      | 991, 125<br>0 | 5, 410      | 996, 53      | -415, 280                   | 581, 255<br>0                  | 1.00<br>2.00 |
| 3. 00          | Physician Assistant<br>Nurse Practitioner                | 0             | 0           |              | 0 124, 624                  | 124, 624                       |              |
| 4. 00          | Visiting Nurse   | 0             | 0           |              | 124, 624                    | 124, 024                       | 4.00         |
| 5. 00          | Other Nurse  | 94, 872       | 0           | 94, 87       | '2 -27, 671                 | 67, 201                        | 5.00         |
| 6. 00          | Clinical Psychologist                                    | 74, 072       | 0           | 74, 07       | 0 -27,071                   | 07, 201                        | 6.00         |
| 7. 00          | Clinical Social Worker                                   | 0             | 0           |              |                             | Ö                              |              |
| 8. 00          | Laboratory Techni ci an                                  | 0             | 0           |              | 0 0                         | o o                            | 8.00         |
| 9. 00          | Other Facility Health Care Staff Costs                   | 143, 836      | 0           | 143, 83      | -41. 952                    | 101, 884                       |              |
| 10.00          | Subtotal (sum of lines 1 through 9)                      | 1, 229, 833   | 5, 410      |              |                             | 874, 964                       |              |
| 11. 00         | Physician Services Under Agreement                       | 0             | 0           | ,            | 0 0                         | 0                              | 11.00        |
| 12.00          | Physician Supervision Under Agreement                    | o             | 0           |              | 0 0                         | 0                              | 12.00        |
| 13.00          | Other Costs Under Agreement                              | 0             | 0           |              | 0 0                         | 0                              | 13.00        |
| 14.00          | Subtotal (sum of lines 11 through 13)                    | o             | 0           |              | 0 0                         | 0                              | 14.00        |
| 15.00          | Medical Supplies   | 0             | 152, 696    | 152, 69      | -44, 536                    | 108, 160                       | 15. 00       |
| 16. 00         | Transportation (Health Care Staff)                       | 0             | 0           |              | 0                           | 0                              | 16. 00       |
| 17. 00         |  | 0             | 0           |              | 0                           | 0                              |              |
| 18. 00         | Professional Liability Insurance                         | 0             | 0           |              | 0                           | 0                              | 18. 00       |
| 19. 00         | · ·  | 0             | 0           |              | 0                           | 0                              |              |
| 20.00          | Allowable GME Costs                                      |               |             |              |                             |                                | 20.00        |
| 21.00          | Subtotal (sum of lines 15 through 20)                    | 0             | 152, 696    |              |                             |                                |              |
| 22. 00         | Total Cost of Health Care Services (sum of               | 1, 229, 833   | 158, 106    | 1, 387, 93   | -404, 815                   | 983, 124                       | 22. 00       |
|                | lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES |               |             |              |                             |                                |              |
| 23. 00         |  | ol            | 0           |              | 0 0                         | 0                              | 23.00        |
| 24. 00         | Dental   | 0             | 0           |              | 0 0                         | 0                              | 24.00        |
| 25. 00         | Optometry  | 0             | 0           |              |                             | Ö                              |              |
| 25. 01         | Tel eheal th   | 0             | 0           |              | 0 0                         | Ö                              |              |
| 25. 02         | · ·  | 0             | 0           |              | 0 0                         | Ö                              |              |
| 26. 00         | All other nonreimbursable costs                          | ol            | 0           |              | 0 0                         | o o                            | 26. 00       |
| 27. 00         | Nonallowable GME costs                                   | ١             | · ·         |              |                             |                                | 27. 00       |
| 28. 00         | Total Nonreimbursable Costs (sum of lines 23             | О             | 0           |              | 0 0                         | 0                              | 28. 00       |
|                | through 27)  |               |             |              |                             |                                |              |
|                | FACILITY OVERHEAD  |               |             |              |                             |                                |              |
|                | Facility Costs   | 0             | 394, 981    | 394, 98      |                             |                                |              |
| 30.00          | Administrative Costs                                     | 220, 479      | 376 732     | 597. 21      | 1 -127 482                  | 469 729                        | 30.00        |

220, 479

1, 450, 312

394, 981 376, 732

771, 713

929, 819

-45, 616 -127, 482 -173, 098

-577, 913

469, 729 819, 094

1, 802, 218

30.00

31.00

32.00

597, 211

992, 192

2, 380, 131

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

| Health Financial Systems WOODLAWN HOSPITAL |             |              | In Lieu of Form CMS-2552-10 |                             |                                |  |
|--|-------------|--------------|-----------------------------|-----------------------------|--------------------------------|--|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS  |             | Provi der CC | CN: 15-1313                 | Peri od:<br>From 01/01/2020 | Worksheet M-1                  |  |
|  |             | Component C  | CCN: 15-8550                | To 12/31/2020               | Date/Time Pre<br>7/29/2021 4:1 |  |
|  |             |              |                             | RHC III                     | Cost                           |  |
|  | Adjustments | Net Expenses |                             |                             |                                |  |

|        |  |             |              |   |         | 7/29/2021 4: 1 | 5 pm   |
|--------|--|-------------|--------------|---|---------|----------------|--------|
|        |  |             |              | _ | RHC III | Cost           |        |
|        |  | Adjustments | Net Expenses |   |         |                |        |
|        |  |             | for          |   |         |                |        |
|        |  |             | Allocation   |   |         |                |        |
|        |  |             | (col. 5 +    |   |         |                |        |
|        |  |             | col. 6)      |   |         |                |        |
|        |  | 6. 00       | 7. 00        |   |         |                |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |             |              |   |         |                |        |
| 1.00   | Physi ci an                                  | 0           | 581, 255     | 5 |         |                | 1.00   |
| 2.00   | Physician Assistant                          | o           | C            |   |         |                | 2.00   |
| 3.00   | Nurse Practitioner                           | ol          | 124, 624     | ı |         |                | 3.00   |
| 4.00   | Visiting Nurse                               | 0           | C            |   |         |                | 4.00   |
| 5. 00  | Other Nurse                                  | 0           | 67, 201      |   |         |                | 5.00   |
| 6. 00  | Clinical Psychologist                        | 0           | 0.,20.       |   |         |                | 6.00   |
| 7. 00  | Clinical Social Worker                       | 0           |              |   |         |                | 7.00   |
| 8. 00  | Laboratory Techni ci an                      | 0           |              |   |         |                | 8.00   |
| 9. 00  | Other Facility Health Care Staff Costs       | 0           | 101, 884     | í |         |                | 9.00   |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 0           | 874, 964     |   |         |                | 10.00  |
| 11.00  | Physician Services Under Agreement           | 0           | 074, 904     | 1 |         |                | 11.00  |
|        |  | U           | _            | 1 |         |                |        |
| 12.00  | Physician Supervision Under Agreement        | 0           | C            | 1 |         |                | 12.00  |
| 13. 00 | 9  | 0           | C            | 1 |         |                | 13.00  |
| 14.00  | Subtotal (sum of lines 11 through 13)        | 0           | C            |   |         |                | 14.00  |
| 15.00  | Medical Supplies                             | 0           | 108, 160     | 1 |         |                | 15.00  |
| 16. 00 | ·  | 0           | C            | 1 |         |                | 16. 00 |
|        | Depreciation-Medical Equipment               | 0           | C            | 1 |         |                | 17. 00 |
|        | Professional Liability Insurance             | 0           | C            | 1 |         |                | 18. 00 |
| 19.00  | Other Health Care Costs                      | 0           | C            | ) |         |                | 19. 00 |
| 20.00  | Allowable GME Costs                          |             |              |   |         |                | 20.00  |
| 21.00  |  | 0           | 108, 160     | ) |         |                | 21.00  |
| 22.00  | Total Cost of Health Care Services (sum of   | 0           | 983, 124     |   |         |                | 22.00  |
|        | lines 10, 14, and 21)                        |             |              |   |         |                |        |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             |              |   |         |                |        |
| 23.00  | Pharmacy                                     | 0           | C            | ) |         |                | 23.00  |
| 24.00  | Dental                                       | 0           | C            |   |         |                | 24.00  |
| 25.00  | Optometry                                    | 0           | C            |   |         |                | 25. 00 |
| 25.01  | Tel eheal th                                 | O           | C            |   |         |                | 25. 01 |
| 25.02  | Chronic Care Management                      | 0           | C            |   |         |                | 25. 02 |
| 26.00  | All other nonreimbursable costs              | o           | C            |   |         |                | 26.00  |
| 27.00  | Nonallowable GME costs                       |             |              |   |         |                | 27.00  |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0           | C            |   |         |                | 28.00  |
|        | through 27)                                  | -           | _            |   |         |                |        |
|        | FACILITY OVERHEAD                            |             |              | 1 |         |                | 1      |
| 29.00  | Facility Costs                               | 0           | 349, 365     |   |         |                | 29. 00 |
| 30.00  | Administrative Costs                         | n           | 469, 729     | 1 |         |                | 30.00  |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | ٥           | 819, 094     | 1 |         |                | 31.00  |
| 31.00  | 30)  | ď           | 017,074      |   |         |                | 31.00  |
| 32. 00 | Total facility costs (sum of lines 22, 28    | n           | 1, 802, 218  |   |         |                | 32.00  |
| 52.00  | and 31)                                      | ď           | 1,002,210    |   |         |                | 02.00  |
|        | Tana or,                                     | ļ           |              | 1 |         |                | 1      |

|                  | Financial Systems   | WOODLAWN F   |              | = 1          |                             | u of Form CMS-2             |        |
|------------------|---|--------------|--------------|--------------|-----------------------------|-----------------------------|--------|
| ANALYS           | SIS OF HOSPITAL-BASED RHC/FQHC COSTS                              |              | Provi der Co | JN: 15-1313  | Peri od:<br>From 01/01/2020 | Worksheet M-1               |        |
|                  |   |              | Component (  | CCN: 15-8549 | To 12/31/2020               | Date/Time Pre 7/29/2021 4:1 |        |
|                  |   |              |              |              | RHC IV                      | Cost                        |        |
|                  |   | Compensation | Other Costs  |              | 1 Reclassi fi cat           | Reclassi fied               |        |
|                  |   |              |              | + col . 2)   | i ons                       | Trial Balance               |        |
|                  |   |              |              |              |                             | (col. 3 +                   |        |
|                  |   | 1. 00        | 2.00         | 3. 00        | 4. 00                       | col . 4)<br>5.00            |        |
|                  | FACILITY HEALTH CARE STAFF COSTS                                  | 1.00         | 2.00         | 3.00         | 4.00                        | 5.00                        |        |
| 1. 00            | Physi ci an   | 128, 007     | 3, 665       | 131, 67      | 72 -15, 670                 | 116, 002                    | 1.00   |
| 2. 00            | Physician Assistant   | 0            | 0, 000       | 101, 0       | 0 0                         | 0                           |        |
| 3. 00            | Nurse Practitioner  | 0            | 0            |              | 0 15, 670                   | 15, 670                     |        |
| 4.00             | Visiting Nurse  | 0            | 0            |              | 0 0                         | 0                           | 1      |
| 5.00             | Other Nurse   | 21, 752      | 0            | 21, 75       | 52 0                        | 21, 752                     | 5.00   |
| 6.00             | Clinical Psychologist   | 0            | 0            |              | 0 0                         | 0                           | 6.00   |
| 7.00             | Clinical Social Worker  | 0            | 0            |              | 0                           | 0                           | 7. 00  |
| 8.00             | Laboratory Techni ci an   | 0            | 0            |              | 0                           | 0                           |        |
| 9. 00            | Other Facility Health Care Staff Costs                            | 11, 372      | 0            | 11, 37       |                             | 11, 372                     |        |
| 10.00            | Subtotal (sum of lines 1 through 9)                               | 161, 131     | 3, 665       | 164, 79      | 96 0                        | 164, 796                    |        |
| 11. 00           | Physician Services Under Agreement                                | 0            | 0            |              | 0                           | 0                           | 11.00  |
| 12.00            | Physician Supervision Under Agreement                             | 0            | 0            |              | 0                           | 0                           |        |
| 13.00            | Other Costs Under Agreement                                       | 0            | 0            |              | 0                           | 0                           |        |
| 14.00            | Subtotal (sum of lines 11 through 13)                             | 0            | 20, 420      | 20.41        | 0 0                         | 0                           |        |
| 15. 00<br>16. 00 | Medical Supplies  | 0            | 29, 430      | 29, 43       | 0 0                         | 29, 430<br>0                | 1      |
| 17. 00           | Transportation (Health Care Staff) Depreciation-Medical Equipment | 0            | 0            |              | 0 0                         | 0                           |        |
| 18. 00           | Professional Liability Insurance                                  | 0            | 0            |              |                             | 0                           | 1      |
| 19. 00           | Other Health Care Costs   | 0            | 0            |              |                             | 0                           |        |
| 20. 00           | Allowable GME Costs   | J            | O            |              |                             | · ·                         | 20.00  |
| 21. 00           | Subtotal (sum of lines 15 through 20)                             | 0            | 29, 430      | 29, 43       | во о                        | 29, 430                     |        |
| 22. 00           | Total Cost of Health Care Services (sum of                        | 161, 131     | 33, 095      | 194, 22      | 26 0                        | 194, 226                    |        |
|                  | lines 10, 14, and 21)   |              | •            |              |                             | · ·                         |        |
|                  | COSTS OTHER THAN RHC/FQHC SERVICES                                |              |              |              |                             |                             |        |
| 23.00            | Pharmacy  | 0            | 0            |              | 0                           |                             |        |
| 24. 00           | Dental  | 0            | 0            |              | 0                           | 0                           |        |
| 25. 00           | Optometry   | 0            | 0            |              | 0                           | 0                           |        |
| 25. 01           | Tel eheal th  | 0            | 0            |              | 0                           | 0                           |        |
| 25. 02           | Chronic Care Management   | 0            | 0            |              | 0                           | 0                           |        |
| 26.00            | All other nonreimbursable costs                                   | 0            | 0            |              | 0                           | 0                           |        |
| 27. 00           | Nonallowable GME costs  | 0            | 0            |              |                             |                             | 27.00  |
| 28. 00           | Total Nonreimbursable Costs (sum of lines 23 through 27)          | U            | 0            |              | 0                           | 0                           | 28. 00 |
|                  | FACILITY OVERHEAD   |              |              |              |                             |                             | -      |
| 29. 00           | Facility Costs  | 0            | 15, 426      | 15, 42       | 26 42, 888                  | 58, 314                     | 29. 00 |
| 30.00            | Administrative Costs  | 15, 638      | 22, 065      | 37, 70       | ·                           | 44, 773                     |        |
| 31. 00           | Total Facility Overhead (sum of lines 29 and                      | ·            | 37, 491      | 53, 12       | 1                           |                             |        |
| 2 50             | 30)   | , 000        | =:/ :/:      |              | , 700                       |                             |        |

176, 769

70, 586

247, 355

49, 958

32.00 Total facility costs (sum of lines 22, 28 and 31)

32.00

297, 313

| Health Financial Systems                  | WOODLAWN HOSPITAL |              |              | In Lieu of Form CMS-2552-10 |               |                |
|---|-------------------|--------------|--------------|-----------------------------|---------------|----------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS |                   | Provi der    | CCN: 15-1313 | Peri od:                    | Worksheet M-1 |                |
|   |                   |              | CON 15 0540  | From 01/01/2020             | D-+- /T: D    |                |
|   |                   | Component    | CCN: 15-8549 | To 12/31/2020               | 7/29/2021 4:1 | parea:<br>5 pm |
|   |                   |              |              | RHC I V                     | Cost          |                |
|   | Adjustments       | Net Expenses | :            |                             |               |                |
|   |                   | for          |              |                             |               |                |
|   |                   | Allocation   |              |                             |               |                |
|   |                   | (col. 5 +    |              |                             |               |                |
|   |                   | col. 6)      |              |                             |               |                |
|   | 6. 00             | 7. 00        |              |                             |               |                |

|        |  | Adjustments | Net Expenses |     |        |
|--------|--|-------------|--------------|-----|--------|
|        |  | •           | for          |     |        |
|        |  |             | Allocation   |     |        |
|        |  |             | (col. 5 +    |     |        |
|        |  |             | col. 6)      |     |        |
|        |  | 6. 00       | 7. 00        |     |        |
|        | FACILITY HEALTH CARE STAFF COSTS       |             |              |     |        |
| 1.00   | Physi ci an                            | 0           | 116, 002     | ·   | 1.00   |
| 2.00   | Physi ci an Assi stant                 | 0           | 0            | l . | 2.00   |
| 3.00   | Nurse Practitioner                     | 0           | 15, 670      |     | 3.00   |
| 4. 00  | Visiting Nurse                         | 0           | 0            |     | 4.00   |
| 5.00   | Other Nurse                            | 0           | 21, 752      |     | 5. 00  |
| 6.00   | Clinical Psychologist                  | 0           | 0            |     | 6. 00  |
| 7. 00  | Clinical Social Worker                 | 0           | 0            |     | 7. 00  |
| 8.00   | Laboratory Techni ci an                | 0           | 0            |     | 8. 00  |
| 9. 00  | Other Facility Health Care Staff Costs | 0           | 11, 372      |     | 9. 00  |
| 10. 00 |  | 0           | 164, 796     |     | 10.00  |
| 11. 00 | ] 3                                    | 0           | 0            |     | 11. 00 |
| 12. 00 |  | 0           | 0            |     | 12.00  |
|        | Other Costs Under Agreement            | 0           | 0            |     | 13. 00 |
| 14.00  | ( )                                    | 0           | 0            | l . | 14.00  |
| 15.00  |  | 0           | 29, 430      |     | 15.00  |
| 16.00  |  | 0           | 0            |     | 16. 00 |
|        | Depreciation-Medical Equipment         | 0           | 0            |     | 17.00  |
| 18. 00 | Professional Liability Insurance       | 0           | 0            |     | 18. 00 |
| 19. 00 | Other Health Care Costs                | 0           | 0            |     | 19.00  |
| 20.00  | Allowable GME Costs                    |             |              |     | 20.00  |
| 21. 00 |  | 0           | 29, 430      |     | 21.00  |
| 22. 00 |  | 0           | 194, 226     |     | 22.00  |
|        | lines 10, 14, and 21)                  |             |              |     |        |
|        | COSTS OTHER THAN RHC/FQHC SERVICES     |             |              |     |        |
| 23. 00 |  | 0           | 0            | l . | 23. 00 |
| 24. 00 | 4                                      | 0           | 0            |     | 24. 00 |
| 25. 00 | 1'                                     | 0           | 0            |     | 25. 00 |
| 25. 01 |  | 0           | 0            |     | 25. 01 |
| 25. 02 | 1                                      | 0           | 0            |     | 25. 02 |
| 26. 00 |  | 0           | 0            |     | 26. 00 |
| 27. 00 | 1                                      |             |              |     | 27. 00 |
| 28. 00 |  | 0           | 0            |     | 28. 00 |
|        | through 27)                            |             |              |     | _      |
|        | FACILITY OVERHEAD                      |             | T            |     | 4      |
|        | Facility Costs                         | 0           | 00,0         |     | 29. 00 |
| 30. 00 |  | 0           | 44, 773      |     | 30.00  |
| 31. 00 |  | 0           | 103, 087     |     | 31.00  |
|        | 30)                                    |             |              |     |        |
| 32. 00 |  | 0           | 297, 313     |     | 32.00  |
|        | and 31)                                |             | I            | I   | 1      |

|        | Financial Systems  | WOODLAWN H   |             |              |                                  | eu of Form CMS- | <u> 2552-10</u> |
|--------|--|--------------|-------------|--------------|----------------------------------|-----------------|-----------------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS                     |              | Provi der C | CN: 15-1313  | Peri od:                         | Worksheet M-1   |                 |
|        |  |              | Component   | CCN: 15-8547 | From 01/01/2020<br>To 12/31/2020 |                 | pared:<br>5 pm  |
|        |  |              |             |              | RHC V                            | Cost            |                 |
|        |  | Compensation | Other Costs |              | 1 Reclassi fi cat                |                 |                 |
|        |  |              |             | + col . 2)   | i ons                            | Trial Balance   |                 |
|        |  |              |             |              |                                  | (col. 3 +       |                 |
|        |  | 1 00         | 2.00        | 2.00         | 4.00                             | col . 4)        |                 |
|        | FACILITY HEALTH CARE STAFF COSTS                         | 1. 00        | 2. 00       | 3.00         | 4. 00                            | 5. 00           |                 |
| 1. 00  | Physician  | 369, 620     | 7, 469      | 377, 0       | -259, 460                        | 117, 629        | 1.00            |
| 2. 00  | Physician Assistant                                      | 309, 020     | 7, 409      | 1            | 0 -239, 400                      | 117, 629        | 1               |
| 3. 00  | Nurse Practitioner                                       | 0            | 0           |              | 0 149, 476                       |                 |                 |
| 4. 00  | Visiting Nurse   | 0            | 0           |              | 0 147, 470                       | 0               |                 |
| 5. 00  | Other Nurse  | 49, 429      | 0           | 49, 4:       | 29 -14, 417                      |                 |                 |
| 6. 00  | Clinical Psychologist                                    | 0            | 0           | .,,          | 0 0                              | 0 0             | 1               |
| 7. 00  | Clinical Social Worker                                   | Ö            | 0           | ,            | o o                              | Ō               |                 |
| 8. 00  | Laboratory Techni ci an                                  | Ö            | 0           | ,            | o o                              | Ō               |                 |
| 9.00   | Other Facility Health Care Staff Costs                   | 51, 624      | 0           | 51, 6        | 24 -15, 057                      | 36, 567         |                 |
| 10.00  | Subtotal (sum of lines 1 through 9)                      | 470, 673     | 7, 469      | 478, 14      | 42 -139, 458                     | 338, 684        | 10.00           |
| 11.00  | Physician Services Under Agreement                       | 0            | 0           |              | 0 0                              | 0               | 11.00           |
| 12.00  | Physician Supervision Under Agreement                    | 0            | 0           |              | 0 0                              | 0               | 12.00           |
| 13.00  | Other Costs Under Agreement                              | 0            | 0           | )            | 0 0                              | 0               | 13.00           |
| 14.00  | Subtotal (sum of lines 11 through 13)                    | 0            | 0           |              | 0 0                              | 0               |                 |
| 15.00  | Medical Supplies   | 0            | 24, 145     | 24, 1        | 45 -7, 043                       | 17, 102         | 15. 00          |
| 16.00  | Transportation (Health Care Staff)                       | 0            | 0           | 1            | 0                                | 0               |                 |
| 17.00  | Depreciation-Medical Equipment                           | 0            | 0           | 1            | 0 0                              | 0               |                 |
| 18. 00 | Professional Liability Insurance                         | 0            | 0           |              | 0 0                              | 0               | 18. 00          |
| 19. 00 | Other Health Care Costs                                  | 0            | 0           | 1            | 0                                | 0               |                 |
| 20.00  | Allowable GME Costs                                      | _            |             |              |                                  |                 | 20.00           |
| 21. 00 | Subtotal (sum of lines 15 through 20)                    | 0            | 24, 145     |              | ·                                | · ·             |                 |
| 22. 00 | Total Cost of Health Care Services (sum of               | 470, 673     | 31, 614     | 502, 28      | -146, 501                        | 355, 786        | 22.00           |
|        | lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES |              |             |              |                                  |                 |                 |
| 23. 00 | Pharmacy   | O            | 0           | ı            | 0 0                              | 0               | 23.00           |
| 24. 00 | Dental   | 0            | 0           | l .          | 0 0                              | 0               |                 |
| 25. 00 | Optometry  | 0            | 0           |              |                                  | 0               |                 |
| 25. 00 | Tel eheal th   | 0            | 0           |              |                                  | 0               |                 |
| 25. 02 | Chronic Care Management                                  | 0            | 0           |              | 0 0                              | 0               |                 |
| 26. 00 | All other nonreimbursable costs                          | 0            | 0           |              | 0 0                              | o o             | 26.00           |
| 27. 00 | Nonallowable GME costs                                   | Ĭ            | O           |              |                                  |                 | 27.00           |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23             | o            | 0           | ,            | 0                                | 0               |                 |
|        | through 27)  |              | · ·         |              |                                  |                 |                 |
|        | FACILITY OVERHEAD  |              |             |              |                                  |                 | ]               |
| 29. 00 | Facility Costs   | 0            | 14, 824     | 14, 82       | 24 15, 122                       | 29, 946         | 29. 00          |
| 30.00  | Admi ni strati ve Costs                                  | 74, 957      | 145, 797    | 220, 7       | 54 -51, 768                      |                 |                 |
| 31 00  | Total Facility Overhead (sum of lines 29 and             | 74 957       | 160 621     | 235 5        | 78 -36 646                       | 198 932         | 1 31 00         |

74, 957

545, 630

160, 621

192, 235

235, 578

737, 865

198, 932

554, 718

-36, 646

-183, 147

31.00

32.00

Total Facility Overhead (sum of lines 29 and

| Health Financial Systems                  | WOODLAWN    | HOSPI TAL   |                | In Lie          | u of Form CMS- | 2552-10         |
|---|-------------|-------------|----------------|-----------------|----------------|-----------------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |             | Provi der   | CCN: 15-1313   | Peri od:        | Worksheet M-1  |                 |
|   |             |             |                | From 01/01/2020 | D. I. (T' D.   |                 |
|   |             | Componer    | t CCN: 15-8547 | To 12/31/2020   | 7/29/2021 4:1  | epared:<br>5 pm |
|   |             |             |                | RHC V           | Cost           |                 |
|   | Adjustments | Net Expense | es             |                 |                |                 |
|   |             | for         |                |                 |                |                 |
|   |             | Allocatio   | ۱              |                 |                |                 |
|   |             | (col. 5 +   |                |                 |                |                 |
|   |             | col. 6)     |                |                 |                |                 |
|   | 6. 00       | 7.00        |                |                 |                |                 |

|        |  | Adjustments | Net Expenses |  |         |
|--------|--|-------------|--------------|--|---------|
|        |  | •           | for          |  |         |
|        |  |             | Allocation   |  |         |
|        |  |             | (col. 5 +    |  |         |
|        |  |             | col. 6)      |  |         |
|        |  | 6. 00       | 7. 00        |  |         |
|        | FACILITY HEALTH CARE STAFF COSTS             |             | T            |  | 4       |
| 1. 00  | Physi ci an                                  | 0           | 117, 629     |  | 1.00    |
| 2.00   | Physici an Assistant                         | 0           | 0            | l .  | 2.00    |
| 3. 00  | Nurse Practitioner                           | 0           | 149, 476     |  | 3. 00   |
| 4.00   | Visiting Nurse                               | 0           | 0            |  | 4. 00   |
| 5.00   | Other Nurse                                  | 0           | 35, 012      |  | 5. 00   |
| 6.00   | Clinical Psychologist                        | 0           | 0            |  | 6. 00   |
| 7.00   | Clinical Social Worker                       | 0           | 0            |  | 7. 00   |
| 8.00   | Laboratory Techni ci an                      | 0           | 0            |  | 8. 00   |
| 9.00   | Other Facility Health Care Staff Costs       | 0           | 36, 567      |  | 9. 00   |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 0           | 338, 684     |  | 10.00   |
| 11.00  | Physician Services Under Agreement           | 0           | 0            |  | 11.00   |
| 12.00  | Physician Supervision Under Agreement        | 0           | 0            |  | 12.00   |
| 13.00  | Other Costs Under Agreement                  | 0           | 0            |  | 13.00   |
| 14.00  | Subtotal (sum of lines 11 through 13)        | 0           | 0            |  | 14.00   |
| 15.00  | Medical Supplies                             | 0           | 17, 102      |  | 15.00   |
| 16.00  | Transportation (Health Care Staff)           | 0           | 0            |  | 16.00   |
| 17.00  | Depreciation-Medical Equipment               | 0           | 0            |  | 17.00   |
| 18.00  | Professional Liability Insurance             | 0           | 0            |  | 18. 00  |
| 19.00  | Other Health Care Costs                      | 0           | 0            |  | 19.00   |
| 20.00  | Allowable GME Costs                          |             |              |  | 20.00   |
| 21. 00 | Subtotal (sum of lines 15 through 20)        | 0           | 17, 102      |  | 21.00   |
| 22. 00 | Total Cost of Health Care Services (sum of   | 0           | 355, 786     | l control of the cont | 22. 00  |
|        | lines 10, 14, and 21)                        | _           |              |  |         |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             |              |  |         |
| 23.00  | Pharmacy                                     | 0           | 0            |  | 23. 00  |
| 24.00  | Dental                                       | 0           | 0            |  | 24.00   |
| 25. 00 | Optometry                                    | 0           | 0            |  | 25. 00  |
| 25. 01 | Tel eheal th                                 | 0           | 0            |  | 25. 01  |
| 25. 02 | Chronic Care Management                      | 0           | 0            |  | 25. 02  |
| 26. 00 | All other nonreimbursable costs              | 0           | 0            |  | 26.00   |
| 27. 00 | Nonallowable GME costs                       | ŭ           |              |  | 27. 00  |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0           | 0            |  | 28.00   |
| 20.00  | through 27)                                  | Ü           | Ĭ            |  | 20.00   |
|        | FACILITY OVERHEAD                            |             |              |  | i       |
| 29 00  | Facility Costs                               | 0           | 29, 946      |  | 29. 00  |
| 30.00  | Administrative Costs                         | 0           | 168, 986     |  | 30.00   |
| 31. 00 | Total Facility Overhead (sum of lines 29 and | 0           | 198, 932     |  | 31.00   |
| 51.00  | 30)  | O           | 170, 732     |  | ] 31.00 |
| 32. 00 | Total facility costs (sum of lines 22, 28    | 0           | 554, 718     |  | 32.00   |
| 52.00  | and 31)                                      | 0           | 354, 710     |  | 02.00   |
|        | [and 01)                                     |             | ı            | I  | 1       |

|        | Financial Systems  | WOODLAWN H   |             |              |                                  | u of Form CMS-2 | 2552-10 |
|--------|--|--------------|-------------|--------------|----------------------------------|-----------------|---------|
| ANALYS | SIS OF HOSPITAL-BASED RHC/FQHC COSTS                             |              | Provi der C | CN: 15-1313  | Peri od:                         | Worksheet M-1   |         |
|        |  |              | Component   | CCN: 15-8548 | From 01/01/2020<br>To 12/31/2020 |                 |         |
|        |  |              |             |              | RHC VI                           | Cost            |         |
|        |  | Compensation | Other Costs |              | 1 Reclassi fi cat                |                 |         |
|        |  |              |             | + col . 2)   | i ons                            | Trial Balance   |         |
|        |  |              |             |              |                                  | (col. 3 +       |         |
|        |  | 1.00         | 2.00        | 2.00         | 4.00                             | col . 4)        |         |
|        | FACILITY HEALTH CARE STAFF COSTS                                 | 1. 00        | 2. 00       | 3. 00        | 4. 00                            | 5. 00           |         |
| 1. 00  | Physician  | 1, 223, 335  | 9, 957      | 1, 233, 29   | -592, 642                        | 640, 650        | 1.00    |
| 2. 00  | Physician Assistant  | 1, 223, 333  | 9, 957      |              | 0 -592, 642                      | 040, 630        | 2.00    |
| 3. 00  | Nurse Practitioner   | 0            | 0           |              | 0 232, 932                       | 232, 932        |         |
| 4. 00  | Visiting Nurse   | 0            | 0           |              | 0 232, 732                       | 232, 732        | 1       |
| 5. 00  | Other Nurse  | 39, 424      | 0           | 39, 42       | 24 -11, 499                      |                 |         |
| 6. 00  | Clinical Psychologist  | 0,, 121      | 0           | 0,, 12       | 0 0                              | 0               | 6.00    |
| 7. 00  | Clinical Social Worker   | ol           | 0           |              | 0 0                              | 0               | 7.00    |
| 8. 00  | Laboratory Techni ci an  | ol           | 0           |              | 0 0                              | Ō               | 8.00    |
| 9. 00  | Other Facility Health Care Staff Costs                           | 175, 253     | 0           | 175, 25      | -51, 115                         | 124, 138        | 9.00    |
| 10.00  | Subtotal (sum of lines 1 through 9)                              | 1, 438, 012  | 9, 957      |              |                                  |                 | 10.00   |
| 11.00  | Physician Services Under Agreement                               | o            | 0           |              | 0 0                              | 0               | 11.00   |
| 12.00  | Physician Supervision Under Agreement                            | o            | 0           |              | 0 0                              | 0               | 12.00   |
| 13.00  | Other Costs Under Agreement                                      | o            | 0           |              | 0 0                              | 0               | 13.00   |
| 14.00  | Subtotal (sum of lines 11 through 13)                            | 0            | 0           |              | 0 0                              | 0               | 14.00   |
| 15.00  | Medical Supplies   | 0            | 112, 236    | 112, 23      | -32, 735                         | 79, 501         | 1       |
| 16. 00 | Transportation (Health Care Staff)                               | 0            | 0           |              | 0                                | 0               |         |
| 17. 00 | Depreciation-Medical Equipment                                   | 0            | 0           |              | 0                                | 0               |         |
| 18. 00 | Professional Liability Insurance                                 | 0            | 0           |              | 0                                | 0               | 18. 00  |
| 19.00  | Other Health Care Costs  | O            | 0           |              | 0                                | 0               | 19.00   |
| 20.00  | Allowable GME Costs  |              | 440.007     | 440.00       | 20 705                           | 70 504          | 20.00   |
| 21. 00 | Subtotal (sum of lines 15 through 20)                            | 1 420 012    | 112, 236    |              | ·                                |                 | 21.00   |
| 22. 00 | Total Cost of Health Care Services (sum of lines 10, 14, and 21) | 1, 438, 012  | 122, 193    | 1, 560, 20   | -455, 059                        | 1, 105, 146     | 22. 00  |
|        | COSTS OTHER THAN RHC/FQHC SERVICES                               |              |             |              |                                  |                 |         |
| 23. 00 | Pharmacy   | O            | 0           |              | 0 0                              | 0               | 23.00   |
| 24. 00 | Dental   | ol           | 0           |              | o o                              |                 |         |
| 25. 00 | Optometry  | ol           | 0           |              | 0 0                              | 0               |         |
| 25. 01 | Tel eheal th   | ō            | 0           |              | 0 0                              | Ō               |         |
| 25. 02 | Chronic Care Management  | o            | 0           |              | 0 0                              | 0               | 25. 02  |
| 26.00  | All other nonreimbursable costs                                  | o            | 0           |              | 0 0                              | 0               | 26.00   |
| 27.00  | Nonallowable GME costs   |              |             |              |                                  |                 | 27.00   |
| 28.00  | Total Nonreimbursable Costs (sum of lines 23                     | o            | 0           |              | 0 0                              | 0               | 28. 00  |
|        | through 27)  |              |             |              |                                  |                 |         |
|        | FACILITY OVERHEAD  |              |             |              |                                  |                 |         |
| 29. 00 | Facility Costs   | 0            | 43, 231     |              | ·                                |                 | 1       |
| 30.00  | Administrative Costs   | 137, 846     | 328, 220    |              | ·                                |                 | 1       |
| 31. 00 | Total Facility Overhead (sum of lines 29 and 30)                 | 137, 846     | 371, 451    | 509, 29      | -16, 057                         | 493, 240        | 31.00   |
|        | 1.5071   |              |             | I .          | 1                                | i               | 1       |

493, 644

1, 575, 858

2, 069, 502

-471, 116

32.00

1, 598, 386

| Health Financial Systems                  | WOODLAWN I  | HOSPI TAL    |              | In Lieu                     | u of Form CMS-2             | 2552-10 |
|---|-------------|--------------|--------------|-----------------------------|-----------------------------|---------|
| ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS |             | Provi der C  | CN: 15-1313  | Peri od:<br>From 01/01/2020 | Worksheet M-1               |         |
|   |             | Component    | CCN: 15-8548 | To 12/31/2020               | Date/Time Pre 7/29/2021 4:1 |         |
|   |             |              |              | RHC VI                      | Cost                        |         |
|   | Adjustments | Net Expenses |              |                             |                             |         |
|   |             | for          |              |                             |                             |         |
|   |             | Allocation   |              |                             |                             |         |
|   |             | (col. 5 +    |              |                             |                             |         |
|   |             | Allocation   |              |                             |                             |         |

|        |  |             |              |   | RHC VI | Cost   |
|--------|--|-------------|--------------|---|--------|--------|
|        |  | Adjustments | Net Expenses |   |        |        |
|        |  | •           | for          |   |        |        |
|        |  |             | Allocation   |   |        |        |
|        |  |             | (col. 5 +    |   |        |        |
|        |  |             |              |   |        |        |
|        |  |             | col. 6)      | - |        |        |
|        |  | 6. 00       | 7. 00        |   |        |        |
|        | FACILITY HEALTH CARE STAFF COSTS             |             | ,            | , |        |        |
| 1. 00  | Physi ci an                                  | 0           | 640, 650     | ) |        | 1.00   |
| 2.00   | Physici an Assistant                         | 0           | 0            | ) |        | 2.00   |
| 3.00   | Nurse Practitioner                           | 0           | 232, 932     |   |        | 3.00   |
| 4.00   | Visiting Nurse                               | 0           | 1            |   |        | 4.00   |
| 5. 00  | Other Nurse                                  | 0           | 27, 925      |   |        | 5. 00  |
|        |  | 0           | 21, 723      |   |        | l l    |
| 6.00   | Clinical Psychologist                        | 0           | 0            | 1 |        | 6.00   |
| 7. 00  | Clinical Social Worker                       | 0           | 0            |   |        | 7.00   |
| 8.00   | Laboratory Techni ci an                      | 0           | 0            |   |        | 8.00   |
| 9.00   | Other Facility Health Care Staff Costs       | 0           | 124, 138     |   |        | 9.00   |
| 10.00  | Subtotal (sum of lines 1 through 9)          | 0           | 1, 025, 645  |   |        | 10.00  |
| 11.00  | Physician Services Under Agreement           | 0           | 1 0          |   |        | 11.00  |
| 12. 00 | Physician Supervision Under Agreement        | 0           | 1            |   |        | 12.00  |
| 13. 00 |  | 0           | 0            |   |        | 13. 00 |
|        |  | 0           | 1            |   |        |        |
| 14.00  |  | 0           | 0            |   |        | 14.00  |
| 15.00  |  | 0           | 79, 501      |   |        | 15.00  |
| 16. 00 | Transportation (Health Care Staff)           | 0           | 0            | ) |        | 16.00  |
| 17.00  | Depreciation-Medical Equipment               | 0           | 0            |   |        | 17.00  |
| 18.00  | Professional Liability Insurance             | 0           | 0            |   |        | 18. 00 |
| 19.00  | Other Health Care Costs                      | 0           | 1 0          |   |        | 19.00  |
| 20.00  | 1  |             |              |   |        | 20.00  |
| 21. 00 |  | 0           | 79, 501      |   |        | 21.00  |
| 22. 00 | Total Cost of Health Care Services (sum of   | 0           | 1            |   |        | 22. 00 |
| 22.00  |  | U           | 1, 105, 146  | 1 |        | 22.00  |
|        | lines 10, 14, and 21)                        |             |              |   |        |        |
|        | COSTS OTHER THAN RHC/FQHC SERVICES           |             | _            |   |        |        |
|        | Pharmacy                                     | 0           |              |   |        | 23.00  |
| 24.00  | Dental                                       | 0           | 0            | 1 |        | 24.00  |
| 25.00  | Optometry                                    | 0           | 0            |   |        | 25.00  |
| 25.01  | Tel eheal th                                 | 0           | 0            | ) |        | 25. 01 |
| 25. 02 | Chronic Care Management                      | 0           | l o          |   |        | 25. 02 |
| 26. 00 | All other nonreimbursable costs              | 0           | 0            | , |        | 26.00  |
| 27. 00 | Nonallowable GME costs                       | Ü           | Ĭ            |   |        | 27.00  |
| 28. 00 | Total Nonreimbursable Costs (sum of lines 23 | 0           | 0            |   |        | 28. 00 |
| 26.00  | · ·  | U           | 0            | 1 |        | 20.00  |
|        | through 27)                                  |             | L            |   |        |        |
|        | FACILITY OVERHEAD                            |             |              |   |        |        |
|        | Facility Costs                               | 0           |              |   |        | 29.00  |
| 30.00  | Administrative Costs                         | 0           | 378, 492     |   |        | 30.00  |
| 31.00  | Total Facility Overhead (sum of lines 29 and | 0           | 493, 240     | ) |        | 31.00  |
|        | 30)  |             |              |   |        |        |
| 32.00  | Total facility costs (sum of lines 22, 28    | 0           | 1, 598, 386  |   |        | 32.00  |
|        | and 31)                                      |             |              |   |        |        |
|        | ! /  |             | 1            |   |        | 1      |

|        | Financial Systems                              | WOODLAWN I      |                 |              |                                  | u of Form CMS-2                |       |
|--------|--|-----------------|-----------------|--------------|----------------------------------|--------------------------------|-------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S  | SERVI CES       | Provi der C     |              | Peri od:                         | Worksheet M-2                  |       |
|        |  |                 | Component       | CCN: 15-8551 | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |       |
|        |  |                 |                 |              | RHC I                            | Cost                           |       |
|        |  | Number of FTE   | Total Visits    |              |                                  | Greater of                     |       |
|        |  | Personnel       |                 | Standard (1) | Visits (col.                     | col. 2 or                      |       |
|        |  |                 |                 |              | 1 x col. 3)                      | col. 4                         |       |
|        |  | 1. 00           | 2.00            | 3.00         | 4. 00                            | 5. 00                          |       |
|        | VISITS AND PRODUCTIVITY                        |                 |                 |              |                                  |                                |       |
|        | Posi ti ons                                    | _               |                 |              |                                  |                                |       |
| 1. 00  | Physi ci an                                    | 0.00            |                 | l .          | 1 0                              |                                | 1.00  |
| 2.00   | Physician Assistant                            | 0.00            |                 | 1            | 1 0                              |                                | 2.00  |
| 3.00   | Nurse Practitioner                             | 0. 47           |                 |              | 1 0                              |                                | 3.00  |
| 4. 00  | Subtotal (sum of lines 1 through 3)            | 0. 47           |                 |              | 0                                | 1, 769                         | 4. 00 |
| 5.00   | Visiting Nurse                                 | 0.00            |                 |              |                                  | 0                              | 5.00  |
| 6. 00  | Clinical Psychologist                          | 0.00            |                 | )            |                                  | 0                              | 6. 00 |
| 7. 00  | Clinical Social Worker                         | 0.00            |                 |              |                                  | 0                              | 7. 00 |
| 7. 01  | Medical Nutrition Therapist (FQHC only)        | 0.00            |                 |              |                                  | 0                              | 7. 01 |
| 7. 02  | Diabetes Self Management Training (FQHC        | 0.00            | C               | )            |                                  | 0                              | 7. 02 |
|        | onl y)   |                 |                 |              |                                  |                                |       |
| 8. 00  | Total FTEs and Visits (sum of lines 4          | 0. 47           | 1, 769          | 7            |                                  | 1, 769                         | 8. 00 |
| 0.00   | through 7)                                     |                 | 0.000           |              |                                  | 0.000                          | 0.00  |
| 9. 00  | Physician Services Under Agreements            |                 | 2, 209          | 1            |                                  | 2, 209                         | 9. 00 |
|        |  |                 |                 |              |                                  | 1 00                           |       |
|        | DETERMINATION OF ALLOWABLE COST APPLICABLE T   | O HOCDITAL DACI | ED DUC/FOUR CE  | DVII CEC     |                                  | 1. 00                          |       |
|        | Total costs of health care services (from Wk   |                 |                 | KVICES       |                                  | 533, 968                       | 10 00 |
| 11. 00 | Total nonreimbursable costs (from Wkst. M-1,   |                 |                 |              |                                  | 533, <del>9</del> 68           | 11.00 |
| 12. 00 | Cost of all services (excluding overhead) (s   | · ·             | ,               |              |                                  | 533, 968                       |       |
| 13. 00 | Ratio of hospital-based RHC/FQHC services (I   |                 |                 |              |                                  | 1. 000000                      |       |
| 14. 00 | Total hospital-based RHC/FQHC overhead - (fr   |                 |                 | ino 21)      |                                  | 162, 944                       |       |
| 15. 00 | Parent provider overhead allocated to facili   |                 | 364, 292        | •            |                                  |                                |       |
| 16. 00 | Total overhead (sum of lines 14 and 15)        |                 | 527, 236        |              |                                  |                                |       |
| 17. 00 | Allowable GME overhead (see instructions)      |                 |                 |              |                                  | 527, 230                       | 17.00 |
|        | Enter the amount from line 16                  |                 |                 |              |                                  | 527, 236                       |       |
|        | Overhead applicable to hospital-based RHC/FC   | NHC services (1 | ine 13 v line   | 18)          |                                  | 527, 236                       |       |
|        | Total allowable cost of hospital-based RHC/F   |                 |                 |              |                                  | 1, 061, 204                    |       |
| 20.00  | 1 Total allowable cost of hospital based kno/1 | and services (  | Jun OI IIIIGJ I | o and 17)    |                                  | 1, 001, 204                    | 20.00 |

|        | Financial Systems  | WOODLAWN I     |                   | ON 45 4040     |                             | u of Form CMS-2                |         |
|--------|--|----------------|-------------------|----------------|-----------------------------|--------------------------------|---------|
| ALLUCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S  | SERVICES       | Provi der C       | CN: 15-1313    | Peri od:<br>From 01/01/2020 | Worksheet M-2                  |         |
|        |  |                | Component         | CCN: 15-8552   | To 12/31/2020               | Date/Time Pre<br>7/29/2021 4:1 |         |
|        |  |                |                   |                | RHC II                      | Cost                           |         |
|        |  | Number of FTE  | Total Visits      | Producti vi ty | y Minimum                   | Greater of                     |         |
|        |  | Personnel      |                   | Standard (1)   | Visits (col.                | col. 2 or                      |         |
|        |  |                |                   |                | 1 x col. 3)                 | col. 4                         |         |
|        |  | 1. 00          | 2. 00             | 3. 00          | 4. 00                       | 5. 00                          |         |
|        | VISITS AND PRODUCTIVITY  |                |                   |                |                             |                                |         |
|        | Posi ti ons  |                |                   |                |                             |                                |         |
| 1. 00  | Physi ci an  | 2. 24          |                   | •              | 1 2                         |                                | 1.00    |
| 2.00   | Physician Assistant  | 0.00           |                   |                | 1 0                         |                                | 2. 00   |
| 3.00   | Nurse Practitioner   | 0. 41          |                   |                | 1 0                         |                                | 3.00    |
| 4.00   | Subtotal (sum of lines 1 through 3)  | 2. 65          |                   |                | 2                           | 8, 805                         |         |
| 5.00   | Visiting Nurse   | 0.00           |                   |                |                             | 0                              |         |
| 6.00   | Clinical Psychologist  | 0.00           |                   |                |                             | 0                              | 6. 00   |
| 7.00   | Clinical Social Worker   | 0.00           |                   |                |                             | 0                              | 7. 00   |
| 7. 01  | Medical Nutrition Therapist (FQHC only)  | 0.00           |                   |                |                             | 0                              | 7. 01   |
| 7. 02  | Diabetes Self Management Training (FQHC  | 0.00           | 0                 |                |                             | 0                              | 7. 02   |
|        | onl y)   |                |                   |                |                             |                                |         |
| 8. 00  | Total FTEs and Visits (sum of lines 4  | 2. 65          | 8, 805            |                |                             | 8, 805                         | 8. 00   |
|        | through 7)   |                | _                 |                |                             | _                              |         |
| 9. 00  | Physician Services Under Agreements  |                | 0                 |                |                             | 0                              | 9. 00   |
|        |  |                |                   |                |                             | 1 00                           |         |
|        | DETERMINATION OF ALLOWARIE COST APPLICABLE T   | O HOCDITAL DAG | ED DUO (EQUID CEI | DVII 050       |                             | 1. 00                          |         |
|        | DETERMINATION OF ALLOWABLE COST APPLICABLE T   |                |                   | RVICES         |                             | 2 1/0 070                      | 10.00   |
|        | Total costs of health care services (from Wk<br>Total nonreimbursable costs (from Wkst. M-1, |                |                   |                |                             | 2, 169, 870<br>0               |         |
|        |  |                |                   |                |                             |                                |         |
| 12.00  | Cost of all services (excluding overhead) (s<br>Ratio of hospital-based RHC/FQHC services (I |                |                   |                |                             | 2, 169, 870                    |         |
| 13.00  |  |                |                   | : 21)          |                             | 1. 000000                      |         |
| 14.00  | Total hospital-based RHC/FQHC overhead - (fr   |                | 251, 283          |                |                             |                                |         |
| 15.00  | Parent provider overhead allocated to facili   | ty (see instru | ctions)           |                |                             | 1, 145, 372                    |         |
| 16.00  | Total overhead (sum of lines 14 and 15)  |                |                   |                |                             | 1, 396, 655                    |         |
| 17.00  | Allowable GME overhead (see instructions)  |                |                   |                |                             | 1 204 455                      |         |
|        | Enter the amount from line 16  | NIC (I         | ! 10   !          | 10)            |                             | 1, 396, 655                    |         |
|        | Overhead applicable to hospital based RHC/FO   |                |                   |                |                             | 1, 396, 655                    |         |
| ∠∪. ∪∪ | Total allowable cost of hospital-based RHC/F   | unc services ( | Sum of Lines I    | o and 19)      |                             | 3, 566, 525                    | J 20.00 |

|        | Financial Systems                             | WOODLAWN H     |                  |              |                                  | u of Form CMS-2                |         |
|--------|---|----------------|------------------|--------------|----------------------------------|--------------------------------|---------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES      | Provi der C      |              | Peri od:                         | Worksheet M-2                  |         |
|        |   |                | Component        | CCN: 15-8550 | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |         |
|        |   |                |                  |              | RHC III                          | Cost                           |         |
|        |   | Number of FTE  | Total Visits     |              |                                  | Greater of                     |         |
|        |   | Personnel      |                  | Standard (1) | Visits (col.                     | col. 2 or                      |         |
|        |   |                |                  |              | 1 x col. 3)                      | col. 4                         |         |
|        |   | 1. 00          | 2. 00            | 3. 00        | 4. 00                            | 5. 00                          |         |
|        | VISITS AND PRODUCTIVITY                       |                |                  |              |                                  |                                |         |
|        | Posi ti ons                                   | 1              |                  |              |                                  |                                |         |
| 1. 00  | Physi ci an                                   | 1. 57          |                  | •            | 1 2                              |                                | 1.00    |
| 2.00   | Physician Assistant                           | 0.00           |                  |              | 1 0                              |                                | 2.00    |
| 3. 00  | Nurse Practitioner                            | 0. 28          |                  |              | 1 0                              |                                | 3.00    |
| 4.00   | Subtotal (sum of lines 1 through 3)           | 1. 85          | ·                |              | 2                                | 9, 305                         | 4.00    |
| 5. 00  | Visiting Nurse                                | 0.00           |                  |              |                                  | 0                              | 5. 00   |
| 6. 00  | Clinical Psychologist                         | 0.00           |                  |              |                                  | 0                              | 6. 00   |
| 7. 00  | Clinical Social Worker                        | 0.00           |                  |              |                                  | 0                              | 7. 00   |
| 7. 01  | Medical Nutrition Therapist (FQHC only)       | 0.00           |                  |              |                                  | 0                              | 7. 01   |
| 7. 02  | Diabetes Self Management Training (FQHC       | 0.00           | 0                |              |                                  | 0                              | 7. 02   |
|        | onl y)  |                |                  |              |                                  |                                |         |
| 8. 00  | Total FTEs and Visits (sum of lines 4         | 1. 85          | 9, 305           |              |                                  | 9, 305                         | 8. 00   |
|        | through 7)                                    |                | _                |              |                                  | _                              |         |
| 9. 00  | Physician Services Under Agreements           |                | 0                |              |                                  | 0                              | 9. 00   |
|        |   |                |                  |              |                                  | 1 00                           |         |
|        | DETERMINATION OF ALLOWARIE COCT APPLICABLE T  | O HOCDITAL DAG | ED DUO (EQUA CEI | DVII 050     |                                  | 1. 00                          |         |
|        | DETERMINATION OF ALLOWABLE COST APPLICABLE T  |                |                  | RVICES       |                                  | 002 124                        | 10.00   |
|        | Total costs of health care services (from Wk  |                |                  |              |                                  | 983, 124                       |         |
|        | Total nonreimbursable costs (from Wkst. M-1,  |                |                  |              |                                  | 0                              | 11.00   |
|        | Cost of all services (excluding overhead) (s  |                |                  |              |                                  | 983, 124                       |         |
|        | Ratio of hospital-based RHC/FQHC services (I  |                |                  | 04)          |                                  | 1. 000000                      |         |
| 14.00  | Total hospital-based RHC/FQHC overhead - (fr  |                |                  | ine 31)      |                                  | 819, 094                       |         |
|        | Parent provider overhead allocated to facili  |                | 490, 289         |              |                                  |                                |         |
| 16.00  | Total overhead (sum of lines 14 and 15)       |                |                  |              |                                  | 1, 309, 383                    |         |
|        | Allowable GME overhead (see instructions)     |                |                  |              |                                  | 1 200 202                      | 17.00   |
|        | Enter the amount from line 16                 | 110            |                  | 10)          |                                  | 1, 309, 383                    |         |
|        | Overhead applicable to hospital-based RHC/FO  |                |                  |              |                                  | 1, 309, 383                    |         |
| ∠∪. ∪∪ | Total allowable cost of hospital-based RHC/F  | unc services ( | Sum of Lines 10  | o and 19)    | l                                | 2, 292, 507                    | J 20.00 |

|                | Financial Systems                             | WOODLAWN H       |                |              |                                  | u of Form CMS-2                | <u> 2552-10</u> |
|----------------|---|------------------|----------------|--------------|----------------------------------|--------------------------------|-----------------|
| ALLOCA         | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES        | Provi der C    |              | Peri od:                         | Worksheet M-2                  |                 |
|                |   |                  | Component      |              | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |                 |
|                |   |                  |                |              | RHC IV                           | Cost                           |                 |
|                |   | Number of FTE    | Total Visits   |              |                                  | Greater of                     |                 |
|                |   | Personnel        |                | Standard (1) | ,                                | col. 2 or                      |                 |
|                |   |                  |                |              | 1 x col. 3)                      | col. 4                         |                 |
|                |   | 1. 00            | 2.00           | 3. 00        | 4. 00                            | 5. 00                          |                 |
|                | VISITS AND PRODUCTIVITY                       |                  |                |              |                                  |                                |                 |
|                | Posi ti ons                                   |                  | 1              | ı            | -l                               |                                |                 |
| 1.00           | Physi ci an                                   | 0. 32            |                | 1            | 1 0                              |                                | 1.00            |
| 2.00           | Physician Assistant                           | 0.00             |                |              | 1 0                              |                                | 2.00            |
| 3.00           | Nurse Practitioner                            | 0. 28            |                | 1            | 0                                | 1 550                          | 3.00            |
| 4. 00<br>5. 00 | Subtotal (sum of lines 1 through 3)           | 0. 60<br>0. 00   |                | 1            | U                                | 1, 558                         | 4. 00<br>5. 00  |
| 6. 00          | Visiting Nurse<br>Clinical Psychologist       | 0.00             |                |              |                                  | 0                              | 6.00            |
| 7. 00          | Clinical Social Worker                        | 0.00             |                |              |                                  | 0                              | 7.00            |
|                | Medical Nutrition Therapist (FQHC only)       | 0.00             |                |              |                                  | 0                              | 7.00            |
| 7. 01          | Di abetes Self Management Training (FQHC      | 0.00             |                |              |                                  | 0                              | 7.01            |
| 7.02           | only)   | 0.00             |                |              |                                  | U                              | 7.02            |
| 8. 00          | Total FTEs and Visits (sum of lines 4         | 0.60             | 1, 558         |              |                                  | 1, 558                         | 8.00            |
| 0.00           | through 7)                                    | 0.00             | 1,000          | Ì            |                                  | 1,000                          | 0.00            |
| 9. 00          | Physician Services Under Agreements           |                  | l o            | i            |                                  | 0                              | 9.00            |
|                | ,   |                  | _              |              |                                  |                                |                 |
|                |   |                  |                |              |                                  | 1. 00                          |                 |
|                | DETERMINATION OF ALLOWABLE COST APPLICABLE T  | O HOSPI TAL-BASI | ED RHC/FQHC SE | RVI CES      |                                  |                                |                 |
| 10.00          | Total costs of health care services (from Wk  | st. M-1, col.    | 7, line 22)    |              |                                  | 194, 226                       | 10.00           |
| 11.00          | Total nonreimbursable costs (from Wkst. M-1,  | col. 7, line     | 28)            |              |                                  | 0                              | 11.00           |
| 12.00          | Cost of all services (excluding overhead) (s  | um of lines 10   | and 11)        |              |                                  | 194, 226                       | 12.00           |
| 13.00          | Ratio of hospital-based RHC/FQHC services (I  | ine 10 divided   | by line 12)    |              |                                  | 1. 000000                      | 13.00           |
| 14.00          | Total hospital-based RHC/FQHC overhead - (fr  | om Worksheet. I  | M-1, col. 7, I | ine 31)      |                                  | 103, 087                       | 14.00           |
| 15.00          | Parent provider overhead allocated to facili  |                  | 83, 575        |              |                                  |                                |                 |
| 16.00          | Total overhead (sum of lines 14 and 15)       |                  |                |              |                                  | 186, 662                       |                 |
|                | Allowable GME overhead (see instructions)     |                  |                |              |                                  | 0                              | 17.00           |
|                |   |                  |                |              |                                  | 186, 662                       | 1               |
|                | Overhead applicable to hospital-based RHC/FQ  |                  |                |              |                                  | 186, 662                       |                 |
| 20. 00         | Total allowable cost of hospital-based RHC/F  | QHC services (   | sum of lines 1 | 0 and 19)    |                                  | 380, 888                       | 20.00           |

|        | Financial Systems   | WOODLAWN I      |                 |                |                                  | u of Form CMS-2                | 2552-10            |
|--------|---|-----------------|-----------------|----------------|----------------------------------|--------------------------------|--------------------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S   | SERVI CES       | Provi der C     |                | Peri od:                         | Worksheet M-2                  |                    |
|        |   |                 | Component       | CCN: 15-8547   | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |                    |
|        |   |                 |                 |                | RHC V                            | Cost                           |                    |
|        |   | Number of FTE   | Total Visits    | Producti vi ty |                                  | Greater of                     |                    |
|        |   | Personnel       |                 | Standard (1)   | ,                                | col. 2 or                      |                    |
|        |   |                 |                 |                | 1 x col. 3)                      | col. 4                         |                    |
|        |   | 1. 00           | 2. 00           | 3. 00          | 4. 00                            | 5. 00                          |                    |
|        | VISITS AND PRODUCTIVITY   |                 |                 |                |                                  |                                |                    |
|        | Posi ti ons   |                 |                 |                |                                  |                                |                    |
| 1.00   | Physi ci an   | 0. 61           |                 |                | 1 1                              |                                | 1.00               |
| 2.00   | Physician Assistant   | 0.00            |                 | 1              | 1 0                              |                                | 2.00               |
| 3.00   | Nurse Practitioner  | 0. 63           |                 |                | 1 1                              |                                | 3.00               |
| 4.00   | Subtotal (sum of lines 1 through 3)   | 1. 24           |                 |                | 2                                | 2, 781                         | 4.00               |
| 5.00   | Visiting Nurse  | 0.00            |                 |                |                                  | 0                              | 5. 00              |
| 6.00   | Clinical Psychologist   | 0.00            |                 |                |                                  | 0                              | 6. 00              |
| 7.00   | Clinical Social Worker  | 0.00            |                 |                |                                  | 0                              | 7. 00              |
| 7. 01  | Medical Nutrition Therapist (FQHC only)   | 0.00            |                 |                |                                  | 0                              | 7. 01              |
| 7. 02  | Diabetes Self Management Training (FQHC only)   | 0.00            | 0               |                |                                  | 0                              | 7. 02              |
| 8. 00  | Total FTEs and Visits (sum of lines 4   | 1. 24           | 2, 781          |                |                                  | 2, 781                         | 8. 00              |
|        | through 7)  |                 |                 |                |                                  |                                |                    |
| 9. 00  | Physician Services Under Agreements   |                 | 0               |                |                                  | 0                              | 9.00               |
|        |   |                 |                 |                |                                  | 1 00                           |                    |
|        | DETERMINATION OF ALLOWABLE COST APPLICABLE T  | O HOCDITAL DACI | ED DUC/FOUR CEI | DVII CEC       |                                  | 1. 00                          |                    |
|        | Total costs of health care services (from Wk  |                 |                 | RVICES         |                                  | 355, 786                       | 10.00              |
| 11. 00 |   |                 |                 |                |                                  | 355, 766                       | 1                  |
| 12. 00 | Cost of all services (excluding overhead) (s  | ·               | ,               |                |                                  | 355, 786                       |                    |
| 12.00  | Ratio of hospital-based RHC/FQHC services (I  |                 |                 |                |                                  | 1. 000000                      |                    |
| 14. 00 | Total hospital-based RHC/FQHC services (i<br>Total hospital-based RHC/FQHC overhead - (fr |                 |                 | ino 21)        |                                  | 1, 000000                      |                    |
| 15. 00 | Parent provider overhead allocated to facili  |                 |                 | The 31)        |                                  | 198, 932<br>266, 953           |                    |
| 16. 00 | Total overhead (sum of lines 14 and 15)   | ty (see mistru  | Ctions)         |                |                                  | 465, 885                       |                    |
| 17. 00 | Allowable GME overhead (see instructions)   |                 |                 |                |                                  |                                | 17.00              |
| 18.00  | , , ,   |                 |                 |                |                                  | 0<br>465, 885                  |                    |
|        | Overhead applicable to hospital-based RHC/FQ  | NUC sorvices (1 | ino 12 v lino   | 10\            |                                  | 465, 885<br>465, 885           |                    |
|        | Total allowable cost of hospital-based RHC/F  |                 |                 |                |                                  | 821, 671                       |                    |
| 20.00  | Tiotal allowable cost of hospital-based knc/r   | uno services (  | Jun UI IIIICS I | 0 anu 17)      |                                  | 021,071                        | <sub>1</sub> 20.00 |

|        | Financial Systems                             | WOODLAWN H     |                 |              |                                  | u of Form CMS-2                |        |
|--------|---|----------------|-----------------|--------------|----------------------------------|--------------------------------|--------|
| ALLOCA | TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S | SERVI CES      | Provi der C     | CN: 15-1313  | Peri od:                         | Worksheet M-2                  |        |
|        |   |                | Component       | CCN: 15-8548 | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |        |
|        |   |                |                 |              | RHC VI                           | Cost                           |        |
|        |   | Number of FTE  | Total Visits    |              |                                  | Greater of                     |        |
|        |   | Personnel      |                 | Standard (1) | Visits (col.                     | col. 2 or                      |        |
|        |   |                |                 |              | 1 x col. 3)                      | col. 4                         |        |
|        |   | 1. 00          | 2. 00           | 3. 00        | 4. 00                            | 5. 00                          |        |
|        | VISITS AND PRODUCTIVITY                       |                |                 |              |                                  |                                |        |
|        | Posi ti ons                                   |                |                 |              |                                  |                                |        |
| 1.00   | Physi ci an                                   | 1. 67          | 7, 874          |              | 1 2                              |                                | 1.00   |
| 2.00   | Physician Assistant                           | 0.00           |                 |              | 1 0                              |                                | 2.00   |
| 3.00   | Nurse Practitioner                            | 0. 56          | 2, 784          |              | 1 1                              |                                | 3.00   |
| 4.00   | Subtotal (sum of lines 1 through 3)           | 2. 23          | 10, 658         |              | 3                                | 10, 658                        | 4.00   |
| 5.00   | Visiting Nurse                                | 0.00           | 0               |              |                                  | 0                              | 5.00   |
| 6.00   | Clinical Psychologist                         | 0.00           | 0               |              |                                  | 0                              | 6.00   |
| 7.00   | Clinical Social Worker                        | 0.00           | 0               |              |                                  | 0                              | 7.00   |
| 7. 01  | Medical Nutrition Therapist (FQHC only)       | 0.00           | 0               |              |                                  | 0                              | 7. 01  |
| 7.02   | Diabetes Self Management Training (FQHC       | 0.00           | 0               |              |                                  | 0                              | 7. 02  |
|        | onl y)  |                |                 |              |                                  |                                |        |
| 8.00   | Total FTEs and Visits (sum of lines 4         | 2. 23          | 10, 658         |              |                                  | 10, 658                        | 8.00   |
|        | through 7)                                    |                |                 |              |                                  |                                |        |
| 9. 00  | Physician Services Under Agreements           |                | 0               |              |                                  | 0                              | 9. 00  |
|        |   |                |                 |              |                                  |                                |        |
|        |   |                |                 |              |                                  | 1. 00                          |        |
|        | DETERMINATION OF ALLOWABLE COST APPLICABLE TO |                |                 | RVI CES      |                                  |                                |        |
|        | Total costs of health care services (from Wk  |                |                 |              |                                  | 1, 105, 146                    |        |
|        | Total nonreimbursable costs (from Wkst. M-1,  |                |                 |              |                                  | 0                              | 11.00  |
| 12.00  | Cost of all services (excluding overhead) (s  |                |                 |              |                                  | 1, 105, 146                    |        |
| 13.00  | Ratio of hospital-based RHC/FQHC services (I  |                |                 |              |                                  | 1. 000000                      |        |
| 14.00  | Total hospital-based RHC/FQHC overhead - (fr  |                |                 | ine 31)      |                                  | 493, 240                       |        |
| 15.00  | Parent provider overhead allocated to facili  |                | 707, 943        |              |                                  |                                |        |
| 16.00  | Total overhead (sum of lines 14 and 15)       |                |                 |              |                                  | 1, 201, 183                    |        |
| 17.00  | Allowable GME overhead (see instructions)     |                |                 |              |                                  | 0                              | 17. 00 |
|        | Enter the amount from line 16                 |                |                 |              |                                  | 1, 201, 183                    |        |
|        | Overhead applicable to hospital-based RHC/FQ  |                |                 |              |                                  | 1, 201, 183                    |        |
| 20.00  | Total allowable cost of hospital-based RHC/F  | QHC services ( | sum of lines 10 | 0 and 19)    |                                  | 2, 306, 329                    | 20.00  |

| leal th          | Financial Systems WOODLAWN HOS  | PI TAL                  | In Lie                           | u of Form CMS-2                | 2552-1           |
|------------------|---|-------------------------|----------------------------------|--------------------------------|------------------|
|                  | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC   | Provider CCN: 15-1313   | Peri od:                         | Worksheet M-3                  |                  |
| SERVI (          | EES   | Component CCN: 15-8551  | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |                  |
|                  |   | Title XVIII             | RHC I                            | Cost                           | . piii           |
|                  |   |                         |                                  | 1 00                           |                  |
|                  | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES  |                         |                                  | 1. 00                          |                  |
| 1. 00            | Total Allowable Cost of hospital-based RHC/FQHC Services (fro   | m Wkst. M-2, line 20)   |                                  | 1, 061, 204                    | 1.00             |
| 2. 00            | Cost of vaccines and their administration (from Wkst. M-4, li   | ne 15)                  |                                  | 24, 970                        |                  |
| 3.00             | Total allowable cost excluding vaccine (line 1 minus line 2)  |                         |                                  | 1, 036, 234                    |                  |
| 4. 00<br>5. 00   | Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,                | line 9)                 |                                  | 1, 769<br>2, 209               |                  |
| 5. 00            | Total adjusted visits (line 4 plus line 5)  | 11116 7)                |                                  | 3, 978                         |                  |
| 7. 00            | Adjusted cost per visit (line 3 divided by line 6)  |                         |                                  | 260. 49                        | 7.00             |
|                  |   |                         | Cal cul ati on                   | of Limit (1)                   |                  |
|                  |   |                         | Pri or to Jan.                   | On or After                    |                  |
|                  |   |                         | 1 (Rate                          | Jan. 1 (Rate                   |                  |
|                  |   |                         | Peri od 1)<br>1.00               | Peri od 2)<br>2.00             |                  |
| 3. 00            | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20   | .6 or your contractor)  | 0.00                             | 0.00                           | 8.00             |
| 9. 00            | Rate for Program covered visits (see instructions)  |                         | 260. 49                          | 260. 49                        | 9.00             |
| 10. 00           | CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from                                    | contractor records)     | O                                | 831                            | 10.00            |
| 11.00            | Program cost excluding costs for mental health services (line   | -                       | 0                                | 216, 467                       | l                |
| 2. 00            | Program covered visits for mental health services (from contr   |                         | o                                | 0                              | 1                |
| 13.00            | Program covered cost from mental health services (line 9 x li   | *                       | 0                                | 0                              | 13.00            |
| 14.00            | Limit adjustment for mental health services (see instructions   | •                       | 0                                | 0                              | 14.00            |
| 15. 00<br>16. 00 | Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 | •                       | 0                                | 216, 467                       | 15. 00<br>16. 00 |
| 16. 01           | Total program charges (see instructions) (from contractor's re  | •                       |                                  | 123, 391                       |                  |
| 16. 02           | Total program preventive charges (see instructions) (from prov  | •                       |                                  | 797                            | 1                |
| 16. 03           | Total program preventive costs ((line 16.02/line 16.01) times   |                         |                                  | 1, 398                         |                  |
| 16. 04           | Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)                          | 3 and 18) times .80)    |                                  | 169, 098                       | 16.0             |
| 16. 05           | Total program cost (see instructions)   |                         | 0                                | 170, 496                       | 16. 0            |
| 17. 00           | Pri mary payer amounts  |                         |                                  | 0                              | 17.0             |
| 18. 00           | Less: Beneficiary deductible for RHC only (see instructions)  | (from contractor        |                                  | 3, 697                         | 18.00            |
| 19. 00           | records) Beneficiary coinsurance for RHC/FQHC services (see instruction   | ns) (from contractor    |                                  | 23, 779                        | 19.00            |
|                  | records)  |                         |                                  | 470 404                        |                  |
| 20. 00<br>21. 00 | Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.       | M-4 line 16)            |                                  | 170, 496<br>8, 561             |                  |
| 22. 00           | Total reimbursable Program cost (line 20 plus line 21)  | M-4, 1111e 10)          |                                  | 179, 057                       |                  |
| 23. 00           | Allowable bad debts (see instructions)  |                         |                                  | 0                              | 23. 00           |
| 23. 01           | Adjusted reimbursable bad debts (see instructions)  |                         |                                  | 0                              |                  |
| 24. 00<br>25. 00 | Allowable bad debts for dual eligible beneficiaries (see inst   | ructions)               |                                  | 0                              | 24. 00<br>25. 00 |
| 25. 50           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction                | s)                      |                                  | 0                              | 25.00            |
|                  | Demonstration payment adjustment amount before sequestration  | -,                      |                                  | 0                              |                  |
| 26. 00           | Net reimbursable amount (see instructions)  |                         |                                  | 179, 057                       | 26.00            |
| 26. 01           | 1   |                         |                                  | 1, 182                         | 1                |
| 26. 02<br>27. 00 | Demonstration payment adjustment amount after sequestration<br>Interim payments   |                         |                                  | 0<br>149, 664                  |                  |
| 28. 00           | 1   |                         |                                  | 149, 004                       | 1                |
| 29. 00           |   | 02, 27, and 28)         |                                  | 28, 211                        |                  |
| 20 00            | Protested amounts (nonallowable cost report items) in accorda   | nce with CMS Pub. 15-II | ,                                | 0                              | 30.00            |

| ealth Financial Systems WOODLAWN HOS   | PITAL                  | In Lie                           | u of Form CMS-2                | <u> 2552-</u> 1  |
|--|------------------------|----------------------------------|--------------------------------|------------------|
| ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC   | Provider CCN: 15-1313  | Peri od:                         | Worksheet M-3                  |                  |
| ERVI CES   | Component CCN: 15-8552 | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |                  |
|  | Title XVIII            | RHC II                           | Cost                           | o pili           |
|  |                        |                                  |                                |                  |
| DETERMINATION OF DATE FOR HOSPITAL PASED DHC/FOHC SERVICES   |                        |                                  | 1. 00                          |                  |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES  .00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro                | m Wkst M-2 line 20)    |                                  | 3, 566, 525                    | 1.00             |
| .00 Cost of vaccines and their administration (from Wkst. M-4, li  |                        |                                  | 137, 083                       |                  |
| .00 Total allowable cost excluding vaccine (line 1 minus line 2)   |                        |                                  | 3, 429, 442                    | 3.00             |
| .00 Total Visits (from Wkst. M-2, column 5, line 8)  |                        |                                  | 8, 805                         |                  |
| .00 Physicians visits under agreement (from Wkst. M-2, column 5,   | line 9)                |                                  | 0 005                          | 5.00             |
| .00   Total adjusted visits (line 4 plus line 5) .00   Adjusted cost per visit (line 3 divided by line 6)                                    |                        |                                  | 8, 805<br>389, 49              | 6. 00<br>7. 00   |
| . oo   Aujusteu cost per visit (iiile 3 urviueu by iiile 0)  |                        | Cal cul ati on                   |                                | 7.00             |
|  |                        |                                  |                                |                  |
|  |                        | Prior to Jan.                    | On or After                    |                  |
|  |                        | 1 (Rate<br>Period 1)             | Jan. 1 (Rate<br>Period 2)      |                  |
|  |                        | 1.00                             | 2. 00                          |                  |
| .00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20  | .6 or your contractor) | 0.00                             | 0.00                           | 8.00             |
| .00 Rate for Program covered visits (see instructions)   |                        | 389. 49                          | 389. 49                        | 9.00             |
| CALCULATION OF SETTLEMENT  |                        |                                  |                                |                  |
| 0.00 Program covered visits excluding mental health services (from   | •                      | 0                                | 369                            | l                |
| 1.00 Program cost excluding costs for mental health services (line<br>2.00 Program covered visits for mental health services (from contr     |                        | 0                                | 143, 722<br>0                  | 1                |
| 3.00 Program covered cost from mental health services (line 9 x li   |                        | 0                                | 0                              | 13.00            |
| 4.00 Limit adjustment for mental health services (see instructions   | *                      | 0                                | 0                              | 14.00            |
| 5.00 Graduate Medical Education Pass Through Cost (see instruction   | s)                     |                                  |                                | 15.00            |
| 6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2   | -                      | 0                                | 143, 722                       |                  |
| 6.01 Total program charges (see instructions)(from contractor's re   | •                      |                                  | 60, 298                        |                  |
| 6.02   Total program preventive charges (see instructions)(from prov<br>6.03   Total program preventive costs ((line 16.02/line 16.01) times | •                      |                                  | 948<br>2, 260                  |                  |
| 6.04 Total Program non-preventive costs ((Time 10.02/Time 10.07) times   |                        |                                  | 111, 214                       |                  |
| (Titles V and XIX see instructions.)   |                        |                                  | ,                              |                  |
| 6.05 Total program cost (see instructions)   |                        | 0                                | 113, 474                       |                  |
| 7.00 Primary payer amounts   | (6                     |                                  | 0                              | 17.00            |
| 8.00 Less: Beneficiary deductible for RHC only (see instructions) records)   | (from contractor       |                                  | 2, 445                         | 18.00            |
| 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction  | ns) (from contractor   |                                  | 11, 381                        | 19.00            |
| records) 0.00 Net Medicare cost excluding vaccines (see instructions)  |                        |                                  | 113, 474                       | 20.00            |
| 1.00 Program cost of vaccines and their administration (from Wkst.   | M-4. line 16)          |                                  | 4, 954                         |                  |
| 2.00 Total reimbursable Program cost (line 20 plus line 21)  |                        |                                  | 118, 428                       |                  |
| 3.00 Allowable bad debts (see instructions)  |                        |                                  | 0                              | 23.00            |
| 3.01 Adjusted reimbursable bad debts (see instructions)  |                        |                                  | 0                              |                  |
| 4.00   Allowable bad debts for dual eligible beneficiaries (see inst<br>5.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                | ructions)              |                                  | 0                              | 24. 00<br>25. 00 |
| 5.00  OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 5.50  Pioneer ACO demonstration payment adjustment (see instruction                     | e)                     |                                  | 0                              | 25.00            |
| 5.99 Demonstration payment adjustment amount before sequestration  | ~,                     |                                  | 0                              |                  |
| 6.00 Net reimbursable amount (see instructions)  |                        |                                  | 118, 428                       |                  |
| 6.01 Sequestration adjustment (see instructions)   |                        |                                  | 782                            |                  |
| 6.02 Demonstration payment adjustment amount after sequestration   |                        |                                  | 0                              |                  |
| 7.00 Interim payments  |                        |                                  | 75, 855                        |                  |
| 8.00   Tentative settlement (for contractor use only)<br>9.00   Balance due component/program (line 26 minus lines 26.01, 26.                | 02 27 and 28)          |                                  | 0<br>41, 791                   |                  |
| 0.00 Protested amounts (nonallowable cost report items) in accorda   |                        | .                                | 41, 741                        | 1                |
| chapter I, §115. 2   |                        |                                  | _                              |                  |

| неагт            | Financial Systems WOODLAWN HOS   | PI TAL                  | In Lie                           | u of Form CMS-2                | 2552-10          |
|------------------|--|-------------------------|----------------------------------|--------------------------------|------------------|
|                  | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC  | Provider CCN: 15-1313   | Peri od:                         | Worksheet M-3                  |                  |
| SERVI (          | EES  | Component CCN: 15-8550  | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |                  |
|                  |  | Title XVIII             | RHC III                          | Cost                           |                  |
|                  |  |                         |                                  | 1. 00                          |                  |
|                  | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES   |                         |                                  |                                |                  |
| 1.00             | Total Allowable Cost of hospital-based RHC/FQHC Services (fro  |                         |                                  | 2, 292, 507                    | 1.00             |
| 2.00             | Cost of vaccines and their administration (from Wkst. M-4, li<br>Total allowable cost excluding vaccine (line 1 minus line 2)  | ne 15)                  |                                  | 114, 236<br>2, 178, 271        | 2. 00<br>3. 00   |
| 4. 00            | Total Visits (from Wkst. M-2, column 5, line 8)  |                         |                                  | 9, 305                         | 4.00             |
| 5.00             | Physicians visits under agreement (from Wkst. M-2, column 5,   | line 9)                 |                                  | 0                              | 5.00             |
| 6.00             | Total adjusted visits (line 4 plus line 5)   |                         |                                  | 9, 305                         | 6. 00            |
| 7. 00            | Adjusted cost per visit (line 3 divided by line 6)   |                         | Calculation                      | 234. 10                        | 7.00             |
|                  |  |                         | Cal cul ati on                   | OI LIMIT (I)                   |                  |
|                  |  |                         | Pri or to Jan.                   | On or After                    |                  |
|                  |  |                         | 1 (Rate                          | Jan. 1 (Rate                   |                  |
|                  |  |                         | Peri od 1)<br>1.00               | Peri od 2)<br>2.00             |                  |
| 8. 00            | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20  | . 6 or your contractor) | 0.00                             | 0.00                           | 8.00             |
| 9. 00            | Rate for Program covered visits (see instructions)   |                         | 234. 10                          | 234. 10                        | 9. 00            |
| 10 00            | CALCULATION OF SETTLEMENT  |                         |                                  | 1 1/2                          | 10.00            |
| 10. 00<br>11. 00 | Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line    | -                       | 0                                | 1, 163<br>272, 258             |                  |
| 12. 00           | Program covered visits for mental health services (from contr  |                         | 0                                | 272, 230                       | 12.00            |
| 13.00            | Program covered cost from mental health services (line 9 x li  | ne 12)                  | 0                                | 0                              | 13.00            |
| 14.00            | Limit adjustment for mental health services (see instructions  | •                       | 0                                | 0                              | 14.00            |
| 15. 00<br>16. 00 | Graduate Medical Education Pass Through Cost (see instruction  | •                       | 0                                | 272 250                        | 15. 00<br>16. 00 |
| 16. 00           | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2<br>Total program charges (see instructions)(from contractor's re | *                       | 0                                | 272, 258<br>163, 524           |                  |
| 16. 02           | Total program preventive charges (see instructions) (from prov   |                         |                                  | 948                            | 1                |
| 16. 03           | Total program preventive costs ((line 16.02/line 16.01) times  | •                       |                                  | 1, 578                         | •                |
| 16. 04           | Total Program non-preventive costs ((line 16 minus lines 16.0  | 3 and 18) times .80)    |                                  | 212, 657                       | 16. 04           |
| 16. 05           | (Titles V and XIX see instructions.) Total program cost (see instructions)   |                         | 0                                | 214, 235                       | 16. 05           |
| 17. 00           | Pri mary payer amounts   |                         |                                  | 0                              | 17.00            |
| 18. 00           | Less: Beneficiary deductible for RHC only (see instructions)   | (from contractor        |                                  | 4, 859                         | 18. 00           |
| 19. 00           | records) Beneficiary coinsurance for RHC/FQHC services (see instruction  | ns) (from contractor    |                                  | 31, 544                        | 19. 00           |
| 20. 00           | records) Net Medicare cost excluding vaccines (see instructions)   |                         |                                  | 214, 235                       | 20.00            |
| 21. 00           | Program cost of vaccines and their administration (from Wkst.  | M-4. line 16)           |                                  | 35, 441                        | 21.00            |
| 22. 00           | Total reimbursable Program cost (line 20 plus line 21)   | ,                       |                                  | 249, 676                       | •                |
| 23. 00           | Allowable bad debts (see instructions)   |                         |                                  | 0                              | 23. 00           |
| 23. 01 24. 00    | Adjusted reimbursable bad debts (see instructions)   | rueti ene)              |                                  | 0                              | 23. 01           |
| 25. 00           | Allowable bad debts for dual eligible beneficiaries (see inst<br>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)                | ructions)               |                                  | 0                              | 24. 00<br>25. 00 |
| 25. 50           | 1 , , , , , , , , , , , , , , , , , , ,  | s)                      |                                  | 0                              | ł                |
| 25. 99           | Demonstration payment adjustment amount before sequestration   | •                       |                                  | 0                              | 25. 99           |
| 26.00            | Net reimbursable amount (see instructions)   |                         |                                  | 249, 676                       | ł                |
| 26. 01<br>26. 02 | Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration                       |                         |                                  | 1, 648<br>0                    | 26. 01<br>26. 02 |
|                  | Interim payments   |                         |                                  | 154, 867                       |                  |
| 28. 00           | 1  |                         |                                  | 0                              | 28. 00           |
|                  | Balance due component/program (line 26 minus lines 26.01, 26.  |                         |                                  | 93, 161                        |                  |
| 30.00            | Protested amounts (nonallowable cost report items) in accorda  | nce with CMS Pub. 15-II |                                  | 0                              | 30.00            |

| Heal th          | Financial Systems WOODLAWN HOS   | PI TAL                 | In Lie                      | u of Form CMS-2                | 2552-10          |
|------------------|--|------------------------|-----------------------------|--------------------------------|------------------|
|                  | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC  | Provider CCN: 15-1313  | Peri od:<br>From 01/01/2020 | Worksheet M-3                  |                  |
| SERVI C          | ES   | Component CCN: 15-8549 | To 12/31/2020               | Date/Time Pre<br>7/29/2021 4:1 |                  |
|                  |  | Title XVIII            | RHC IV                      | Cost                           |                  |
|                  |  |                        |                             | 1. 00                          |                  |
|                  | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES   |                        |                             |                                |                  |
| 1.00             | Total Allowable Cost of hospital-based RHC/FQHC Services (fro  |                        |                             | 380, 888                       |                  |
| 2. 00<br>3. 00   | Cost of vaccines and their administration (from Wkst. M-4, li<br>Total allowable cost excluding vaccine (line 1 minus line 2)  | ne 15)                 |                             | 15, 955<br>364, 933            | 2. 00<br>3. 00   |
| 4. 00            | Total Visits (from Wkst. M-2, column 5, line 8)  |                        |                             | 1, 558                         | •                |
| 5.00             | Physicians visits under agreement (from Wkst. M-2, column 5,   | line 9)                |                             | 0                              | 5.00             |
| 6.00             | Total adjusted visits (line 4 plus line 5)   |                        |                             | 1, 558                         | 6.00             |
| 7. 00            | Adjusted cost per visit (line 3 divided by line 6)   |                        | Cal cul ati on              | 234.23<br>of limit (1)         | 7.00             |
|                  |  |                        | our cur at r on             | 01 21 111 (1)                  |                  |
|                  |  |                        | Pri or to Jan.              | On or After                    |                  |
|                  |  |                        | 1 (Rate<br>Period 1)        | Jan. 1 (Rate<br>Period 2)      |                  |
|                  |  |                        | 1.00                        | 2. 00                          |                  |
| 8. 00            | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20  | .6 or your contractor) | 0.00                        | 0. 00                          | 8. 00            |
| 9. 00            | Rate for Program covered visits (see instructions)   |                        | 234. 23                     | 234. 23                        | 9.00             |
| 10. 00           | CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from                                       | contractor records)    | 0                           | 331                            | 10.00            |
| 11. 00           | Program cost excluding costs for mental health services (line  |                        | 0                           | 77, 530                        | •                |
| 12.00            | Program covered visits for mental health services (from contr  | actor records)         | 0                           | 0                              | 12.00            |
| 13.00            | Program covered cost from mental health services (line 9 x li  |                        | 0                           | 0                              | 13.00            |
| 14. 00<br>15. 00 | Limit adjustment for mental health services (see instructions<br>Graduate Medical Education Pass Through Cost (see instruction | •                      | 0                           | 0                              | 14. 00<br>15. 00 |
| 16. 00           | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2  |                        | 0                           | 77, 530                        | •                |
| 16. 01           | Total program charges (see instructions) (from contractor's re   | •                      |                             | 48, 874                        | •                |
| 16. 02           | Total program preventive charges (see instructions)(from prov  |                        |                             | 0                              | 16. 02           |
| 16. 03           | Total program preventive costs ((line 16.02/line 16.01) times  | •                      |                             | 0<br>E0 470                    | 16.03            |
| 16. 04           | Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)                             | 3 and 18) times .80)   |                             | 59, 470                        | 16. 04           |
| 16. 05           | Total program cost (see instructions)  |                        | 0                           | 59, 470                        | 16.05            |
| 17. 00           | Primary payer amounts  |                        |                             | 0                              | 17.00            |
| 18. 00           | Less: Beneficiary deductible for RHC only (see instructions) records)  | (from contractor       |                             | 3, 192                         | 18. 00           |
| 19. 00           | Beneficiary coinsurance for RHC/FQHC services (see instruction records)  | ns) (from contractor   |                             | 9, 136                         | 19. 00           |
| 20. 00           | Net Medicare cost excluding vaccines (see instructions)  |                        |                             | 59, 470                        | 20.00            |
| 21. 00           | Program cost of vaccines and their administration (from Wkst.  | M-4, line 16)          |                             | 6, 063                         | 21.00            |
| 22. 00           | Total reimbursable Program cost (line 20 plus line 21)   |                        |                             | 65, 533                        | •                |
| 23. 00<br>23. 01 | Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)                                      |                        |                             | 0                              | 23. 00<br>23. 01 |
|                  | Allowable bad debts for dual eligible beneficiaries (see inst  | ructions)              |                             | 0                              | 24.00            |
| 25. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   | ,                      |                             | 0                              | 25.00            |
|                  | Pioneer ACO demonstration payment adjustment (see instruction  | s)                     |                             | 0                              | 25. 50           |
|                  | Demonstration payment adjustment amount before sequestration<br>Net reimbursable amount (see instructions)                     |                        |                             | 65 522                         | ı                |
| 26. 00<br>26. 01 | Sequestration adjustment (see instructions)  |                        |                             | 65, 533<br>433                 | •                |
| 26. 02           | Demonstration payment adjustment amount after sequestration  |                        |                             | 0                              | ı                |
|                  | Interim payments   |                        |                             | 27, 969                        | •                |
|                  | Tentative settlement (for contractor use only)   | 00 07 and 00)          |                             | 0                              | 28.00            |
|                  | Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda    |                        |                             | 37, 131<br>0                   | 1                |
| 55.00            | chapter I, §115.2  |                        | '                           | O                              | 55.55            |

| Ith Financial Systems WOODLAWN HOSP  |                         |                             | u of Form CMS-2                |            |
|--|-------------------------|-----------------------------|--------------------------------|------------|
|  | Provider CCN: 15-1313   | Peri od:<br>From 01/01/2020 | Worksheet M-3                  |            |
| RVI CES  | Component CCN: 15-8547  | To 12/31/2020               | Date/Time Pre<br>7/29/2021 4:1 |            |
|  | Title XVIII             | RHC V                       | Cost                           |            |
|  |                         |                             | 1. 00                          |            |
| DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES   |                         |                             |                                |            |
| Total Allowable Cost of hospital-based RHC/FQHC Services (from   |                         |                             | 821, 671                       | 1. 0       |
| Cost of vaccines and their administration (from Wkst. M-4, lir   | ne 15)                  |                             | 32, 709                        |            |
| OO   Total allowable cost excluding vaccine (line 1 minus line 2) OO   Total Visits (from Wkst. M-2, column 5, line 8)             |                         |                             | 788, 962<br>2, 781             | 3.0        |
| Physicians visits under agreement (from Wkst. M-2, column 5, I   | ine 9)                  |                             | 2, 731                         | 5. (       |
| Total adjusted visits (line 4 plus line 5)   |                         |                             | 2, 781                         | 6. (       |
| 00   Adjusted cost per visit (line 3 divided by line 6)  |                         | Cal aul ati an              | 283. 70                        | 7. (       |
|  |                         | Cal cul ati on              | or Limit (1)                   |            |
|  |                         | Pri or to Jan.              | On or After                    |            |
|  |                         | 1 (Rate<br>Period 1)        | Jan. 1 (Rate<br>Period 2)      |            |
|  |                         | 1.00                        | 2. 00                          |            |
| Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.   | 6 or your contractor)   | 0.00                        | 0. 00                          | 8.         |
| Rate for Program covered visits (see instructions)   |                         | 283. 70                     | 283. 70                        | 9.         |
| CALCULATION OF SETTLEMENT  OD Program covered visits excluding mental health services (from  | contractor records)     | O                           | 427                            | 10.        |
| 00 Program cost excluding costs for mental health services (line   | •                       | 0                           | 121, 140                       | 1          |
| 00 Program covered visits for mental health services (from contra  |                         | O                           | 0                              | 12.        |
| 00 Program covered cost from mental health services (line 9 x lir  | •                       | 0                           | 0                              | 1          |
| Old Limit adjustment for mental health services (see instructions)   |                         | 0                           | 0                              | 14.        |
| 00 Graduate Medical Education Pass Through Cost (see instructions 00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 | •                       | 0                           | 121, 140                       | 15.<br>16. |
| 01 Total program charges (see instructions) (from contractor's red   | -                       |                             | 68, 982                        |            |
| 02 Total program preventive charges (see instructions)(from provi  |                         |                             | 3, 820                         |            |
| O3 Total program preventive costs ((line 16.02/line 16.01) times   | •                       |                             | 6, 708                         |            |
| 04   Total Program non-preventive costs ((line 16 minus lines 16.03 (Titles V and XIX see instructions.)                           | 3 and 18) times .80)    |                             | 90, 006                        | 16.        |
| 05 Total program cost (see instructions)   |                         | 0                           | 96, 714                        | 16.        |
| 00 Primary payer amounts   |                         |                             | 0                              | 17.        |
| 00 Less: Beneficiary deductible for RHC only (see instructions)  | (from contractor        |                             | 1, 924                         | 18.        |
| records)  8 Beneficiary coinsurance for RHC/FQHC services (see instruction)  | ns) (from contractor    |                             | 12, 648                        | 19.        |
| records) 00 Net Medicare cost excluding vaccines (see instructions)  |                         |                             | 96, 714                        | 20.        |
| 00 Program cost of vaccines and their administration (from Wkst.   | M-4, line 16)           |                             | 9, 740                         |            |
| 00 Total reimbursable Program cost (line 20 plus line 21)  | ,                       |                             | 106, 454                       | 22.        |
| 00 Allowable bad debts (see instructions)  |                         |                             | 0                              | 23.        |
| 01 Adjusted reimbursable bad debts (see instructions) 00 Allowable bad debts for dual eligible beneficiaries (see instr            | suctions)               |                             | 0                              | 23.<br>24. |
| OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  | uctions)                |                             | 0                              | 1          |
| 50 Pioneer ACO demonstration payment adjustment (see instructions  | s)                      |                             | 0                              |            |
| 99 Demonstration payment adjustment amount before sequestration  |                         |                             | 0                              | 1          |
| 00 Net reimbursable amount (see instructions)  |                         |                             | 106, 454                       | 1          |
| 01   Sequestration adjustment (see instructions) 02   Demonstration payment adjustment amount after sequestration                  |                         |                             | 703<br>0                       | 1          |
| 00 Interim payments  |                         |                             | 51, 771                        |            |
| OO Tentative settlement (for contractor use only)  |                         |                             | 0                              | 28.        |
| 00 Balance due component/program (line 26 minus lines 26.01, 26.0  | •                       |                             | 53, 980                        | 1          |
| 00 Protested amounts (nonallowable cost report items) in accordar chapter I, §115.2  | nce with CMS Pub. 15-II |                             | 0                              | 30.        |

| неаι τn          | Financial Systems WOODLAWN HOS  | PI TAL                  | In Lie                           | u of Form CMS-2                | 2552-10          |
|------------------|---|-------------------------|----------------------------------|--------------------------------|------------------|
|                  | ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC   | Provider CCN: 15-1313   | Peri od:                         | Worksheet M-3                  |                  |
| SERVI (          | EES   | Component CCN: 15-8548  | From 01/01/2020<br>To 12/31/2020 | Date/Time Pre<br>7/29/2021 4:1 |                  |
|                  |   | Title XVIII             | RHC VI                           | Cost                           |                  |
|                  |   |                         |                                  | 1. 00                          |                  |
|                  | DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES  |                         |                                  |                                |                  |
| 1.00             | Total Allowable Cost of hospital-based RHC/FQHC Services (fro   |                         |                                  | 2, 306, 329                    | 1.00             |
| 2. 00<br>3. 00   | Cost of vaccines and their administration (from Wkst. M-4, li<br>Total allowable cost excluding vaccine (line 1 minus line 2) | ne 15)                  |                                  | 122, 234<br>2, 184, 095        | 2. 00<br>3. 00   |
| 4. 00            | Total Visits (from Wkst. M-2, column 5, line 8)   |                         |                                  | 10, 658                        | •                |
| 5.00             | Physicians visits under agreement (from Wkst. M-2, column 5,  | line 9)                 |                                  | 0                              | 5.00             |
| 6.00             | Total adjusted visits (line 4 plus line 5)  |                         |                                  | 10, 658                        | 6. 00            |
| 7. 00            | Adjusted cost per visit (line 3 divided by line 6)  |                         | Cal cul ati on                   | 204. 93                        | 7.00             |
|                  |   |                         | Carcuration                      | OI LIMIT (I)                   |                  |
|                  |   |                         | Pri or to Jan.                   | On or After                    |                  |
|                  |   |                         | 1 (Rate                          | Jan. 1 (Rate                   |                  |
|                  |   |                         | Peri od 1)<br>1.00               | Peri od 2)<br>2.00             |                  |
| 8. 00            | Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20   | .6 or your contractor)  | 0.00                             | 0.00                           | 8. 00            |
| 9. 00            | Rate for Program covered visits (see instructions)  | <u> </u>                | 204. 93                          | 204. 93                        | 9. 00            |
| 10 00            | CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from                                      | contractor records)     | 0                                | 1, 324                         | 10.00            |
| 10. 00<br>11. 00 | Program cost excluding costs for mental health services (line   | •                       | 0                                | 271, 327                       |                  |
| 12. 00           | Program covered visits for mental health services (from contr   |                         | 0                                | 0                              | 12.00            |
| 13.00            | Program covered cost from mental health services (line 9 x li   | ne 12)                  | 0                                | 0                              | 13.00            |
| 14.00            | Limit adjustment for mental health services (see instructions   | •                       | 0                                | 0                              | 14.00            |
| 15. 00<br>16. 00 | Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2   | · ·                     | 0                                | 271, 327                       | 15. 00<br>16. 00 |
| 16. 01           | Total program charges (see instructions) (from contractor's re  | •                       | J                                | 196, 911                       | •                |
| 16.02            | Total program preventive charges (see instructions) (from prov  | •                       |                                  | 11, 381                        | •                |
| 16. 03           | Total program preventive costs ((line 16.02/line 16.01) times   | •                       |                                  | 15, 682                        | 1                |
| 16. 04           | Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)                            | 3 and 18) times .80)    |                                  | 198, 673                       | 16. 04           |
| 16. 05           | Total program cost (see instructions)   |                         | 0                                | 214, 355                       | 16. 05           |
| 17. 00           | Pri mary payer amounts  |                         |                                  | 0                              | 17.00            |
| 18. 00           | Less: Beneficiary deductible for RHC only (see instructions)  | (from contractor        |                                  | 7, 304                         | 18. 00           |
| 19. 00           | records) Beneficiary coinsurance for RHC/FQHC services (see instruction   | ns) (from contractor    |                                  | 35, 645                        | 19. 00           |
| 20. 00           | records) Net Medicare cost excluding vaccines (see instructions)  |                         |                                  | 214, 355                       | 20.00            |
| 21. 00           | Program cost of vaccines and their administration (from Wkst.   | M-4, line 16)           |                                  | 38, 915                        | •                |
| 22. 00           | Total reimbursable Program cost (line 20 plus line 21)  |                         |                                  | 253, 270                       | •                |
| 23.00            | Allowable bad debts (see instructions)  |                         |                                  | 0                              | 23.00            |
| 23. 01 24. 00    | Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst              | ructions)               |                                  | 0                              | 23. 01<br>24. 00 |
| 25. 00           | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  | ructions)               |                                  | 0                              | 25.00            |
| 25.50            | 1 , , , , , , , , , , , , , , , , , , ,   | s)                      |                                  | 0                              | ł                |
|                  | Demonstration payment adjustment amount before sequestration  |                         |                                  | 0                              | ł                |
| 26. 00<br>26. 01 | Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)  |                         |                                  | 253, 270<br>1, 672             | 1                |
| 26. 01           | Demonstration payment adjustment amount after sequestration   |                         |                                  | 1, 6/2                         | 26.01            |
|                  | Interim payments  |                         |                                  | 147, 025                       |                  |
| 28. 00           | Tentative settlement (for contractor use only)  |                         |                                  | 0                              | 28. 00           |
|                  | Balance due component/program (line 26 minus lines 26.01, 26.   |                         |                                  | 104, 573                       |                  |
| 30.00            | Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2   | nce with CMS Pub. 15-II | ,                                | 0                              | 30.00            |

| Health Financial Systems                            | WOODLAWN HOS               | PI TAL                 | In Lieu                     | u of Form CMS-2552-10 |
|---|----------------------------|------------------------|-----------------------------|-----------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-1313  | Peri od:<br>From 01/01/2020 | Worksheet M-4         |
| VACCINE COST  |                            | Component CCN: 15-8551 |                             |                       |
|   |                            | Ti +Lo VVIII           | DUC I                       | Cost                  |

|        |   |                          |              | //29/2021 4.13 | o piii |
|--------|---|--------------------------|--------------|----------------|--------|
|        |   | Title XVIII              | RHC I        | Cost           |        |
|        |   |                          | Pneumococcal | I nfl uenza    |        |
|        |   |                          | 1. 00        | 2. 00          |        |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)      |                          | 236, 159     | 236, 159       | 1.00   |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to tot | al health care staff tim | e 0. 002137  | 0. 008146      | 2.00   |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (li | ne 1 x line 2)           | 505          | 1, 924         | 3.00   |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (f | rom your records)        | 4, 755       | 5, 380         | 4.00   |
| 5.00   | Direct cost of pneumococcal and influenza vaccine (line 3 plu | s line 4)                | 5, 260       | 7, 304         | 5.00   |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Worksh | eet M-1, col. 7, line 22 | 533, 968     | 533, 968       | 6.00   |
| 7.00   | Total overhead (from Wkst. M-2, line 19)                      |                          | 527, 236     | 527, 236       | 7.00   |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to | tal direct cost (line 5  | 0. 009851    | 0. 013679      | 8.00   |
|        | divided by line 6)  |                          |              |                |        |
| 9.00   | Overhead cost - pneumococcal and influenza vaccine (line 7 x  | line 8)                  | 5, 194       | 7, 212         | 9.00   |
| 10.00  | Total pneumococcal and influenza vaccine cost and its (their) | administration (sum of   | 10, 454      | 14, 516        | 10.00  |
|        | lines 5 and 9)  |                          |              |                |        |
| 11. 00 | Total number of pneumococcal and influenza vaccine injections |                          | 48           |                | 11.00  |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 1 |                          | 217. 79      | 79. 32         | 12.00  |
| 13.00  | Number of pneumococcal and influenza vaccine injections admin | istered to Program       | 16           | 64             | 13.00  |
|        | benefi ci ari es  |                          |              |                |        |
| 14.00  | Program cost of pneumococcal and influenza vaccine and its (t | heir) administration     | 3, 485       | 5, 076         | 14.00  |
|        | (line 12 x line 13)   |                          |              |                |        |
| 15. 00 | Total cost of pneumococcal and influenza vaccine and its (the | ,                        |              | 24, 970        | 15. 00 |
|        | of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3 |                          |              |                |        |
| 16. 00 | Total Program cost of pneumococcal and influenza vaccine and  |                          |              | 8, 561         | 16. 00 |
|        | administration (sum of cols. 1 and 2, line 14) (transfer this | amount to Wkst. M-3,     |              |                |        |
|        | line 21)  |                          |              |                |        |

| Health Financial Systems                            | WOODLAWN HOS               | PITAL                  | In Lieu                     | ı of Form CMS-2552-10                 |
|---|----------------------------|------------------------|-----------------------------|---------------------------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST | PNEUMOCOCCAL AND INFLUENZA | Provi der CCN: 15-1313 | Peri od:<br>From 01/01/2020 | Worksheet M-4                         |
| VACCINE COST  |                            | Component CCN: 15-8552 | To 12/31/2020               | Date/Time Prepared: 7/29/2021 4:15 pm |
|   |                            | Title XVIII            | RHC II                      | Cost                                  |

|       |   |                           |              | 7/29/2021 4: 1! | 5 pm  |
|-------|---|---------------------------|--------------|-----------------|-------|
|       |   | Title XVIII               | RHC II       | Cost            |       |
|       |   |                           | Pneumococcal | I nfl uenza     |       |
|       |   |                           | 1. 00        | 2. 00           |       |
| 1.00  | Health care staff cost (from Wkst. M-1, col. 7, line 10)        |                           | 1, 843, 288  | 1, 843, 288     | 1.00  |
| 2.00  | Ratio of pneumococcal and influenza vaccine staff time to total | al health care staff time | 0. 002992    | 0. 007065       | 2.00  |
| 3.00  | Pneumococcal and influenza vaccine health care staff cost (li   | ne 1 x line 2)            | 5, 515       | 13, 023         | 3.00  |
| 4.00  | Medical supplies cost - pneumococcal and influenza vaccine (fi  | rom your records)         | 38, 138      | 26, 725         | 4.00  |
| 5.00  | Direct cost of pneumococcal and influenza vaccine (line 3 plus  | s line 4)                 | 43, 653      | 39, 748         | 5.00  |
| 6.00  | Total direct cost of the hospital-based RHC/FQHC (from Worksho  | eet M-1, col. 7, line 22) | 2, 169, 870  | 2, 169, 870     | 6.00  |
| 7.00  | Total overhead (from Wkst. M-2, line 19)                        |                           | 1, 396, 655  | 1, 396, 655     | 7.00  |
| 8.00  | Ratio of pneumococcal and influenza vaccine direct cost to to   | tal direct cost (line 5   | 0. 020118    | 0. 018318       | 8. 00 |
|       | divided by line 6)  |                           |              |                 |       |
| 9.00  | Overhead cost - pneumococcal and influenza vaccine (line 7 x    | line 8)                   | 28, 098      | 25, 584         | 9. 00 |
| 10.00 | Total pneumococcal and influenza vaccine cost and its (their)   | administration (sum of    | 71, 751      | 65, 332         | 10.00 |
|       | lines 5 and 9)  |                           |              |                 |       |
| 11.00 | Total number of pneumococcal and influenza vaccine injections   | (from your records)       | 385          | 909             | 11.00 |
| 12.00 | Cost per pneumococcal and influenza vaccine injection (line 10  | 0/line 11)                | 186. 37      | 71. 87          | 12.00 |
| 13.00 | Number of pneumococcal and influenza vaccine injections admini  | istered to Program        | 10           | 43              | 13.00 |
|       | benefi ci ari es  |                           |              |                 |       |
| 14.00 | Program cost of pneumococcal and influenza vaccine and its (t   | heir) administration      | 1, 864       | 3, 090          | 14.00 |
|       | (line 12 x line 13)   |                           |              |                 |       |
| 15.00 | Total cost of pneumococcal and influenza vaccine and its (the   |                           |              | 137, 083        | 15.00 |
|       | of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,  |                           |              |                 |       |
| 16.00 |   |                           |              | 4, 954          | 16.00 |
|       | administration (sum of cols. 1 and 2, line 14) (transfer this   | amount to Wkst. M-3,      |              |                 |       |
|       | line 21)  |                           |              |                 |       |

| Health Financial Systems                            | WOODLAWN HOS               | PITAL                  | In Lieu                     | of Form CMS-2552-10                   |
|---|----------------------------|------------------------|-----------------------------|---------------------------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-1313  | Peri od:<br>From 01/01/2020 | Worksheet M-4                         |
| VACCINE COST  |                            | Component CCN: 15-8550 | To 12/31/2020               | Date/Time Prepared: 7/29/2021 4:15 pm |
|   |                            | Title XVIII            | RHC III                     | Cost                                  |

|        |  |                           |              | 7/29/2021 4: 1: | b pm   |
|--------|--|---------------------------|--------------|-----------------|--------|
|        |  | Title XVIII               | RHC III      | Cost            |        |
|        |  |                           | Pneumococcal | I nfl uenza     |        |
|        |  |                           | 1. 00        | 2. 00           |        |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)               |                           | 874, 964     | 874, 964        | 1.00   |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to tot          | al health care staff time | e 0. 002294  | 0. 006767       | 2.00   |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (li          | ne 1 x line 2)            | 2, 007       | 5, 921          | 3.00   |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (f          | rom your records)         | 21, 892      | 19, 169         | 4.00   |
| 5.00   | Direct cost of pneumococcal and influenza vaccine (line 3 plu          | s line 4)                 | 23, 899      | 25, 090         | 5.00   |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Worksh          | eet M-1, col. 7, line 22  | 983, 124     | 983, 124        | 6.00   |
| 7.00   | Total overhead (from Wkst. M-2, line 19)                               |                           | 1, 309, 383  | 1, 309, 383     | 7.00   |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to          | tal direct cost (line 5   | 0. 024309    | 0. 025521       | 8.00   |
|        | divided by line 6)   |                           |              |                 |        |
| 9.00   | Overhead cost - pneumococcal and influenza vaccine (line 7 x           | line 8)                   | 31, 830      | 33, 417         | 9.00   |
| 10.00  | Total pneumococcal and influenza vaccine cost and its (their)          | administration (sum of    | 55, 729      | 58, 507         | 10.00  |
|        | lines 5 and 9)   |                           |              |                 |        |
| 11. 00 | Total number of pneumococcal and influenza vaccine injections          |                           | 221          |                 | 11.00  |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 1          |                           | 252. 17      | 89. 73          | 12.00  |
| 13.00  | Number of pneumococcal and influenza vaccine injections admin          | istered to Program        | 74           | 187             | 13.00  |
|        | benefi ci ari es   |                           |              |                 |        |
| 14. 00 | Program cost of pneumococcal and influenza vaccine and its (t          | heir) administration      | 18, 661      | 16, 780         | 14.00  |
|        | (line 12 x line 13)  |                           |              |                 |        |
| 15. 00 |  |                           |              | 114, 236        | 15.00  |
|        | of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) |                           |              |                 |        |
| 16. 00 | Total Program cost of pneumococcal and influenza vaccine and           |                           |              | 35, 441         | 16. 00 |
|        | administration (sum of cols. 1 and 2, line 14) (transfer this          | amount to Wkst. M-3,      |              |                 |        |
|        | line 21)   |                           |              |                 |        |
|        |  |                           |              |                 |        |

| Health Financial Systems                            | WOODLAWN HOS                   | SPI TAL   | In Lieu         | of Form CMS-2552-10 |
|---|--------------------------------|---|-----------------|---------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/F<br>VACCINE COST | QHC PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-1313<br>Component CCN: 15-8549 | From 01/01/2020 | Date/Time Prepared: |
|   |                                |   |                 | 7/29/2021 4:15 pm   |
|   |                                | Title XVIII                                     | RHC LV          | Cost                |

|        |   |                           |              | 7/29/2021 4: 1! | 5 pm  |
|--------|---|---------------------------|--------------|-----------------|-------|
|        |   | Title XVIII               | RHC IV       | Cost            |       |
|        |   |                           | Pneumococcal | I nfl uenza     |       |
|        |   |                           | 1. 00        | 2. 00           |       |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)        |                           | 164, 796     | 164, 796        | 1.00  |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to total | al health care staff time | e 0. 001603  | 0. 017361       | 2.00  |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (li   | ne 1 x line 2)            | 264          | 2, 861          | 3.00  |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (f   | rom your records)         | 1, 189       | 3, 822          | 4.00  |
| 5.00   | Direct cost of pneumococcal and influenza vaccine (line 3 plus  | s line 4)                 | 1, 453       | 6, 683          | 5.00  |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Workshi  | eet M-1, col. 7, line 22) | 194, 226     | 194, 226        | 6.00  |
| 7.00   | Total overhead (from Wkst. M-2, line 19)                        |                           | 186, 662     | 186, 662        | 7.00  |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to   | tal direct cost (line 5   | 0. 007481    | 0. 034408       | 8.00  |
|        | divided by line 6)  |                           |              |                 |       |
| 9.00   | Overhead cost - pneumococcal and influenza vaccine (line 7 x    | line 8)                   | 1, 396       | 6, 423          | 9.00  |
| 10.00  | Total pneumococcal and influenza vaccine cost and its (their)   | administration (sum of    | 2, 849       | 13, 106         | 10.00 |
|        | lines 5 and 9)  |                           |              |                 |       |
| 11. 00 | Total number of pneumococcal and influenza vaccine injections   | (from your records)       | 12           | 130             | 11.00 |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 1   | 0/line 11)                | 237. 42      | 100. 82         | 12.00 |
| 13.00  | Number of pneumococcal and influenza vaccine injections admin   | istered to Program        | 6            | 46              | 13.00 |
|        | benefi ci ari es  |                           |              |                 |       |
| 14. 00 |   | heir) administration      | 1, 425       | 4, 638          | 14.00 |
|        | (line 12 x line 13)   |                           |              |                 |       |
| 15. 00 |   |                           |              | 15, 955         | 15.00 |
|        | of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3   |                           |              |                 |       |
| 16. 00 | 13 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                          | ,                         |              | 6, 063          | 16.00 |
|        | administration (sum of cols. 1 and 2, line 14) (transfer this   | amount to Wkst. M-3,      |              |                 |       |
|        | line 21)  |                           |              | l               |       |

| Health Financial Systems               | WOODLAWN HOS               | PI TAL                 | In Lieu                     | u of Form CMS-2552-10 |
|--|----------------------------|------------------------|-----------------------------|-----------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC | PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-1313  | Peri od:<br>From 01/01/2020 | Worksheet M-4         |
| VACCINE COST                           |                            | Component CCN: 15-8547 |                             |                       |
|  |                            | Title VVIII            | DHC V                       | Cost                  |

|        |   |                           |              | 7/29/2021 4.13 | o piii |
|--------|---|---------------------------|--------------|----------------|--------|
|        |   | Title XVIII               | RHC V        | Cost           |        |
|        |   |                           | Pneumococcal | I nfl uenza    |        |
|        |   |                           | 1. 00        | 2. 00          |        |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)      |                           | 338, 684     | 338, 684       | 1.00   |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to tot | al health care staff time | 0. 001587    | 0. 008709      | 2.00   |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (li | ne 1 x line 2)            | 537          | 2, 950         | 3.00   |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (f | rom your records)         | 4, 061       | 6, 615         | 4.00   |
| 5.00   | Direct cost of pneumococcal and influenza vaccine (line 3 plu | s line 4)                 | 4, 598       | 9, 565         | 5.00   |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Worksh | eet M-1, col. 7, line 22) | 355, 786     | 355, 786       | 6.00   |
| 7.00   | Total overhead (from Wkst. M-2, line 19)                      |                           | 465, 885     | 465, 885       | 7.00   |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to | tal direct cost (line 5   | 0. 012923    | 0. 026884      | 8.00   |
|        | divided by line 6)  |                           |              |                |        |
| 9.00   | Overhead cost - pneumococcal and influenza vaccine (line 7 x  | line 8)                   | 6, 021       | 12, 525        | 9.00   |
| 10.00  | Total pneumococcal and influenza vaccine cost and its (their) | administration (sum of    | 10, 619      | 22, 090        | 10.00  |
|        | lines 5 and 9)  |                           |              |                |        |
| 11. 00 | Total number of pneumococcal and influenza vaccine injections | (from your records)       | 41           | 225            | 11.00  |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 1 | 0/line 11)                | 259. 00      | 98. 18         | 12.00  |
| 13.00  | Number of pneumococcal and influenza vaccine injections admin | istered to Program        | 16           | 57             | 13.00  |
|        | benefi ci ari es  |                           |              |                |        |
| 14.00  | Program cost of pneumococcal and influenza vaccine and its (t | heir) administration      | 4, 144       | 5, 596         | 14.00  |
|        | (line 12 x line 13)   |                           |              |                |        |
| 15. 00 | Total cost of pneumococcal and influenza vaccine and its (the | ,                         |              | 32, 709        | 15. 00 |
|        | of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3 |                           |              |                |        |
| 16. 00 | Total Program cost of pneumococcal and influenza vaccine and  | ,                         |              | 9, 740         | 16.00  |
|        | administration (sum of cols. 1 and 2, line 14) (transfer this | amount to Wkst. M-3,      |              |                |        |
|        | line 21)  |                           |              | l              |        |

| Health Financial Systems                            | WOODLAWN HOS               | PITAL                  | In Lieu                     | u of Form CMS-2552-10                 |
|---|----------------------------|------------------------|-----------------------------|---------------------------------------|
| COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST | PNEUMOCOCCAL AND INFLUENZA | Provider CCN: 15-1313  | Peri od:<br>From 01/01/2020 | Worksheet M-4                         |
| VACOTAL GOST  |                            | Component CCN: 15-8548 | To 12/31/2020               | Date/Time Prepared: 7/29/2021 4:15 pm |
|   |                            | Title XVIII            | RHC VI                      | Cost                                  |

|        |   |                          |              | 7/29/2021 4: 1! | 5 pm  |
|--------|---|--------------------------|--------------|-----------------|-------|
|        |   | Title XVIII              | RHC VI       | Cost            |       |
|        |   |                          | Pneumococcal | I nfl uenza     |       |
|        |   |                          | 1. 00        | 2. 00           |       |
| 1.00   | Health care staff cost (from Wkst. M-1, col. 7, line 10)      |                          | 1, 025, 645  | 1, 025, 645     | 1.00  |
| 2.00   | Ratio of pneumococcal and influenza vaccine staff time to tot | al health care staff tim | e 0. 003436  | 0. 013185       | 2.00  |
| 3.00   | Pneumococcal and influenza vaccine health care staff cost (li | ne 1 x line 2)           | 3, 524       | 13, 523         | 3.00  |
| 4.00   | Medical supplies cost - pneumococcal and influenza vaccine (f | rom your records)        | 19, 416      | 22, 109         | 4.00  |
| 5. 00  | Direct cost of pneumococcal and influenza vaccine (line 3 plu | s line 4)                | 22, 940      | 35, 632         | 5.00  |
| 6.00   | Total direct cost of the hospital-based RHC/FQHC (from Worksh | eet M-1, col. 7, line 22 | 1, 105, 146  | 1, 105, 146     | 6.00  |
| 7. 00  | Total overhead (from Wkst. M-2, line 19)                      |                          | 1, 201, 183  | 1, 201, 183     | 7.00  |
| 8.00   | Ratio of pneumococcal and influenza vaccine direct cost to to | tal direct cost (line 5  | 0. 020757    | 0. 032242       | 8.00  |
|        | divided by line 6)  |                          |              |                 |       |
| 9. 00  | Overhead cost - pneumococcal and influenza vaccine (line 7 x  | line 8)                  | 24, 933      | 38, 729         | 9.00  |
| 10.00  | Total pneumococcal and influenza vaccine cost and its (their) | administration (sum of   | 47, 873      | 74, 361         | 10.00 |
|        | lines 5 and 9)  |                          |              |                 |       |
| 11. 00 | Total number of pneumococcal and influenza vaccine injections | (from your records)      | 196          | 752             | 11.00 |
| 12.00  | Cost per pneumococcal and influenza vaccine injection (line 1 | 0/line 11)               | 244. 25      | 98. 88          | 12.00 |
| 13.00  | Number of pneumococcal and influenza vaccine injections admin | istered to Program       | 82           | 191             | 13.00 |
|        | beneficiaries   |                          |              |                 |       |
| 14.00  | Program cost of pneumococcal and influenza vaccine and its (t | heir) administration     | 20, 029      | 18, 886         | 14.00 |
|        | (line 12 x line 13)   |                          |              |                 |       |
| 15.00  | Total cost of pneumococcal and influenza vaccine and its (the | ir) administration (sum  |              | 122, 234        | 15.00 |
|        | of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3 |                          |              |                 |       |
| 16.00  | Total Program cost of pneumococcal and influenza vaccine and  | its (their)              |              | 38, 915         | 16.00 |
|        | administration (sum of cols. 1 and 2, line 14) (transfer this | amount to Wkst. M-3,     |              |                 |       |
|        | line 21)  |                          |              |                 |       |

| Health Financial Systems  | WOODLAWN HOS | PI TAL   | In Lie          | u of Form CMS-2552-10 |
|---|--------------|--|-----------------|-----------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA |              | Provi der CCN: 15-1313<br>Component CCN: 15-8551 | From 01/01/2020 |                       |
|   |              |  | DHC I           | Coct                  |

|          |  |                             |                | 7/29/2021 4: 15     | 5 pm |
|----------|--|-----------------------------|----------------|---------------------|------|
|          |  |                             | RHC I          | Cost                |      |
|          |  |                             | Par            | rt B                |      |
|          |  |                             | mm/dd/yyyy     | Amount              |      |
|          |  |                             | 1. 00          | 2.00                |      |
| 00       | Total interim payments paid to hospital-based RHC/FQHC           |                             |                | 149, 664            | 1.   |
| 00       | Interim payments payable on individual bills, either submit      | tted or to be submitted to  |                | 0                   | 2.   |
|          | the contractor for services rendered in the cost reporting       | period. If none, write      |                |                     |      |
|          | "NONE" or enter a zero   |                             |                |                     |      |
| 00       | List separately each retroactive lump sum adjustment amount      |                             |                |                     | 3    |
|          | 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  |                             |                |                     |      |
| 01       |  |                             |                | 0                   | 3    |
| )2       |  |                             |                | 0                   | 3    |
| )3       |  |                             |                | 0                   | 3    |
| 04       |  |                             |                | 0                   | 3    |
| 05       |  |                             |                | 0                   | 3    |
|          | Provider to Program  |                             |                |                     |      |
| 50       |  |                             |                | 0                   | 3    |
| 51       |  |                             |                | 0                   | 3    |
| 52       |  |                             |                | 0                   | 3    |
| 53       |  |                             |                | 0                   | 3    |
| 54       |  |                             |                | 0                   | 3    |
| 99       | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.      |                             |                | 0                   | 3    |
| 00       | Total interim payments (sum of lines 1, 2, and 3.99) (trans      | sfer to Worksheet M-3, line |                | 149, 664            | 4    |
|          | 27)  |                             |                |                     |      |
|          | TO BE COMPLETED BY CONTRACTOR                                    |                             | _              |                     | _    |
| 00       | List separately each tentative settlement payment after des      | sk review. Also show date o | Ť              |                     | 5    |
|          | each payment. If none, write "NONE" or enter a zero. (1)         |                             |                |                     |      |
| 01       | Program to Provider  |                             |                | 0                   | 5    |
| )1<br>)2 |  |                             |                |                     | 5    |
| )2       |  |                             |                | 0                   | 5    |
| JS       | Provider to Program  |                             |                | U                   | C    |
| 50       | Frovider to Frogram  |                             |                | 0                   | 5    |
| 51       |  |                             |                |                     | 5    |
| 52       |  |                             |                |                     | 5    |
| 99       | <br> Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. | 98)                         |                |                     | 5    |
| 00       | Determined net settlement amount (balance due) based on the      |                             |                |                     | 6    |
| )1       | SETTLEMENT TO PROVIDER   | e cost report. (1)          |                | 28, 211             | 6    |
| )2       | SETTLEMENT TO PROGRAM  |                             |                | 20, 211             | 6    |
| 00       | Total Medicare program liability (see instructions)              |                             |                | 177, 875            | 7    |
| 50       | Total modicale program trability (see instructions)              |                             | Contractor     | NPR Date            |      |
|          |  |                             | COILLIACTO     | WIN Date            |      |
|          |  |                             | Number         | (Mo/Day/Yr)         |      |
|          |  | 0                           | Number<br>1.00 | (Mo/Day/Yr)<br>2.00 |      |

| Health Financial Systems   | WOODLAWN HOS | PI TAL  | In Lieu                          | u of Form CMS-2552-10                               |
|--|--------------|---|----------------------------------|---|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH<br>SERVICES RENDERED TO PROGRAM BENEFICIARIE |              | Provider CCN: 15-1313<br>Component CCN: 15-8552 | From 01/01/2020<br>To 12/31/2020 | Worksheet M-5 Date/Time Prepared: 7/29/2021 4:15 pm |
|  |              |   | RHC II                           | Cost  |

|                |   | Component CCN: 15-8552      | To 12/31/2020  | Date/Time Prep<br>7/29/2021 4:15 |                |
|----------------|---|-----------------------------|----------------|----------------------------------|----------------|
|                |   |                             | RHC II         | Cost                             |                |
|                |   |                             |                | t B                              |                |
|                |   |                             | mm/dd/yyyy     | Amount                           |                |
|                |   |                             | 1. 00          | 2. 00                            |                |
| 1. 00          | Total interim payments paid to hospital-based RHC/FQHC  |                             |                | 75, 855                          | 1. 00          |
| 2.00           | Interim payments payable on individual bills, either submit   |                             |                | 0                                | 2.00           |
|                | the contractor for services rendered in the cost reporting "NONE" or enter a zero                                   | period. If none, write      |                |                                  |                |
| 3. 00          | List separately each retroactive lump sum adjustment amount   | hased on subsequent         |                |                                  | 3. 00          |
| 3.00           | revision of the interim rate for the cost reporting period.   |                             |                |                                  | 3.00           |
|                | payment. If none, write "NONE" or enter a zero. (1)   | 711 30 Show date of each    |                |                                  |                |
|                | Program to Provider   |                             |                |                                  |                |
| 3. 01          |   |                             |                | 0                                | 3. 01          |
| 3. 02          |   |                             |                | 0                                | 3.02           |
| 3. 03          |   |                             |                | 0                                | 3.03           |
| 3. 04          |   |                             |                | 0                                | 3.04           |
| 3. 05          |   |                             |                | 0                                | 3. 05          |
| 2 50           | Provider to Program   |                             |                | 0                                | 2 50           |
| 3. 50<br>3. 51 |   |                             |                | 0 0                              | 3. 50<br>3. 51 |
| 3. 52          |   |                             |                | 0                                | 3. 52          |
| 3. 53          |   |                             |                | Ö                                | 3. 53          |
| 3. 54          |   |                             |                | ol                               | 3. 54          |
| 3. 99          | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.   | 98)                         |                | 0                                | 3. 99          |
| 4.00           | Total interim payments (sum of lines 1, 2, and 3.99) (trans   | sfer to Worksheet M-3, line | е              | 75, 855                          | 4.00           |
|                | 27)   |                             |                |                                  |                |
|                | TO BE COMPLETED BY CONTRACTOR   |                             |                |                                  |                |
| 5. 00          | List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1) | sk review. Also show date ( | of             |                                  | 5. 00          |
|                | Program to Provider   |                             |                |                                  |                |
| 5. 01          |   |                             |                | 0                                | 5. 01          |
| 5. 02          |   |                             |                | 0                                | 5. 02          |
| 5. 03          | Provider to Program   |                             |                | 0                                | 5. 03          |
| 5. 50          | Frovider to Frogram   |                             |                | 0                                | 5. 50          |
| 5. 51          |   |                             |                | ٥                                | 5. 51          |
| 5. 52          |   |                             |                | l ol                             | 5. 52          |
| 5. 99          | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.   | 98)                         |                | 0                                | 5. 99          |
| 6.00           | Determined net settlement amount (balance due) based on the   | cost report. (1)            |                |                                  | 6.00           |
| 6. 01          | SETTLEMENT TO PROVIDER  |                             |                | 41, 791                          | 6. 01          |
| 6. 02          | SETTLEMENT TO PROGRAM   |                             |                | 0                                | 6. 02          |
| 7. 00          | Total Medicare program liability (see instructions)   |                             |                | 117, 646                         | 7. 00          |
|                |   |                             | Contractor     | NPR Date                         |                |
|                |   | 0                           | Number<br>1.00 | (Mo/Day/Yr)<br>2.00              |                |
| 8. 00          | Name of Contractor  | U                           | 1.00           | 2.00                             | 8. 00          |
| 3. 00          | 1.00.00   |                             | (              | 1                                | 0.00           |

| Health Financial Systems   | WOODLAWN HOSPITAL | L   | In Lieu                          | of Form CMS-2552-10                                 |
|--|-------------------|---|----------------------------------|---|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED I<br>SERVICES RENDERED TO PROGRAM BENEFICIARI | ES                | vider CCN: 15-1313<br>ponent CCN: 15-8550 | From 01/01/2020<br>To 12/31/2020 | Worksheet M-5 Date/Time Prepared: 7/29/2021 4:15 pm |
|  |                   |   | DHC III                          | Cost  |

|              |  | Component CCN: 15-8550     | 10 12/31/2020 | 7/29/2021 4: 15 |      |
|--------------|--|----------------------------|---------------|-----------------|------|
|              |  |                            | RHC III       | Cost            |      |
|              |  |                            | Par           | t B             |      |
|              |  |                            | mm/dd/yyyy    | Amount          |      |
|              |  |                            | 1.00          | 2. 00           |      |
| . 00         | Total interim payments paid to hospital-based RHC/FQHC   |                            |               | 154, 867        | 1. 0 |
| . 00         | Interim payments payable on individual bills, either submitted the contractor for services rendered in the cost reporting properties or enter a zero   | period. If none, write     |               | 0               | 2. 0 |
| . 00         | List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)  Program to Provider |                            |               |                 | 3. 0 |
| . 01         | <del>g</del>   |                            |               | 0               | 3. 0 |
| . 02         |  |                            |               | ol ol           | 3. 0 |
| . 03         |  |                            |               | ol ol           | 3. 0 |
| . 04         |  |                            |               | l ol            | 3. 0 |
| . 05         |  |                            |               |                 | 3.0  |
| . 00         | Provider to Program  |                            |               | U               | J. C |
| 50           | 11 ovi dei 10 11 ogi alli  |                            |               | 0               | 3. 5 |
| 51           |  |                            |               | l ől            | 3. 5 |
| 52           |  |                            |               |                 | 3. ! |
| 53           |  |                            |               |                 | 3. ! |
| 54           |  |                            |               |                 | 3. ! |
| 99           | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9   | 20)                        |               |                 | 3. 9 |
| . 99<br>. 00 | Total interim payments (sum of lines 1, 2, and 3.99) (transf   |                            |               | 154, 867        | 4.0  |
| . 00         | 27)  | er to worksneet w-s, ittle | 7             | 134, 607        | 4. ( |
|              | TO BE COMPLETED BY CONTRACTOR  |                            |               |                 |      |
| . 00         | List separately each tentative settlement payment after deskeach payment. If none, write "NONE" or enter a zero. (1)   | c review. Also show date o | of            |                 | 5. 0 |
|              | Program to Provider  |                            |               |                 |      |
| 01           | 11 ogi ami to 11 ovi dei   |                            |               | 0               | 5. ( |
| 02           |  |                            |               |                 | 5.0  |
| 03           |  |                            |               |                 | 5. ( |
| 03           | Provider to Program  |                            |               | U               | 5. ( |
| 50           | 11 ovi doi 120 11 ogi diii   |                            |               | 0               | 5. 5 |
| 51           |  |                            |               | l ol            | 5. ! |
| 52           |  |                            |               |                 | 5. ! |
| 99           | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9   | 987                        |               |                 | 5.   |
| 00           | Determined net settlement amount (balance due) based on the  |                            |               | ١               | 6. ( |
| 01           | SETTLEMENT TO PROVIDER   | cost report. (1)           |               | 93, 161         | 6. ( |
| 02           | SETTLEMENT TO PROVIDER   |                            |               | 93, 161         | 6. ( |
|              |  |                            |               | -               |      |
| .00          | Total Medicare program liability (see instructions)  |                            | C             | 248, 028        | 7. ( |
|              |  |                            | Contractor    | NPR Date        |      |
|              |  | 0                          | Number        | (Mo/Day/Yr)     |      |
| -00          | Name of Contractor   | 0                          | 1. 00         | 2. 00           |      |
| . 00         | Name of Contractor   |                            |               |                 | 8.0  |

| Health Financial Systems   | WOODLAWN HOS | PI TAL                 | In Lieu         | ı of Form CMS-2552-10                 |
|--|--------------|------------------------|-----------------|---------------------------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIE |              |                        | From 01/01/2020 |                                       |
|  |              | Component CCN: 15-8549 |                 | Date/lime Prepared: 7/29/2021 4:15 pm |
|  |              |                        | RHC IV          | Cost                                  |

| 10 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero are retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O  Provider to Program  O  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  O  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM  O  Total Medicare program liability (see instructions)  O  O  O  O  O  O  O  O  O  O  O  O  O   |  |                | Component CCN: 15-8549    |            | 7/29/2021 4:15                        |    |
|--|--|----------------|---------------------------|------------|---------------------------------------|----|
| Total interim payments paid to hospital-based RHC/FDHC Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NoNE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero. (1)  Program to Provider  Program to Provider  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969 27) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider to Program  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 3 ( |  |                |                           |            |                                       |    |
| Total Interim payments paid to hospital-based RHC/FOHC Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Program to Provider  Provider to Program  O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O Total Interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Provider to Program  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROKRAM O Total Medicare program liability (see instructions)  O Contractor Number (Wo/Day/Yrr) Loop 2, 00  Interim payments payable on individual bills, either submitted or to be submitted to the cost report. (1)  Provider to Program O Contractor Number (Wo/Day/Yrr) Loop 2, 00  Interim payments payable on individual bills, either submitted or leach payment after desk review. Also show date of cach payment. If none, write "NONE" or enter a zero. (1)  Provider to Program O Contractor Number (Wo/Day/Yrr) Loop 2, 00  Provider to Program liability (see instructions)   |  |                |                           |            | t B                                   |    |
| Total interim payments paid to hospi tal-based RMC/FOMC interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero IList separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Program to Provider  Provider to Program  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Provider to Program  On Total interim payments (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)  SETTILEMENT TO PROGRAM TO TOROGRAM Total Medicare program liability (see instructions)  On Total Medicare program liability (see instructions)   |  |                |                           | mm/dd/yyyy | Amount                                |    |
| Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O  Provider to Program  O  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM  O  Total Medicare program liability (see instructions)  O  NPR Date (Mo/Day/Yr)  Ner Date (Mo/Day/Yr)  O  1.00  2.00  NPR Date (Mo/Day/Yr)  Ner Date (Mo/Day/Yr)  |  |                |                           | 1. 00      |                                       |    |
| the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 1. List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969) To BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTILEMENT TO PROGRAM To Total Medicare program liability (see instructions)  O  O  O  O  O  O  O  O  O  O  O  O  O  | O   Total interim payments paid to hospital-based RH | HC/FQHC        |                           |            | 27, 969                               | 1. |
| NONE" or enter a zero  List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969)  To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  O  1.00  O  O  O  O  O  O  O  O  O  O  O  O   |  |                |                           |            | 0                                     | 2. |
| 1 ist separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | the contractor for services rendered in the cost     | t reporting pe | eriod. If none, write     |            |                                       |    |
| 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  O  Provider to Program  O  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969 27) TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Provider to Program  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) O  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM O  Total Medicare program liability (see instructions)  O  Contractor (Mo/Day/Yr) O  NPR Date (Mo/Day/Yr)  | "NONE" or enter a zero                               |                |                           |            |                                       |    |
| payment. If none, write "NONE" or enter a zero. (1) Program to Provider    Program to Provider   | O List separately each retroactive lump sum adjust   | tment amount b | based on subsequent       |            |                                       | 3. |
| Program to Provider  O  O  O  O  Provider to Program  O  O  Provider to Program  O  O  O  Provider to Program  O  O  O  O  O  O  O  O  O  O  O  O  O   | revision of the interim rate for the cost report     | ting period. A | Also show date of each    |            |                                       |    |
| 1  | payment. If none, write "NONE" or enter a zero.      | (1)            |                           |            |                                       |    |
| Provider to Program  O Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR UList separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  O Provider to Program  O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) O Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM O Total Medicare program liability (see instructions)  O Contractor Number (Mo/Day/Yr) O 1.00 O 2.00  O 1.00 O 2.00 O 0 O 0 O 0 O 0 O 0 O 0 O 0 O 0 O 0   | Program to Provider                                  |                |                           |            |                                       |    |
| Provider to Program  O  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) O  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969 27) TO BE COMPLETED BY CONTRACTOR O  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider  O  Provider to Program  O  Provider to Program  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) O  Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER  SETTLEMENT TO PROVIGEM  O  Total Medicare program liability (see instructions)  Contractor Number ((lio/Day/Yr) None  O  1.00 2.00  O  3.00  O  3.00  O  3.00  O  3.00  O  4.00  O  4.00  O  5.00  O  6.00  O  7.00  O  7. | 1  |                |                           |            | 0                                     | 3. |
| Provider to Program  | 2  |                |                           |            | 0                                     | 3. |
| Provider to Program  | 3  |                |                           |            | 0                                     | 3. |
| Provider to Program  On 1  | 4  |                |                           |            | 0                                     | 3. |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   | 5  |                |                           |            | o                                     | 3. |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27,969 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O Provider to Program  O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  O NPR Date (Mo/Day/Yr)  O 1.00  O 2.00   | Provider to Program                                  |                |                           |            |                                       |    |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   | 0  |                |                           |            | 0                                     | 3  |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27,969 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O Provider to Program  O O O O O O O O O O O O O O O O O O O  | 1  |                |                           |            | 0                                     | 3  |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969 27)  To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)  O SUBSTITUTE OF CONTRACTOR  Contractor Number Numbe | 2  |                |                           |            | 0                                     | 3  |
| Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27, 969 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM O Total Medicare program liability (see instructions)  O  Contractor Number (Mo/Day/Yr) A Date (Mo/Day/Yr) O  1.00 2.00  | 3  |                |                           |            | o                                     | 3  |
| Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27,969 27)  To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  O  NPR Date (Mo/Day/Yr)  O  1.00  2.00  | 4  |                |                           |            | o                                     | 3  |
| 27) TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  1   | 9 Subtotal (sum of lines 3.01-3.49 minus sum of li   | ines 3.50-3.98 | 3)                        |            | 0                                     | 3  |
| TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O  Provider to Program  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  Contractor Number  Number  (Mo/Day/Yr)  0  1.00  2.00   | O Total interim payments (sum of lines 1, 2, and 3   | 3.99) (transfe | er to Worksheet M-3, line | 9          | 27, 969                               | 4  |
| List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O Provider to Program  O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) Number (Mo/Day/Yr)  O 1.00  Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr)   | 27)  | , ,            |                           |            |                                       |    |
| each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O Provider to Program  O Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr)  O 1.00 2.00  | TO BE COMPLETED BY CONTRACTOR                        |                |                           |            |                                       |    |
| Program to Provider    Provider to Program   |  |                | review. Also show date o  | of         |                                       | 5. |
| 1  | each payment. If none, write "NONE" or enter a z     | zero. (1)      |                           |            |                                       |    |
| Provider to Program  | Program to Provider                                  |                |                           |            |                                       |    |
| Provider to Program  | 1  |                |                           |            | 0                                     | 5. |
| Provider to Program  | 2  |                |                           |            | 0                                     | 5  |
| 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0  | 3  |                |                           |            | 0                                     | 5  |
| 1  | Provider to Program                                  |                |                           |            |                                       |    |
| 2  | 0  |                |                           |            | · · · · · · · · · · · · · · · · · · · | 5. |
| 9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 Determined net settlement amount (balance due) based on the cost report. (1) 1 SETTLEMENT TO PROVIDER 2 SETTLEMENT TO PROGRAM 0 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00  |  |                |                           |            |                                       | 5  |
| Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00   |  |                |                           |            | · · · · · · · · · · · · · · · · · · · | 5  |
| 1 SETTLEMENT TO PROVIDER 2 SETTLEMENT TO PROGRAM 37, 131 2 O Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00  |  |                |                           |            | 0                                     | 5  |
| 2 SETTLEMENT TO PROGRAM 0 Total Medicare program liability (see instructions)  |  |                |                           |            |                                       | 6  |
| 0 Total Medicare program liability (see instructions)         65,100           Contractor Number (Mo/Day/Yr)         0           0         1.00           2.00   |  |                |                           |            |                                       | 6  |
| Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00   |  |                |                           |            | - 1                                   | 6  |
| Number         (Mo/Day/Yr)           0         1.00         2.00   | O Total Medicare program liability (see instruction  | ons)           |                           |            |                                       | 7  |
| 0 1.00 2.00  |  |                |                           | Contractor |                                       |    |
|  |  |                |                           |            |                                       |    |
| 0  Name of Contractor  |  |                | 0                         | 1. 00      | 2. 00                                 |    |
|  | O Name of Contractor                                 |                |                           |            |                                       | 8. |

| Health Financial Systems                  | WOODLAWN HOS | PITAL                  | In Lieu                     | u of Form CMS-2552-10 |
|---|--------------|------------------------|-----------------------------|-----------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH |              | Provi der CCN: 15-1313 | Peri od:<br>From 01/01/2020 | Worksheet M-5         |
| SERVICES RENDERED TO FROGRAM DENETICIARIE | .3           | Component CCN: 15-8547 |                             |                       |
|   |              |                        | RHC V                       | Cost                  |

|      |  | Component CCN: 15-8547      | 10 12/31/2020 | 7/29/2021 4: 15 |      |
|------|--|-----------------------------|---------------|-----------------|------|
|      |  |                             | RHC V         | Cost            |      |
|      |  |                             | Par           | t B             |      |
|      |  |                             | mm/dd/yyyy    | Amount          |      |
|      |  |                             | 1. 00         | 2. 00           |      |
| . 00 | Total interim payments paid to hospital-based RHC/FQHC   |                             |               | 51, 771         | 1. C |
| . 00 |  |                             |               | 0               | 2.0  |
| 00   | List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)  Program to Provider |                             |               |                 | 3. ( |
| 01   | 1 rogram to 11 ovider  |                             |               | 0               | 3. ( |
| 02   |  |                             |               | 0               | 3. ( |
| 03   |  |                             |               | 0               | 3.   |
| 04   |  |                             |               | 0               | 3.   |
| 05   |  |                             |               | 0               | 3.   |
| US   | Dravi dan ta Dragnam   |                             |               | U               | 3.   |
| 50   | Provider to Program  |                             |               | 0               | 3.   |
| 51   |  |                             |               | 0               | 3.   |
|      |  |                             |               |                 |      |
| 52   |  |                             |               | 0               | 3.   |
| 53   |  |                             |               | 0               | 3.   |
| 54   |  | 00)                         |               | 0               | 3.   |
| 99   | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.  |                             |               | 0               | 3.   |
| 00   | Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)  | ster to Worksheet M-3, line | 9             | 51, 771         | 4.   |
|      | TO BE COMPLETED BY CONTRACTOR  |                             |               |                 |      |
| 00   | List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)  | sk review. Also show date o | of            |                 | 5.   |
|      | Program to Provider  |                             |               |                 |      |
| 01   |  |                             |               | 0               | 5.   |
| 02   |  |                             |               | 0               | 5.   |
| 03   |  |                             |               | 0               | 5.   |
|      | Provider to Program  |                             |               |                 |      |
| 50   |  |                             |               | 0               | 5.   |
| 51   |  |                             |               | 0               | 5.   |
| 52   |  |                             |               | 0               | 5.   |
| 99   | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   |                             |               | 0               | 5.   |
| 00   | Determined net settlement amount (balance due) based on the cost report. (1)   |                             |               |                 | 6.   |
| 01   | SETTLEMENT TO PROVIDER   |                             |               | 53, 980         | 6.   |
| 02   | SETTLEMENT TO PROGRAM  |                             |               | 0               | 6.   |
| 00   | Total Medicare program liability (see instructions)  |                             |               | 105, 751        | 7.   |
|      |  |                             | Contractor    | NPR Date        |      |
|      |  |                             | Number        | (Mo/Day/Yr)     |      |
|      |  |                             |               |                 |      |
|      |  | 0                           | 1.00          | 2.00            |      |

| Health Financial Systems   | WOODLAWN HOS | PITAL                  | In Lieu                     | ı of Form CMS-2552-10                 |
|--|--------------|------------------------|-----------------------------|---------------------------------------|
| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHOSERVICES RENDERED TO PROGRAM BENEFICIARIES |              | Provider CCN: 15-1313  | Peri od:<br>From 01/01/2020 | Worksheet M-5                         |
|  |              | Component CCN: 15-8548 |                             | Date/Time Prepared: 7/29/2021 4:15 pm |
|  |              |                        | RHC VI                      | Cost                                  |

|    |   | Component CCN: 15-8548     | To 12/31/2020 | Date/Time Prep<br>7/29/2021 4:15 |    |
|----|---|----------------------------|---------------|----------------------------------|----|
|    |   |                            | RHC VI        | Cost                             |    |
|    |   |                            | Par           | rt B                             |    |
|    |   |                            | mm/dd/yyyy    | Amount                           |    |
|    |   |                            | 1.00          | 2. 00                            |    |
| 00 | Total interim payments paid to hospital-based RHC/FQHC      |                            |               | 147, 025                         | 1. |
| 00 | Interim payments payable on individual bills, either submit | ted or to be submitted to  |               | 0                                | 2. |
|    | the contractor for services rendered in the cost reporting  | period. If none, write     |               |                                  |    |
|    | "NONE" or enter a zero                                      |                            |               |                                  |    |
| 00 | List separately each retroactive lump sum adjustment amount | based on subsequent        |               |                                  | 3. |
|    | 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   |                            | ·             |                                  |    |
| 01 |   |                            |               | 0                                | 3  |
| 02 |   |                            |               | 0                                | 3  |
| 03 |   |                            |               | 0                                | 3  |
| 04 |   |                            |               | l ol                             | 3  |
| 05 |   |                            |               | ol                               | 3  |
|    | Provider to Program   |                            |               |                                  |    |
| 50 |   |                            |               | 0                                | 3  |
| 51 |   |                            |               | 0                                | 3  |
| 52 |   |                            |               | 0                                | 3  |
| 53 |   |                            |               | 0                                | 3  |
| 54 |   |                            |               | 0                                | 3  |
| 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3. | 98)                        |               | 0                                | 3  |
| 00 | Total interim payments (sum of lines 1, 2, and 3.99) (trans | fer to Worksheet M-3, line | e             | 147, 025                         | 4  |
|    | 27)   |                            |               |                                  |    |
|    | TO BE COMPLETED BY CONTRACTOR                               |                            |               |                                  |    |
| 00 | List separately each tentative settlement payment after des | k review. Also show date   | of            |                                  | 5  |
|    | each payment. If none, write "NONE" or enter a zero. (1)    |                            |               |                                  |    |
|    | Program to Provider   |                            |               |                                  |    |
| 01 |   |                            |               | 0                                | 5  |
| )2 |   |                            |               | 0                                | 5  |
| )3 |   |                            |               | 0                                | 5  |
|    | Provider to Program   |                            |               |                                  | _  |
| 50 |   |                            |               | 0                                | 5  |
| 51 |   |                            |               | 0                                | 5  |
| 52 |   | 00)                        |               | 0                                | 5  |
| 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5. |                            |               | 0                                | 5  |
| 00 | Determined net settlement amount (balance due) based on the | e cost report. (1)         |               |                                  | 6  |
| 01 | SETTLEMENT TO PROVIDER                                      |                            |               | 104, 573                         | 6  |
| 02 | SETTLEMENT TO PROGRAM                                       |                            |               | 0                                | 6  |
| 00 | Total Medicare program liability (see instructions)         |                            |               | 251, 598                         | 7  |
|    |   |                            | Contractor    | NPR Date                         |    |
|    |   |                            | Number        | (Mo/Day/Yr)                      |    |
|    |   | 0                          | 1.00          | 2. 00                            |    |
| 00 | Name of Contractor  |                            |               |                                  | 8  |