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 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 11:35 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2022 Time: 11:35 am] 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. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(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 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 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Carı	rie Bowers	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Carri e Bowers			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	<u> </u>	1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	59, 728	-734, 771	0	13, 472	1.00
2.00	Subprovi der – IPF	0	0	0		0	2.00
3.00	Subprovi der – I RF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	10, 949	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		75, 938		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		39, 490		0	10. 01
10. 02	RURAL HEALTH CLINIC III	0		134, 961		0	10. 02
10. 03	RURAL HEALTH CLINIC IV	0		27, 003		0	10. 03
10.04	RURAL HEALTH CLINIC V	0		59, 001		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		116, 645		0	10. 05
200.00	Total	0	70, 677	-281, 733	0	13, 472	200.00
The ab	ove amounts represent "due to" or "due from"	the annlicable	program for t	he element of	the above comp	ex indicated	•

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 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 11:35 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1400 EAST 9TH STREET 1.00 PO Box: 1.00 2.00 City: ROCHESTER State: IN Zip Code: 46975 County: FULTON 2.00 Component Name Payment System (P, CCN CBSA Provi der Date 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 Swing Beds - SNF 7 00 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 Hospi tal -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 0 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 Ν 0 0 15.03 CENTER - DUNN ١V 158547 99915 15.04 Hospital-Based Health Clinic - RHC WAKRON MEDICAL CLINIC 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) 01/01/2021 12/31/2021 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 N 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 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

22.04 Did this hospital receive a geographic reclassification from urban to N Ν Ν 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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.

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 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 11: 35 am 1. 00 2.00 3.00 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. Ν 58.00 Pt. I 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2 IME Direct GME IME Direct GME 1.00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	WOO	DLAWN HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 01/01/2021	Worksheet S-2 Part I Date/Time Pre 5/26/2022 11:	pared:
		, , , , , , , , , , , , , , , , , , ,	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	33 am
Section 5504 of the ACA Base Yea	ur FTF Pasidants in N	onnrovider Settings-	1.00	2.00	3.00	
period that begins on or after			Till 3 base year	13 your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)	ber of unweighted nor etations occurring in e number of unweighted our hospital. Enter in	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
(5.00 5.1 1.0	1. 00	2. 00	3.00	4. 00	5. 00	45.00
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col.	65. 00
			FTEs	FTEsin	1/ (col. 1 +	
			Nonprovi der Si te	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 66.00 Enter in column 1 the number of		ry caro rosidont	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 +	ccurring in all nonpounce unweighted non-priman al. Enter in column (rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 00000	00.00
	Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
			Nonprovider Site	Hospi tal	col. 4))	
	1. 00	2. 00	3.00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00			67.00

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 11:35 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 N 75 00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 $\S413.40(f)(1)(ii)$? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 N yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 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. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ 98.00 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. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 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. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 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 98.04 N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ Υ 98.06 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. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems WOODLAWN HO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-1313 Pe	IN LIE	eu of Form CMS- Worksheet S-2	
THOSE THE THOSE THE HEALTH SAIRE SOME ELA TELEVITION ON ENTIRE	Trovider of		om 01/01/2021	Part I	
				5/26/2022 11:	
			V 1. 00	XI X 2. 00	-
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2. 00	3. 00	4. 00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	1
110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	Y" for yes or	"N" for no. I	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 Jumn 1 is Y, ticipating ir	period? Enter enter the 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 ceal participation in the demonstration, if applicable.	peri od? : "Y", enter :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		1 ,	_ 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) 3" percent includes				0110.00
116.00 is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116. 00
117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	Y			117. 00
"Y" for yes or "N" for no. 118.00 Is 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	
		1.00	2. 00	3.00	1
118.01 List amounts of malpractice premiums and paid losses:		295, 323	(0	0 118. 01
			1.00	2. 00	
118. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119. 00 D0 NOT USE THIS LINE			N		118. 02
				N	120.00
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	column 1, "\ alifies for t	/" for yes or the Outpatient	N		
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	column 1, "\ alifies for t ts? (see inst	(" for yes or the Outpatient tructions)	N Y		121. 00
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.	column 1, "\ alifies for t ts? (see inst ntable device ined in §1903	f" for yes or the Outpatient tructions) es charged to 3(w)(3) of the			
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	column 1, "Y lalifies for t lts? (see inst lintable device lined in §1903 is "Y", ente	(" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	Y		122. 00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CO	CN: 15-1313			u of Form CMS Worksheet S- Part I Date/Time Pr	2
					12/31/2021	5/26/2022 11	: 35 ar
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30.00 If this is a Medicare certified pa			ti fi cati on				130. (
date in column 1 and termination d 31.00 f this is a Medicare certified in			erti fi cati o	n			131. (
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32.00 f this is a Medicare certified is in column 1 and termination date,			ication date	е			132.
33.00 Removed and reserved	eganization (ODO) anton	the ODO number	in column 1				133.
34.00 If this is an organ procurement or and termination date, if applicabl		the OPO number	TH COLUMN I				134.
All Providers 40.00 Are there any related organization	or home office costs a	s defined in CMS	Dub 15_1		N		140.
chapter 10? Enter "Y" for yes or "	N" for no in column 1.	If yes, and home	office cos	ts	IN .		140.
are claimed, enter in column 2 the		er. (see instruc .00	ctions)		3. 00		
If this facility is part of a chai	n organization, enter c	on lines 141 thro	ough 143 the	name a		of the home	
office and enter the home office of 41.00Name:	contractor name and cont Contractor's Name:	ractor number.	Contrac	tor's N	ımher:		141.
42. 00 Street:	PO Box:		Contrac	101 3 N	umber.		142.0
43. 00 Ci ty:	State:		Zi p Cod	e:			143. (
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44.00 Are provider based physicians' cos	sts included in Workshee	t A?				Υ	144. (
					1. 00	2. 00	
45.00 If costs for renal services are cl inpatient services only? Enter "Y"							145.
no, does the dialysis facility inc	clude Medicare utilizati						
period? Enter "Y" for yes or "N"		developed	+		N		1 4 4
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in				lf	N		146.
yes, enter the approval date (mm/d	ld/yyyy) in column 2.	•					
						1. 00	+
						N	
48.00 Was there a change in the order of	allocation? Enter "Y"	for yes or "N" f	or no.	or no.			147. (148. (149. (
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Health Financial Systems	Health Financial Systems WOODLAWN HOSPITAL			u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1313 Per				
			From 01/01/2021 To 12/31/2021		norod.
			10 12/31/2021	Date/Time Pre 5/26/2022 11:	35 am
			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 provide			N	0	171. 00
section 1876 Medicare cost plans rep					
"Y" for yes and "N" for no in column		enter the number of section	on		
1876 Medicare days in column 2. (see	e instructions)				

	Financial Systems WOODLAWN H AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	^N: 15_1313	Peri od:	worksheet S-	
/3111	AL AND HOST THE HEALTH CARE RETWOORDENENT QUESTIONNALIRE	Trovider of	ON. 13-1313	From 01/01/2021 To 12/31/2021	Part II	epared:
				Y/N	Date	. 55 am
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter Mmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ent	er all dates in	the	
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	o boginning of	the cost	N	I	1.00
00	reporting period? If yes, enter the date of the change in					1.00
	reporting period. It yes, onter the date of the change in	00. 4	Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare lyes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2.00
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proving officers, medical staff, management personnel, or members of directors through ownership, control, or family and other lationships? (see instructions)	offices, drug der or its of the board	N			3.00
	Toratronom por (eee rinetraetrono)		Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports				1	
00	Column 1: Were the financial statements prepared by a Cer-Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffi	for Compiled, ailable in	Y	A		4. 00 5. 00
00	those on the filed financial statements? If yes, submit re		.,			0.00
				Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, i:	s the provide	er N		6.00
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	ne N		7. 00 8. 00
00	Are costs claimed for Interns and Residents in an approved		cal education	N N		9. 00
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11.00
					Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s see Instruc	tions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N N	13. 00
	If line 12 is yes, were patient deductibles and/or co-paymed Complement		-		N	14.00
. 00	Did total beds available change from the prior cost report		yes, see ins t A		<u>N</u> ^t B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
00	PS&R Data Was the cost report prepared using the PS&R Report only?	Y	01/20/2022	Y	01/29/2022	16.00
JU	as the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	T	01/28/2022	ī	01/28/2022	10.00
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. 00
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
. 00		N		N		19. 00

		Provi der CCN: 15-1313		Date/Time F 5/26/2022 1		
		Descr			Y/N	
	<u> </u>		0	1. 00	3. 00	
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
	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 (EXCE	EDT CHILDDENS	HOSDI TAI S)		1.00	
	Capital Related Cost	LI I CIII EDICENS	11031 1 TALS)			
	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00
	Have changes occurred in the Medicare depreciation expense			ring the cost	l N	23. 00
	reporting period? If yes, see instructions.	duc to apprai	3ar 3 made da	iring the cost	"	25.00
24. 00 N	Were new leases and/or amendments to existing leases enter	ed into durino	g this cost r	eporting period?	N	24. 00
- 1	If yes, see instructions					
	Have there been new capitalized leases entered into during	tne cost repo	orting period	₹11 yes, see	N	25. 00
- 1	instructions.			1.6		0, 00
	Were assets subject to Sec.2314 of DEFRA acquired during thinstructions.	ne cost repor	ting period?	ri yes, see	N	26. 00
- 1	Has the provider's capitalization policy changed during the	a cost ranorti	ing period2 L	f vas submit	N	27. 00
	copy.	e cost reporti	ing period: i	i yes, subili t		27.00
	Interest Expense					
	Were new Loans, mortgage agreements or Letters of credit er	ntered into du	uring the cos	t reporting	Υ	28.00
	period? If yes, see instructions.					
	Did the provider have a funded depreciation account and/or	bond funds (I	Debt Service	Reserve Fund)	N	29. 00
	treated as a funded depreciation account? If yes, see inst	ructions .		·		
	Has existing debt been replaced prior to its scheduled matu		w debt? If ye	s, see	N	30.00
	i nstructi ons.					
	Has debt been recalled before scheduled maturity without is	ssuance of nev	w debt? If ye	s, see	N	31.00
	instructions.					
	Purchased Services	6				
	Have changes or new agreements occurred in patient care ser		nea through c	ontractual	N	32.00
	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		ing to compot	itivo bidding? If	N	33.00
	no, see instructions.	prieu pertarni	ing to compet	itive bruding: i	in in	33.00
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an a	rrangement wi	th provider-h	ased physicians?	Υ	34.00
	If yes, see instructions.	r ungemerre wi	in provider b	asca physicians.		01.00
	If line 34 is yes, were there new agreements or amended exi	isting agreeme	ents with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see in					
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been pr	repared by the	e home office	?		37.00
	If yes, see instructions.	e:: - CC		_	i	20.00
	If line 36 is yes, was the fiscal year end of the home of			Γ		38.00
	the provider? If yes, enter in column 2 the fiscal year end					39.00
	If line 36 is yes, did the provider render services to othe see instructions.	ы спаги сошро	ments: 11 ye	ي د		39.00
- 1	If line 36 is yes, did the provider render services to the	home office?	If ves see			40.00
	instructions.	311106:	. 1 303, 366			1.0.00
	1.00 2.					
	Cost Report Preparer Contact Information					
	Enter the first name, last name and the title/position	KYLE		SMI TH		41.00
11.00 I				1		
11. 00 [I	held by the cost report preparer in columns 1, 2, and 3,					
11.00 [I	held by the cost report preparer in columns 1, 2, and 3, respectively.	DILLE 0 00 ···	0			40.05
11. 00 I - - - 	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	BLUE & CO. LL	С			42. 00
11.00 [1 	held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	BLUE & CO. LL 317-713-7957	С	KCSMI TH@BLUEAN	DC0 C0M	42.00

Heal th	Financial Systems WOODLAW	N HOSPI TAL	In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1313	Peri od: From 01/01/2021 To 12/31/2021		pared:
		3, 00			
	Cost Report Preparer Contact Information				
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	DI RECTOR			41.00
42 00	respectively. Enter the employer/company name of the cost report				42.00
42.00	preparer.				42.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43. 00

Health Financial Systems W00
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time | Prepared: | Provider CCN: 15-1313

				Т	o 12/31/2021	Date/Time Pre 5/26/2022 11:	
						1/P Days /	33 alli
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number	5000	Avai I abl e	07117 11041 0		
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	21	7, 665	58, 440. 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 IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7. 00	Total Adults and Peds. (exclude observation		21	7, 665	58, 440. 00	0	7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31. 00	4	1, 460	9, 096. 00	0	8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00					12.00
13.00	NURSERY	43. 00	0.5	0.405	(7.50/.00	0	13.00
14.00	Total (see instructions)		25	9, 125	67, 536. 00		14.00
15.00	CAH visits					0	15.00
16. 00 17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF						16. 00 17. 00
18.00	SUBPROVI DER - TRF						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)	30.00					24. 10
25. 00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01				0	26. 01
26.02	RURAL HEALTH CLINIC III	88. 02				0	26. 02
26.03	RURAL HEALTH CLINIC IV	88. 03				0	26. 03
26.04	RURAL HEALTH CLINIC V	88. 04				0	26. 04
26.05	RURAL HEALTH CLINIC VI	88. 05				0	26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		25				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	C	1		32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01
JJ. UI	LIGHT SITE HEUTHAL MAYS AND UISCHALIGES	Ĭ	I	I	1	I	33.01

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

				'	0 12/31/2021	5/26/2022 11:	
		I/P Davs	/ O/P Visits	/ Trips	Full Time	Equi val ents	00 4
		.,, -=-,-					
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9, 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		46				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)	552	244				2.00
3.00	HMO IPF Subprovider	o	0				3.00
4.00	HMO IRF Subprovider	o	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	92	0	92			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	33			6.00
7.00	Total Adults and Peds. (exclude observation	907	46	2, 454			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	120	0	379			8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	311			13.00
14.00	Total (see instructions)	1, 027	46	3, 144	0.00	280. 31	14.00
15.00	CAH vi si ts	o	0	0			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	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	RURAL HEALTH CLINIC	1, 599	726	6, 449	0.00	5. 62	26.00
26. 01	RURAL HEALTH CLINIC II	585	3, 628	15, 799	0.00	22. 69	26. 01
26. 02	RURAL HEALTH CLINIC III	1, 806	2, 299	12, 729	0. 00	14. 48	26. 02
26. 03	RURAL HEALTH CLINIC IV	670	570	3, 120	0. 00	0. 86	26. 03
26.04	RURAL HEALTH CLINIC V	696	595	4, 398	0. 00	5. 81	26. 04
26.05	RURAL HEALTH CLINIC VI	2, 136	2, 609	15, 759	0. 00	15. 22	26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0. 00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0. 00	344. 99	27.00
28.00	Observation Bed Days		104	783			28. 00
29.00	Ambul ance Trips	o					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	22	106			32.00
32.01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	o					33. 01

Provider CCN: 15-1313

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/26/2022	11:35 am

						5/26/2022 11:	35 am
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	229	14	784	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)			129	92		2. 00
3. 00	HMO IPF Subprovi der			127	0		3. 00
4. 00	HMO IRF Subprovider				ol		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				آ		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00 13. 00
14. 00	NURSERY Total (see instructions)	0.00	0	229	14	784	14.00
15. 00	CAH visits	0.00	U	229	14	704	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 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24. 10 25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 03	RURAL HEALTH CLINIC IV	0.00					26.03
26. 04	RURAL HEALTH CLINIC V	0.00					26.04
26.05	RURAL HEALTH CLINIC VI	0.00					26.05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF						31. 00 32. 00
32. 00	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32.00
32. UI	outpatient days (see instructions)						JZ. U I
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
					'		

	Financial Systems	WOODLAWN I				eu of Form CMS		552-10
HOSPI 1	AL-BASED RHC/FQHC STATISTICAL DATA			CCN: 15-1313 CCN: 15-8551	Period: From 01/01/2021 To 12/31/2021			pared:
						5/26/2022 1	1: 3	
					RHC I	Cost	t	
					1.	00	_	
4 00	Clinic Address and Identification				1 100 F OTH CTP) FFT		4 00
1. 00	Street		Ci	ty	1430 E 9TH STR State	ZIP Code	\dashv	1. 00
				00	2.00	3.00	_	
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 1.00	2. 00	_	
	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 7. 00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	O(d), PHS Act)						6. 00 7. 00
7. 00 8. 00	Look-Alikes							8.00
9. 00	OTHER (SPECIFY)							9. 00
10.00	Describes Control of the Control of		DUO - FOURO F		1.00	2. 00		10.00
10.00	Does this facility operate as other than a h yes 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	10.00
		Sun	day	M	onday	Tuesday		
		from	to	from	to	from	4	
	Facility hours of operations (1)	1. 00	2.00	3.00	4. 00	5. 00	-	
11. 00	CLINIC			08: 00	17: 00	08: 00		11.00
					4.00	2 00		
12. 00	Have you received an approval for an excepti	on to the prod	uctivity stand	lard?	1. 00 Y	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 col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	er 9, section umn 2 the	N			13.00
	Trumber 3 berow.			Provi	der name	CCN number		
					1. 00	2.00		
14. 00	RHC/FQHC name, CCN number	V//NI	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	VO (I I I	VIV	T-+-! \/: -: +	_	14.00
		Y/N 1. 00	V 2. 00	3. 00	XI X 4. 00	Total Visit	S	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in		2.00	3.00	4.00	3.00		15. 00
	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)		Col	intv				
				unty .00				
	City, State, ZIP Code, County		FULTON					2.00
2. 00		Tuesday	Wedn	esday	Thur	rsday		
2. 00		Tuesday	Wear					
2. 00		to	from	to	from	to	_	
2. 00	Facility hours of operations (1)			to 8.00	from 9.00	to 10.00		

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: 15-8551	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:		
				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	

Heal th	Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	eu of Form C	MS-2	552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CCN: 15-1313	Peri od:	Worksheet		
			Component	CCN: 15-8552	From 01/01/2021 To 12/31/2021			
					RHC II	Co:		35 aiii
					1	. 00		
1 00	Clinic Address and Identification				1 400 F OTH CT	DEET		1 00
1.00	Street		Ci	ty	1400 E 9TH STI State	ZIP Code		1.00
				00	2. 00	3.00		
2. 00	City, State, ZIP Code, County		ROCHESTER			N 46975		2. 00
	•							
	LUGORI TAL BAGER FOUG ONLY D. I	"5" 6				1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		nt Award	Doto	0	3.00
				Gra	nt Award 1.00	2. 00		
	Source of Federal Funds			1	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	ct)						5.00
6.00	Health Services for the Homeless (Section 34)	O(d), PHS Act)						6.00
7. 00	Appalachian Regional Commission							7.00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)							8. 00 9. 00
9.00	OTHER (SPECIFI)							9.00
					1. 00	2.00		
10.00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for			0	10.00
	yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o hours.)							
	Illoui S.)	Sun	iday	1 1	Mondav	Tuesday		
		from	to	from	to	from		
		1. 00	2.00	3.00	4. 00	5. 00		
	Facility hours of operations (1)		,					
11. 00	CLINIC			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 prod	uctivity stand	lard?	1.00 Y	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.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	er 9, section umn 2 the			0	13.00
	numbers below.			Prov	ider name	CCN numbe	r	
				11.01	1. 00	2.00		
14.00	RHC/FQHC name, CCN number							14.00
		Y/N	V	XVIII	XI X	Total Visi	ts	
15.00		1. 00	2. 00	3.00	4. 00	5. 00		45.00
15. 00	Have you provided all or substantially all							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)		Cou	lntv		1		
				unty .00				
2. 00	City, State, ZIP Code, County		FULTON	00				2.00
	,	Tuesday		esday	Thu	rsday		
		to	from	to	from	to		
		6. 00	7. 00	8. 00	9. 00	10.00		
	Facility hours of operations (1)		1	1	1-2	1.=		
11.00	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00		11.00

Health Financial Systems	WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8552	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
				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	Financial Systems	WOODLAWN	HOSPI TAL		In Lie	eu of Form CM	//S-2	552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1313	Peri od:	Worksheet		
			Component	CCN: 15-8550	From 01/01/2021 To 12/31/2021			
					RHC III	Cos		o am
					1.	. 00		
1 00	Clinic Address and Identification				700 MALN STREE	-т	_	1 00
1. 00	Street		Ci	ty	700 MAIN STREE State	ZIP Code		1. 00
				00	2. 00	3. 00		
2. 00	City, State, ZIP Code, County		ROCHESTER			46975		2. 00
	•							
	LUGGRITHI DAGER FOUR ONLY D. I. I. F. L.	"D" C				1. 00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for		n+ Award	Doto	0	3. 00
				Gra	nt Award 1.00	2. 00		
	Source of Federal Funds			1	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	ct)						5.00
6.00	Health Services for the Homeless (Section 34	O(d), PHS Act)						6.00
7.00	Appalachian Regional Commission							7.00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)							8. 00 9. 00
9.00	JUTHER (SPECIFT)							9.00
					1. 00	2. 00		
10.00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N		0	10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)							
	Tiour S.)	Sur	nday	I	londav	Tuesday		
		from	to	from	to	from		
		1. 00	2.00	3.00	4. 00	5. 00		
	Facility hours of operations (1)			_		,		
11. 00	CLINIC			08: 00	17: 00	08: 00		11. 00
					1. 00	2.00		
12. 00	Have you received an approval for an excepti	on to the prod	luctivity stand	ard?	1.00 Y	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 col number of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the			0	13. 00
	numbers below.			Prov	ider name	CCN numbe	r	
				1.00	1. 00	2.00		
14. 00	RHC/FQHC name, CCN number							14.00
		Y/N	V	XVIII	XI X	Total Visi	ts	
45.00	In the second of	1. 00	2. 00	3.00	4. 00	5. 00		45.00
15. 00	Have you provided all or substantially all							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)		Cou	l unty				
				00				
2. 00	City, State, ZIP Code, County		FULTON					2.00
		Tuesday		esday	Thui	rsday		
		to	from	to	from	to		
		6. 00	7. 00	8. 00	9. 00	10.00		
11 00	Facility hours of operations (1)	17.00	00.00	17.00	00.00	17.00	_	11 00
11.00	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	1	11.00

Health Financial Systems	WOODLAWN	HOSPI TAL		In Lieu of Form CMS-2552-1			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3	
		Component	CCN: 15-8550	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:		
				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	

	Financial Systems	WOODLAWN F				eu of Form CM		2552-10
HOSPI T	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CCN: 15-1313	Peri od: From 01/01/2021	Worksheet S	S-8	
			Component	CCN: 15-8549	To 12/31/2021			
					RHC IV	Cos		
						00		
	Clinic Address and Identification				1	. 00		
1. 00	Street				100 EAST DUN	N STREET		1.00
	15.0.50		Ci	ty	State	ZIP Code		
	Tax and a second			. 00	2.00	3.00		
2. 00	City, State, ZIP Code, County		FULTON			46931		2.00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur:	al or "U" for	urban		1.00	0	3.00
					it Award	Date		
	0.5.1.1.5.1				1. 00	2.00		
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Ac+)		T		T		4. 00
5. 00	Migrant Health Center (Section 329(d), PHS A							5. 00
6. 00	Health Services for the Homeless (Section 34							6. 00
7.00	Appalachian Regional Commission							7.00
8. 00	Look-Alikes							8.00
9. 00	OTHER (SPECIFY)							9.00
					1. 00	2.00		
10.00	Does this facility operate as other than a h	ospi tal -based 1	RHC or FQHC? E	nter "Y" for	N		0	10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)							
	Tiour 3.)	Sun	day	M	onday	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	Have you received an approval for an excepti	on to the produ	uctivity stand	lard?	Y			12.00
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.	umn 1. If yes,	enter in colu	ımn 2 the	N		0	13. 00
	numbers below.			Provi	der name	CCN number	_	
					1. 00	2.00		
14.00	RHC/FQHC name, CCN number							14.00
		Y/N	V	XVIII	XIX	Total Visit	ts	
15 00		1. 00	2. 00	3. 00	4. 00	5. 00		15 00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in							15. 00
	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)							
	(See Thati deti ons)		Cou	unty		·		
			4.	.00				
								2.00
2. 00	City, State, ZIP Code, County		FULTON					
2. 00	City, State, ZIP Code, County	Tuesday	Wedn	esday		rsday		
2.00	City, State, ZIP Code, County	Tuesday to	Wedn from	to	from	to		
2.00	City, State, ZIP Code, County Facility hours of operations (1)	Tuesday	Wedn					

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lieu of Form CMS-2552-1			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	}	
		Component		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:		
				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	

Health Financial Systems	WOODLAWN H	IOSPI TAL		In Lie	u of Form CMS	-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od: From 01/01/2021	Worksheet S-	-8
		Component	CCN: 15-8547	To 12/31/2021	Date/Time Pr 5/26/2022 11	
				RHC V	Cost	
				1.	00	_
Clinic Address and Identification						
1.00 Street		Ci	ty	105 SR 14 N State	ZIP Code	1.00
			00	2. 00	3. 00	
2.00 City, State, ZIP Code, County		AKRON		IN	46910	2. 00
					1. 00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for				0 3.00
			Gra	nt Award 1.00	2. 00	
Source of Federal Funds				1.00	2.00	
4.00 Community Health Center (Section 330(d), PHS						4.00
5.00 Migrant Health Center (Section 329(d), PHS A 6.00 Health Services for the Homeless (Section 34						5. 00 6. 00
7. 00 Appal achi an Regional Commission	o(u), This Act)					7.00
8. 00 Look-Alikes						8. 00
9. 00 OTHER (SPECIFY)						9.00
				1.00	2. 00	
10.00 Does this facility operate as other than a h						0 10.00
yes or "N" for no in column 1. If yes, indic 2.(Enter in subscripts of line 11 the type o						
hours.)	Sund	day	T	l Nonday	Tuesday	
	from	to	from	to	from	
[1.00	2. 00	3.00	4.00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	08: 00	11.00
12.00 Have you received an approval for an excepti	on to the produ	ictivity stand	ard?	1. 00 Y	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 col	ed in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the			0 13.00
number of providers included in this report. numbers below.	List the names	s of all provi	ders and			
			Prov	ider name	CCN number	
14.00 RHC/FQHC name, CCN number				1. 00	2. 00	14.00
14.00 RHC/FQHC Haille, CCN Hulliber	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						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)						
			unty			
		4. FULTON	00			2.00
2 00 City State 7LP Code County						1 2.00
2.00 City, State, ZIP Code, County	Tuesday	Wedn	esday	Thur	sday	
2.00 City, State, ZIP Code, County	Tuesday to	from	to	from	to	
2.00 City, State, ZIP Code, County Facility hours of operations (1)	Tuesday					

Health Financial Systems	WOODLAWN	HOSPI TAL		In Lieu of Form CMS-2552-1			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3	
		Component	CCN: 15-8547	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:		
				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	

Health Financial Systems	WOODLAWN F	HOSPI TAL		In Li∈	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8548	From 01/01/2021 To 12/31/2021		
				RHC VI	Cost	33 diii
				1.	00	
Clinic Address and Identification 1.00 Street				530 N MI CHI GAN	I STDEET	1.00
1.00 311 ee t		Ci	ty	State	ZIP Code	1.00
			00	2. 00	3. 00	
2.00 City, State, ZIP Code, County		ARGOS		1 N	46501	2.00
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urban		1.00	3.00
3.00 HOSPITAL-BASED FUNCS ONLY: DESIGNATION - EITE	er k for fura	al or u ror		nt Award	Date	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 7.00 Appalachian Regional Commission	U(d), PHS ACT)					6. 00 7. 00
8.00 Look-Alikes			•			8.00
9. 00 OTHER (SPECIFY)						9.00
			•			
				1.00	2. 00	
10.00 Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operatio	ns in column	N	0	10.00
(Hour S.)	Sun	day	M	onday	Tuesday	
	from	to	from	to	from	
	1. 00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	17: 00	08: 00	11.00
TI. OU CEINIC			06.00	17.00	06.00	11.00
				1. 00	2.00	
12.00 Have you received an approval for an excepti	on to the produ	uctivity stand	ard?	Y		12.00
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.	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.00
numbers below.		·				
				der name	CCN number 2.00	
14.00 RHC/FQHC name, CCN number				1. 00	2.00	14.00
THE THIRD TAINE, CONTINUED	Y/N	V	XVIII	XIX	Total Visits	1 1. 00
	1. 00	2.00	3.00	4.00	5. 00	
15.00 Have you provided all or substantially all						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)		Col	l inty			
			00			
2.00 City, State, ZIP Code, County		MARSHALL				2.00
	Tuesday		esday	Thur	rsday	
	to	from	to	from	to	
Facility bours of secretical (1)	6. 00	7. 00	8.00	9. 00	10.00	
Facility hours of operations (1) 11.00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
55 55 11 5	00	100.00	1	130. 00	1	1

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lieu of Form CMS-2552-1				
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der	CCN: 15-1313	Peri od:	Worksheet S-8	3		
				From 01/01/2021				
		Component	CCN: 15-8548	To 12/31/2021	Date/Time Pre			
					5/26/2022 11:	35 am		
				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		

Heal th	Financial Systems WOODLAWN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-1313	Peri od:	Worksheet S-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 Medicaid (see instructions for each line)	divided by li	ne 202 colum	n 8)	0. 345039	1.00
2.00	Net revenue from Medicaid				1, 391, 730	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplem	ai d?	Y	4.00		
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges	rrom wedicai	a		0 24, 045, 132	5. 00 6. 00
7. 00	Medicaid cost (line 1 times line 6)				8, 296, 508	
8. 00	Difference between net revenue and costs for Medicaid progra	m (line 7 min	nus sum of li	nes 2 and 5; if	6, 904, 778	1
	< zero then enter zero)					
9. 00	Children's Health Insurance Program (CHIP) (see instructions Net revenue from stand-alone CHIP	for each lir	ne)		0	9.00
10. 00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHI	P (line 11 mi	nus line 9;	if < zero then	0	12.00
	enter zero) Other state or local government indigent care program (see i	nstructions 1	for each line)		
13.00	Net revenue from state or local indigent care program (Not i				0	13.00
14.00	Charges for patients covered under state or local indigent c	are program	(Not included	lin lines 6 or	0	14.00
15 00	10)	14)			0	15.00
15. 00 16. 00	State or local indigent care program cost (line 1 times line Difference between net revenue and costs for state or local		e program (Li	ne 15 minus line		16.00
.0.00	13; if < zero then enter zero)					10.00
	Grants, donations and total unreimbursed cost for Medicaid, instructions for each line)	CHIP and stat	te/local indi	gent care progra	ams (see	
17. 00	Private grants, donations, or endowment income restricted to				0	17. 00
18.00	Government grants, appropriations or transfers for support o			(0	18.00
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and Io 8, 12 and 16)	ical indigent	care program	ns (sum of lines	6, 904, 778	19. 00
	1		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1. 00	2. 00	3. 00	
20. 00		facility	1, 013, 18	36 0	1, 013, 186	20.00
21. 00	Cost of patients approved for charity care and uninsured dis	counts (see	349, 58	39 0	349, 589	21.00
22. 00	instructions) Payments received from patients for amounts previously writt	en off as		0 0	0	22.00
23 00	charity care Cost of charity care (line 21 minus line 22)		349, 58	39 0	349, 589	23 00
20.00	Today of Grant Grant Committee Tring 227		31773	5,		20.00
24.00	Dear the amount on live 20 religion 2 include themse for not			-£ -4	1.00	24.00
	Does the amount on line 20 column 2, include charges for pat imposed on patients covered by Medicaid or other indigent ca	re program?		•	N	24.00
∠5. 00	If line 24 is yes, enter the charges for patient days beyond stay limit	i the indigen	care progra	ını s rength or	0	25.00
	Total bad debt expense for the entire hospital complex (see instructions)					
	Medicare reimbursable bad debts for the entire hospital complex (see instructions) 240,872					
27. 01 28. 00	Medicare allowable bad debts for the entire hospital complex Non-Medicare bad debt expense (see instructions)	(See Instru	LI UIIS)		370, 571 3, 221, 462	
29. 00	1 , , , , , , , , , , , , , , , , , , ,	expense (see	instructions	5)	1, 241, 229	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 590, 818	30.00
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			8, 495, 596	31.00

COST CENTER DESCRIPTION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider COX: 15-1310 Period (7017/2020) Total (7	Health Financial Systems	WOODLAWN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST CENTER DESCRIPTION Salaries	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 15-1313 F	Peri od:	Worksheet A	
COST CENTER DESCRIPTION Salaries				<u>F</u>	rom 01/01/2021	D . I . /T' D	
COST CENTED PROPERTY COST CENTERS 1.00 2.00 3.00 4.00 COST CENTERS 1.00 COST CENTERS 1.00 2.00 3.00 4.00 COST CENTERS 1.00 COST CENTERS 1.00 COST CENTERS 2.463, 932 2.463, 932 -133, 960 2.227, 952 1.00 COST CENTERS 1.00 COST CENTERS 2.463, 932 2.463, 932 -133, 960 2.227, 952 1.00 COST CENTERS 1.00 COST CE					0 12/31/2021		
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RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-1313 Peri

Peri od: Worksheet A From 01/01/2021 To 12/31/2021 Date/Time Prepared:

5/26/2022 11:35 am Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6. 00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT -9, 833 2, 320, 119 1.00 00102 AKRON BUILDING 1.02 0 48, 591 1.02 00103 ARGOS BUILDING 109, 610 1 03 0 1.03 1.04 00101 CLAYS BUILDING 0 161, 589 1.04 4, 076, 161 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL -2.466.939 7, 234, 509 5.00 7.00 00700 OPERATION OF PLANT 2, 698, 008 0 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 168, 928 8.00 9 00 00900 HOUSEKEEPI NG 0 553, 737 9 00 01000 DI ETARY -17, 788 10.00 271.498 10.00 01100 CAFETERI A 11.00 -111, 354 361, 239 11.00 13.00 01300 NURSING ADMINISTRATION 586, 685 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 -3, 377 15.00 01500 PHARMACY 4, 562, 844 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY -19, 606 1, 299, 116 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 2.754.684 30.00 0 03100 INTENSIVE CARE UNIT 31.00 0 815, 546 31 00 04300 NURSERY 43.00 0 604, 763 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 2, 953, 328 50.00 0 50.00 05100 RECOVERY ROOM 51.00 0 671, 694 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 173, 915 52.00 05300 ANESTHESI OLOGY 53.00 -854, 667 60, 786 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 -194, 324 2, 875, 354 54 00 60.00 06000 LABORATORY 3,024,225 60.00 06500 RESPIRATORY THERAPY 1, 410, 402 65.00 -100, 396 65.00 66.00 06600 PHYSI CAL THERAPY 792.829 66.00 -844 06700 OCCUPATI ONAL THERAPY 67.00 -48, 279 225, 745 67.00 68.00 06800 SPEECH PATHOLOGY 127, 368 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 828, 532 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 -252, 506 1, 271, 315 88.00 88 01 08801 RURAL HEALTH CLINIC II 3, 691, 133 88 01 -179, 265 -18, 431 88.02 08802 RURAL HEALTH CLINIC III 2, 443, 081 88.02 374, 637 08803 RURAL HEALTH CLINIC IV 88.03 88.03 88 04 08804 RURAL HEALTH CLINIC V -5. 245 772, 463 88.04 08805 RURAL HEALTH CLINIC VI 88.05 -21, 597 2, 147, 212 88.05 09100 EMERGENCY -1, 860, 172 2, 292, 252 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 WOODLAWN MEDICAL PROFESSIONALS -1 049 889 93 00 161, 599 93 00 93.01 04951 SHAFER MEDICAL CENTER -2, 114, 269 656, 230 93.01 11, 966 93.02 04040 INTERNAL MEDICINE -722, 172 93.02 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 -10, 050, 953 55, 593, 693 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 192 00 192. 01 19201 FCMC 0 192.01 0 192. 02 19202 ARGOS MEDICAL CENTER 0 0 192.02 192. 03 19203 AKRON MEDICAL CENTER 0 192.03 0 193. 00 19300 NONPALD WORKERS 0 Λ 193.00 194. 00 07950 ADVERTI SI NG 194.00 0 538, 642 TOTAL (SUM OF LINES 118 through 199) 200.00 -10, 050, 953 200.00 56, 132, 335

Health Financial Systems RECLASSIFICATIONS WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-1313

| Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

COST Center						10	26/2022 11:35 am
2			Increases			'	
A - CAFETERIA RECLASS 11,00							
1.00			3. 00	4. 00	5. 00		
C	4 00		44.00	070 000	100 710		4.00
B - ADVERTISING RECLASS 1.00	1.00	CAFETERIA					1.00
ADMINISTRATIVE & GENERAL 5.00 3.077 17,836 C - DEPRECIATION RECLASS		D ADVEDTISING DECLASS		273,880	198, 713		
C DEPRECIATION RECLASS CLAYS BUILDING	1 00		5.00	3 077	17 836		1.00
C - DEPRECIATION RECLASS 1.04	1.00	0	 				1.00
1.00		C - DEPRECIATION RECLASS	II	5, 5, 1	177000		
D - NURSERY RECLASS 2. 00 2. 00 2. 00 2. 00 0	1.00		1. 04	0	133, 980		1.00
1.00		0		0	133, 980		
DELI VERY ROM & LABOR ROOM 52, 00 115, 043 58, 872							
1.00			l I				1.00
E - NURSI NG SUPERVI SOR RECLASS NURSI NG ADMINI STRATI ON 13. 00 4.00 0.0	2. 00	DELIVERY ROOM & LABOR ROOM	5200				2. 00
1.00		0		515, 087	263, 591		
2.00 4.00 0.00 0.00 0.00 0.00 0.00 0.00	1 00			202 502	0		1.00
3.00 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		NURSING ADMINISTRATION	l I	203, 303			2.00
4.00 0 283.503 0			l I	0			3.00
Color Colo				0			4.00
F - MAINTENANCE RECLASS OPERATION OF PLANT 7.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	1. 00		— — " "	283. 503	 		1.00
2. 00 3. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00		F - MAINTENANCE RECLASS	<u> </u>	200,000	5		
3. 00 4. 00 4. 00 5. 00 6. 00 7. 00 6. 00 7. 00 8. 00 9. 00	1.00	OPERATION OF PLANT	7. 00	0	1, 198, 526		1.00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 9. 00 9. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10.	2.00		0.00	0	0		2.00
5. 00 6. 00 7. 00 6. 00 7. 00 8. 00 9. 00 9. 00 10. 00 9. 00 10. 00 9. 00 11. 00 12. 00 13. 00 14. 00 14. 00 15. 00 16. 00 17. 00 18. 00 17. 00 18. 00 19. 0	3.00		0.00	0	0		3. 00
6. 00 7. 00 8. 00 9. 00 9. 00 10. 00 10. 00 10. 00 11. 00 12. 00 13. 00 14. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10. 00	4.00		1	0	0		4.00
7. 00 8. 00 9. 00 0. 00 0. 00 0. 00 0. 00 0. 00 10. 00 11. 00 11. 00 12. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 13. 00 14. 00 15. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 16. 00 17. 00 18. 00 0.			1	0	-		5. 00
8. 00				0			6. 00
9.00 10.00 11.00 11.00 11.00 12.00 12.00 13.00 14.00 0.00 0.00 0.00 0.00 0.00 0.00			1	0	-		7. 00
10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 19. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 00 10 10. 19. 00 10 10. 00 10 10. 00 10.			l I	0			8.00
11. 00 12. 00 12. 00 13. 00 14. 00 14. 00 15. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 299 24. 00 25. 406 26. 00 26. 796 27. 406 28. 00 26. 796 27. 406 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 29. 00 20.				0			9.00
12. 00 13. 00 14. 00 14. 00 15. 00 0. 00 0. 00 0. 00 0. 00 15. 00 16. 00 17. 00 18. 00 0. 00 0. 00 0. 00 0. 00 19. 00 19. 00 20. 00 21. 00 21. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	-		10.00
13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20			l I	U O			11. 00 12. 00
14. 00 15. 00 16. 00 17. 00 17. 00 18. 00 19. 00 20. 00 21			l I	0	-		13. 00
15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 19. 00 20. 00 21. 00 21. 00 RURAL HEALTH CLINIC IV 38. 00 20. 00 21. 00 20. 00 21. 00 21. 00 21. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20. 00				0			14.00
16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 10 10 10 10 10 10 10 10 10			l I	0	- 1		15.00
17. 00 18. 00 19. 00 20. 00 20. 00 21. 00 O			l I	0			16.00
18. 00 19. 00 20. 00 20. 00 21. 00 0 0 0 0 0 0 0 0 0 0 0 0			l I	o	Ö		17. 00
19. 00 20. 00 21. 00 0				O	0		18. 00
21.00	19.00		0.00	0	0		19. 00
0	20.00		0.00	O	0		20.00
G - RENT RECLASS 1. 00 RURAL HEALTH CLINIC IV 88.03 0 35, 299 O 35, 299 H - RHC OVERHEAD RECLASS 1. 00 ADMINISTRATIVE & GENERAL 5. 00 525, 406 2. 00 RURAL HEALTH CLINIC 88. 00 26, 796 3. 00 RURAL HEALTH CLINIC III 88. 02 52, 889 4. 00 RURAL HEALTH CLINIC IV 88. 03 12, 964 5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC V 88. 05 65, 479 O 176, 414 525, 406	21.00		0.00	0	0		21. 00
1. 00 RURAL HEALTH CLINIC IV 88. 03 0 35, 299 H - RHC OVERHEAD RECLASS 1. 00 ADMINISTRATI VE & GENERAL 5. 00 525, 406 2. 00 RURAL HEALTH CLINIC 88. 00 26, 796 3. 00 RURAL HEALTH CLINIC III 88. 02 52, 889 4. 00 RURAL HEALTH CLINIC IV 88. 03 12, 964 5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC VI 88. 05 65, 479 0 176, 414 525, 406		0		0	1, 198, 526		
0 35, 299 H - RHC OVERHEAD RECLASS 1. 00 ADMINISTRATIVE & GENERAL 5. 00 525, 406 2. 00 RURAL HEALTH CLINIC 88. 00 26, 796 3. 00 RURAL HEALTH CLINIC III 88. 02 52, 889 4. 00 RURAL HEALTH CLINIC IV 88. 03 12, 964 5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC VI 88. 05 65, 479 0 176, 414 525, 406							
H - RHC OVERHEAD RECLASS 1. 00 ADMINISTRATI VE & GENERAL 5. 00 525, 406 2. 00 RURAL HEALTH CLINIC 88. 00 26, 796 3. 00 RURAL HEALTH CLINIC III 88. 02 52, 889 4. 00 RURAL HEALTH CLINIC IV 88. 03 12, 964 5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC VI 88. 05 65, 479 0 176, 414 525, 406	1. 00	RURAL HEALTH CLINIC IV					1.00
1. 00 ADMINISTRATIVE & GENERAL 5. 00 525, 406 2. 00 RURAL HEALTH CLINIC 88. 00 26, 796 3. 00 RURAL HEALTH CLINIC III 88. 02 52, 889 4. 00 RURAL HEALTH CLINIC IV 88. 03 12, 964 5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC VI 88. 05 65, 479 0 176, 414 525, 406		U DUC OVERHEAD DECLACE		0	35, 299		
2. 00 RURAL HEALTH CLINIC 88. 00 26, 796 3. 00 RURAL HEALTH CLINIC III 88. 02 52, 889 4. 00 RURAL HEALTH CLINIC IV 88. 03 12, 964 5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC VI 88. 05 65, 479 0 176, 414 525, 406	1 00		E 00		EDE 404		1 00
3. 00 RURAL HEALTH CLINIC III 88. 02 52, 889 4. 00 RURAL HEALTH CLINIC IV 88. 03 12, 964 5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC VI 88. 05 65, 479 0 176, 414 525, 406				24 704	525, 406		1.00
4. 00 RURAL HEALTH CLINIC IV 88. 03 12, 964 5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC VI 88. 05 65, 479 0 176, 414 525, 406							2. 00 3. 00
5. 00 RURAL HEALTH CLINIC V 88. 04 18, 286 6. 00 RURAL HEALTH CLINIC VI 88. 05 65, 479 0 176, 414 525, 406							4.00
6. 00 RURAL HEALTH CLINIC VI							5. 00
0 176, 414 525, 406							6.00
	5. 50	0	 		525. 406		0.00
		I - ALDRIDGE CONVERSION RECLA	ASS	., 5,	323, .00		
1.00 RURAL HEALTH CLINIC II 88.01 28,048 2,542	1. 00				2, 542		1.00
TOTALS 28, 048 2, 542							
500.00 Grand Total: Increases 1, 280, 009 2, 375, 893	500.00	Grand Total: Increases					500.00

Provider CCN: 15-1313

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 11: 35 am

						5/26/2022 11: 3	<u>35 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - CAFETERIA RECLASS						
1.00	DI ETARY	10. 00	27 <u>3, 8</u> 80	19 <u>8, 7</u> 13			1.00
	0		273, 880	198, 713	3		
	B - ADVERTISING RECLASS						
1.00	ADVERTI SI NG	194. 00	3, 077	17, 836	0		1.00
			3,077	17, 836			
	C - DEPRECIATION RECLASS	<u> </u>					
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	133, 980	9		1.00
				133, 980			
	D - NURSERY RECLASS		- 1		1		
1.00	ADULTS & PEDIATRICS	30.00	515, 087	263, 591	0		1.00
2.00		0.00	0	0	o		2.00
2.00			515, 087	263, 591			2.00
	E - NURSING SUPERVISOR RECLAS	SS	0.07007	200,07.			
1. 00	ADULTS & PEDIATRICS	30.00	245, 050	C	0		1.00
2. 00	INTENSIVE CARE UNIT	31.00	3, 215	Ö			2. 00
3. 00	OPERATING ROOM	50.00	4, 176	0			3.00
4. 00	RADI OLOGY-DI AGNOSTI C	54. 00	31, 062	0			4. 00
4.00	NADI OLOGI - DI AGNOSTI C		283, 503	0			4.00
	F - MAINTENANCE RECLASS		203, 303		,		
1. 00	ADMINISTRATIVE & GENERAL	5. 00		391, 438	0		1.00
	HOUSEKEEPING	l l	0				
2.00		9. 00	0	1, 135			2.00
3.00	DI ETARY	10.00	0	15, 534			3.00
4. 00	NURSI NG ADMI NI STRATI ON	13.00	0	2, 118			4.00
5.00	PHARMACY	15. 00	0	42, 558			5.00
6.00	MEDICAL RECORDS & LIBRARY	16. 00	0	82, 094			6.00
7. 00	ADULTS & PEDIATRICS	30. 00	0	30, 991			7. 00
8.00	INTENSIVE CARE UNIT	31. 00	0	5, 577			8.00
9. 00	OPERATING ROOM	50.00	0	120, 677			9.00
10.00	ANESTHESI OLOGY	53. 00	0	775			10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	294, 117			11.00
12.00	LABORATORY	60.00	0	100, 429			12.00
13.00	RESPI RATORY THERAPY	65. 00	0	10, 071	0		13.00
14.00	PHYSI CAL THERAPY	66. 00	0	3, 280	0		14.00
15.00	RURAL HEALTH CLINIC	88. 00	0	190	0		15.00
16.00	RURAL HEALTH CLINIC II	88. 01	0	553	0		16.00
17.00	RURAL HEALTH CLINIC V	88. 04	0	14, 792	0		17.00
18.00	RURAL HEALTH CLINIC VI	88. 05	o	36, 272	0		18.00
19.00	EMERGENCY	91.00	O	16, 520	0		19.00
20.00	WOODLAWN MEDICAL	93. 00	0	3, 748	o o		20.00
	PROFESSI ONALS						
21.00	SHAFER MEDICAL CENTER	93. 01	O	25, 657	o		21.00
				1, 198, 526			
	G - RENT RECLASS		-1				
1.00	RURAL HEALTH CLINIC III	88. 02	0	35, 299	0		1.00
	0		 	35, 299			
	H - RHC OVERHEAD RECLASS		31	33,277			
1. 00	RURAL HEALTH CLINIC II	88. 01	176, 414	525, 406	0		1.00
2. 00	The second secon	0.00	.,5,	320, 700			2. 00
3. 00		0.00	0	0			3.00
4. 00		0.00	9	0			4.00
5.00		0.00	0	0			5.00
			O O	0			
6. 00		0.00_			,		6. 00
	U ALDDIDGE COMMEDCION DECL	100	176, 414	525, 406			
1 00	I - ALDRIDGE CONVERSION RECLA		00.046	0.510			1 00
1. 00	INTERNAL MEDICINE	<u>93.</u> 02	2 <u>8, 0</u> 48				1. 00
E00 00	TOTALS		28, 048	2, 542			E00.00
500.00	Grand Total: Decreases		1, 280, 009	2, 375, 893		[500.00

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

| Peri od: | Worksheet A-7 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:

				Ic	12/31/2021	Date/lime Pre 5/26/2022 11:	
				Acqui si ti ons		0, 20, 2022 111	00 4
		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	508, 688	5, 094	0	5, 094	0	2.00
3. 00	Buildings and Fixtures	27, 445, 912	82, 851	0	82, 851	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5. 00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	10, 868, 623	525, 902	0	525, 902	0	6.00
7. 00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39, 419, 439	613, 847	0	613, 847	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	,
10.00	Total (line 8 minus line 9)	39, 419, 439	613, 847	0	613, 847	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DART I ANNUALO OF GUANGES IN CARLEY AGOS	6. 00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		al				
1.00	Land	596, 216	0				1.00
2. 00	Land Improvements	513, 782	0				2.00
3. 00	Buildings and Fixtures	27, 528, 763	0				3.00
4.00	Building Improvements	0	0				4.00
5. 00	Fi xed Equi pment	0	0				5.00
6. 00	Movabl e Equi pment	11, 394, 525	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	40, 033, 286	0				8.00
9.00	Reconciling Items	40.000.004	0				9.00
10. 00	Total (line 8 minus line 9)	40, 033, 286	0				10.00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-1313	Period: Worksheet A-7 From 01/01/2021 Part II
		To 12/31/2021 Date/Time Prepared:

Depreciation Lease					Т	o 12/31/2021	Date/Time Pre 5/26/2022 11:	pared: 35 am
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00				SL	JMMARY OF CAPIT	AL		
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00		Cost Center Description	Denreciation	Lease	Interest	Insurance	Tayes (see	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2		Cost Center Bescription	Depreer at ron	Lease	Titterest			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							,	
1.00			9. 00	10. 00	11.00	12.00	13.00	
1.02								
1. 03 ARGOS BUILDING 51, 743 0 0 0 22, 573 0 1. 03 1. 04 CLAYS BUILDING 0 0 0 0 0 0 0 0 1. 04 3. 00 Total (sum of lines 1-2) 1, 461, 923 0 434, 350 625, 137 0 3. 00 Cost Center Description Cost Center Description Other Capital -Related Costs (see instructions) 14. 00 15. 00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 CAP REL COSTS-BLDG & FIXT					434, 350	602, 564	0	
1. 04 CLAYS BUILDING 3. 00 Total (sum of lines 1-2) Cost Center Description Capital -Relat (sum of cols. ed Costs (see instructions) 14.00 15.00				l e	0	0	0	1
3.00 Total (sum of lines 1-2) 1,461,923 0 434,350 625,137 0 3.00			51, 743	0	0	22, 573	0	1
Cost Center Description			0	0	0	0	0	1
Cost Center Description Other Capital -Relat ed Costs (see instructions) PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 45, 304 2, 463, 932 1.00 AKRON BUILDING 20, 125 48, 591 1.00 1.03 ARGOS BUILDING 35, 294 109, 610 1.03 1.04 CLAYS BUILDING 27, 609 27, 609 1.04	3. 00	Total (sum of lines 1-2)			434, 350	625, 137	0	3.00
Capi tal -Rel at ed Costs (see instructions) 14.00 15.00			SUMMARY O	F CAPITAL				
Capi tal -Rel at ed Costs (see instructions) 14.00 15.00		Cook Cooks Decorated on	0+1	T-+-1 (1)				
ed Costs (see 9 through 14)		cost center bescription						
Instructions								
14.00 15.00				19 till ough 14)				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1. 00				15 00				
1. 00 CAP REL COSTS-BLDG & FIXT 45, 304 2, 463, 932 1. 00 1. 02 AKRON BUI LDI NG 20, 125 48, 591 1. 02 1. 03 ARGOS BUI LDI NG 35, 294 109, 610 1. 03 1. 04 CLAYS BUI LDI NG 27, 609 27, 609 1. 04		PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1. 02 AKRON BUI LDI NG 20, 125 48, 591 1. 03 ARGOS BUI LDI NG 35, 294 109, 610 1. 04 CLAYS BUI LDI NG 27, 609 27, 609	1. 00							1.00
1. 03 ARGOS BUI LDI NG 35, 294 109, 610 1. 03 1. 04 CLAYS BUI LDI NG 27, 609 27, 609	1. 02				•			1.02
	1.03	ARGOS BUILDING	35, 294	l .	•			1.03
3.00 Total (sum of lines 1-2) 128,332 2,649,742 3.00	1.04	CLAYS BUILDING						1.04
	3.00	Total (sum of lines 1-2)	128, 332	2, 649, 742				3.00

Heal th	Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/26/2022 11:3	pared:
		COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
		1. 00	2.00	col . 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1. 00 1. 02	CAP REL COSTS-BLDG & FLXT AKRON BUILDING	31, 067, 198 998, 991	0	998, 99	0. 024954	0	1. 00 1. 02
1. 03	ARGOS BUILDING CLAYS BUILDING	2, 140, 695 5, 826, 402	О	2, 140, 69 5, 826, 40	0. 145539	0	1. 03 1. 04
3. 00	Total (sum of lines 1-2)	40, 033, 286	[O TION OF OTHER (40, 033, 28		OF CAPITAL	3. 00
		ALLOCA	TION OF OTHER V	DALLIAL	JOIWIMART	OI CAITTAL	
	Cost Center Description	Taxes	Other Capi tal -Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7.00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			2.00			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1	1, 247, 093		1.00
1. 02	AKRON BUILDING	0	0		28, 466		1. 02
1.03	ARGOS BUILDING	0	0	1	51, 743		1.03
1. 04 3. 00	CLAYS BUILDING Total (sum of lines 1-2)	0	0		133, 980 1, 461, 282		1. 04 3. 00
3.00	Total (sull of Titles 1-2)	U		U JMMARY OF CAPI		U	3.00
			30	JIMINATE OF CALL	IAL		
	Cost Center Description	Interest	I nsurance (see	Taxes (see instructions)	Other Capi tal -Rel at	Total (2) (sum of cols.	
			instructions)		ed Costs (see instructions)	9 through 14)	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			T			
1.00	CAP REL COSTS-BLDG & FIXT	425, 158	1		45, 304		1.00
1. 02 1. 03	AKRON BUILDING ARGOS BUILDING	0	1	1	20, 125 35, 294		1. 02 1. 03
1. 03	CLAYS BUILDING		22, 573		35, 294		1. 03
3. 00	Total (sum of lines 1-2)	425, 158	625, 137	1	128, 332		3. 00
			'	•	, , , , , , , , , , , , , , , , , , , ,		

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-1313 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 11:35 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -9, 192 CAP REL COSTS-BLDG & FIXT 1.00 1.00 COSTS-BLDG & FIXT (chapter 2) 1.02 O AKRON BUILDING Investment income - AKRON 1.02 1.02 BUILDING (chapter 2) 1.03 Investment income - ARGOS O ARGOS BUILDING 1.03 1.03 BUILDING (chapter 2) 1.04 Investment income -- CLAYS OCLAYS BUILDING 1.04 1.04 BUILDING (chapter 2) Investment income - CAP REL 2.00 0 *** Cost Center Deleted *** 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) Investment income - other 3.00 0.00 3.00 (chapter 2) 4 00 Trade, quantity, and time 0 00 4 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 0.00 6.00 7.00 Tel ephone services (pay 7.00 0.00 stations excluded) (chapter 8.00 Television and radio service 8.00 0.00 (chapter 21) 9.00 Parking Lot (chapter 21) 9.00 0.0010.00 Provi der-based physici an A-8-2 -6, 806, 677 10.00 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) 12.00 Related organization 12.00 A-8-1 transactions (chapter 10) Laundry and linen service 0.00 13.00 13.00 14.00 Cafeteria-employees and guests В -111, 349 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents Sale of drugs to other than 17.00 17.00 0.00 0 pati ents -19, 606 MEDICAL RECORDS & LIBRARY 18.00 Sale of medical records and В 16.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20 00 Vending machines B -5 CAFETERI A 11.00 ol 20.00 Income from imposition of 21.00 21.00 0.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 22.00 0.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 23.00 A-8-3 65.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL 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 (chapter 21) 26.00 Depreciation - CAP REL O CAP REL COSTS-BLDG & FIXT 1.00 26.00 COSTS-BLDG & FLXT 26.02 Depreciation - AKRON BUILDING O AKRON BUILDING 1.02 26.02 Depreciation - ARGOS BUILDING Depreciation - CLAYS BUILDING OLARGOS BUILDING 26.03 1.03 ol 26.03 26.04 OCLAYS BUILDING 1.04 0 26.04 Depreciation - CAP REL 0 *** Cost Center Deleted *** 2.00 27.00

COSTS-MVBLE EQUIP

From 01/01/2021

				Т	o 12/31/2021	Date/Time Pre 5/26/2022 11:	
				Expense Classification on	Workshoot A	3/20/2022 11.	30 alli
				To/From Which the Amount is			
				TO/FIOII WITCH THE AMOUNT IS	to be Aujusteu		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Allouitt	cost center	LITIE #	Ref.	
		1. 00	2. 00	3.00	4.00	5. 00	
28. 00	Non-physician Anesthetist	1.00		*** Cost Center Deleted ***	19.00	3. 00	28. 00
29.00	Physicians' assistant		0	Cost center bereted	0.00	0	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00	O	30.00
30.00	therapy costs in excess of	A-0-3	O	CCCO ATTONAL THENATT	07.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
30. 77	i nstructi ons)		U	ADDETS & FEDIATRICS	30.00		30. 77
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
31.00	pathology costs in excess of	A-0-3	O	SI EEGII TATIIOEGGI	00.00		31.00
	limitation (chapter 14)						
32. 00		В	-641	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
32.00	Depreciation and Interest	Ь	041	CAI REE COSTS BEBG & TTAT	1.00	,	32.00
33. 00	PHYSI CI AN RECRUITMENT	А	-1 504	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
34. 00	HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	1
35. 00	ADMIN OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
36.00	HOME MEAL PROGRAM	В	-17, 788		10.00	0	
37. 00	DRUG SALES	В		PHARMACY	15. 00	0	
38. 00	PT - OTHER REVENUE	В		PHYSI CAL THERAPY	66.00	0	•
39.00	OCC THER OTH REV	В		OCCUPATI ONAL THERAPY	67. 00	0	
40.00	MISC REV -OTH REV	В	•	ADMI NI STRATI VE & GENERAL	5. 00	0	
41. 00	STAFF RENTAL AGREEMENTS	В		RESPIRATORY THERAPY	65.00	0	
42.00	I HA & AHA LOBBYING	A		ADMINISTRATIVE & GENERAL	5. 00	0	
43.00	PART B BILLING OFFSET	A	•	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00	0	
44. 00	LTC EXPENSES	A	•	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00	0	
45.00	RHC OFFSETS	A		RURAL HEALTH CLINIC	88.00	0	
45. 00	RHC OFFSETS	A		RURAL HEALTH CLINIC	88. 01	0	
	4			RURAL HEALTH CLINIC III	88. 02	-	ı
45. 02	RHC OFFSETS	A				0	
45. 03	RHC OFFSETS	A		RURAL HEALTH CLINIC V	88. 04	0	1 .0.00
45. 04	RHC OFFSETS	A	•	RURAL HEALTH CLINIC VI	88. 05	0	1 .0.0.
50. 00			-10, 050, 953				50.00
	(Transfer to Worksheet A,						
(1) 5	column 6, line 200.)			010 D L 45 4			

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).

 A. Costs if cost, including applicable overhead, can be determined.

 B. Amount Received if cost cannot be determined.

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

| Peri od: | Worksheet A-8-2 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

					'	0 12/31/2021	5/26/2022 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1.00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00		ANESTHESI OLOGY	866, 667	854, 667	12, 000	0		1.00
2.00		RADI OLOGY-DI AGNOSTI C	194, 324			0		
3.00		RESPI RATORY THERAPY	19, 834			0		
4. 00		EMERGENCY	2, 417, 940		· ·	0	0	
5. 00		WOODLAWN MEDICAL	1, 049, 889	1, 049, 889	0	0	0	5. 00
,		PROFESSI ONALS	0.44.040					,
6.00		SHAFER MEDICAL CENTER	2, 114, 269			0	0	
7.00		INTERNAL MEDICINE	722, 172	722, 172	0	0	0	7.00
8. 00	0.00		0		0	0	0	8.00
9.00	0.00		0			0	ľ	9.00
10.00			7 205 005	4 004 477	U 570 410	U	0	10.00
200.0	Wkst. A Line #	Cost Center/Physician	7, 385, 095 Unadj usted RCE		578, 418 Cost of	Provi der	Physician Cost	200.00
	WKSt. A LITTE #	I denti fi er	Li mi t		Memberships &		of Malpractice	
		ruentiriei		Li mi t	Continuing	Share of col.	Insurance	
				L1 t	Education	12	Trisul direc	
	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		ANESTHESI OLOGY	0	C		0		1.00
2. 00		RADI OLOGY-DI AGNOSTI C	0	O	0	0		2.00
3.00	65. 00	RESPI RATORY THERAPY	0	C	0	0	0	3.00
4.00	91.00	EMERGENCY	0	O	0	0	0	4.00
5.00	93. 00	WOODLAWN MEDICAL	0	0	0	0	0	5.00
		PROFESSI ONALS						
6.00	93. 01	SHAFER MEDICAL CENTER	0	C	0	0	0	6.00
7. 00		INTERNAL MEDICINE	0	0	0	0	0	
8.00	0.00		0	0	0	0	0	
9. 00	0. 00		0	0	0	0	0	
10.00			0	0	0	0		
200.0			0	C	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ANESTHESI OLOGY	15.00			854, 667		1.00
2. 00		RADI OLOGY-DI AGNOSTI C		· ·	_	194, 324		2.00
3. 00	l l	RESPIRATORY THERAPY	0		-	11, 184		3.00
4. 00		EMERGENCY	0		_	1, 860, 172		4.00
5. 00		WOODLAWN MEDICAL	1 0	Ö		1, 049, 889		5. 00
0.00		PROFESSI ONALS		Ĭ		1,017,007		0.00
6. 00	93. 01	SHAFER MEDICAL CENTER	l 0		0	2, 114, 269		6.00
7. 00		INTERNAL MEDICINE	0	C	0	722, 172		7. 00
8. 00	0.00		0	C	0	. 0		8. 00
9. 00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10.00
200.0	0		0	O	0	6, 806, 677		200.00

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared: 5/26/2022 11:35 am

			10	12/31/2021	5/26/2022 11:	
			CAPITAL REL	ATED COSTS		
Cost Contor Doscription	Net Expenses	BLDG & FLXT	AKRON	ARGOS	CLAYS	
Cost Center Description	for Cost	DLUG & FIAI	BUI LDI NG	BUI LDI NG	BUI LDI NG	
	Allocation		DOT EDT NO	DOI LDI NO	DOLLDING	
	(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, 320, 119	2, 320, 119				1.00
1. 02 00102 AKRON BUILDING	48, 591	0	48, 591			1. 02
1. 03 00103 ARGOS BUILDING	109, 610	0	0	109, 610		1.03
1. 04 00101 CLAYS BUILDING	161, 589	0	0	0	161, 589	1. 04
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	4, 076, 161	0	0	0	0	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	7, 234, 509	250, 186	5, 553	8, 769	127	5.00
7. 00 00700 OPERATION OF PLANT	2, 698, 008	225, 779	3, 332	9, 996	36, 863	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	168, 928	6, 842	0	0	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	553, 737	25, 856	0	0	340 0	9. 00 10. 00
11. 00 01100 CAFETERI A	271, 498 361, 239	84, 347 28, 841	0	0	0	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	586, 685	58, 363	0	0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	30, 303	0	0	0	14. 00
15. 00 01500 PHARMACY	4, 562, 844	29, 544	0	0	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 299, 116		0	o	33, 633	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	., = ,	==,	-	-1	22/ 222	
30. 00 03000 ADULTS & PEDIATRICS	2, 754, 684	321, 809	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	815, 546		0	0	0	31.00
43. 00 04300 NURSERY	604, 763	3, 986	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 953, 328		0	0	0	50.00
51.00 05100 RECOVERY ROOM	671, 694	105, 237	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	173, 915	17, 202	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	60, 786	2, 920	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 875, 354	254, 556	0	0	0	54.00
60. 00 06000 LABORATORY	3, 024, 225	55, 912	0	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 410, 402	88, 653	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	792, 829 225, 745	67, 167	0	0	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	127, 368	0	0	0	0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	127, 300	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	828, 532	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	020,002	0	0	o	0	73.00
OUTPATIENT SERVICE COST CENTERS		-	-	-1		
88. 00 08800 RURAL HEALTH CLINIC	1, 271, 315	0	0	0	44, 596	88. 00
88.01 08801 RURAL HEALTH CLINIC II	3, 691, 133	163, 643	0	O	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	2, 443, 081	0	0	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	374, 637	0	0	0	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	772, 463	0	39, 706	0	0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI	2, 147, 212	0	0	90, 845	0	88. 05
91. 00 09100 EMERGENCY	2, 292, 252	133, 396	0	O	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4/4 500	404 004			0	92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	161, 599		0	0	0	93.00
93. 01 04951 SHAFER MEDICAL CENTER	656, 230		0	0	46, 030 0	93. 01
93. 02 04040 I NTERNAL MEDI CI NE SPECI AL PURPOSE COST CENTERS	11, 966	8, 654	U	<u> </u>	0	93. 02
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	55, 593, 693	2, 300, 124	48, 591	109, 610	161, 589	
NONREI MBURSABLE COST CENTERS	00/0/0/0/0	2,000,121	107 07 1	1077010	1017007	
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	0	12, 470	0	Ö		192.00
192. 01 19201 FCMC	0	0	0	0		192. 01
192.02 19202 ARGOS MEDICAL CENTER	0	o	0	o		192. 02
192.03 19203 AKRON MEDICAL CENTER	0	0	0	0		192. 03
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 ADVERTI SI NG	538, 642	7, 525	0	0		194. 00
200.00 Cross Foot Adjustments			_	_		200.00
201.00 Negative Cost Centers	E/ 100 005	0 220 440	40 501	100 (10		201.00
202.00 TOTAL (sum lines 118 through 201)	56, 132, 335	2, 320, 119	48, 591	109, 610	161, 589	ZUZ. UU

Peri od: Worksheet B From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 11:35 am

				'	0 12/31/2021	5/26/2022 11:	
	Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		DEPARTMENT					
	I	4. 00	4A	5. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	Г		T			
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						1. 04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 076, 161					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	524, 213	8, 023, 357				5. 00
7. 00	00700 OPERATION OF PLANT	56, 341	3, 030, 319		3, 535, 700		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	3, 166	178, 936		10, 281	219, 059	8. 00
9. 00	00900 HOUSEKEEPI NG	50, 571	630, 504			36, 185	9. 00
10.00	01000 DI ETARY	24, 510	380, 355			5, 105	10.00
11. 00	01100 CAFETERI A	40, 040	430, 120			0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	69, 480	714, 528		87, 693	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500 PHARMACY	59, 457	4, 651, 845			0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	54, 125	1, 415, 011	235, 988	178, 364	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	259, 148	3, 335, 641	556, 302		47, 145	30.00
31.00	03100 INTENSIVE CARE UNIT	57, 049	916, 463			5, 705	31.00
43.00		58, 485	667, 234	111, 278	5, 989	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	120, 705	3, 247, 268			12, 912	50.00
51.00	05100 RECOVERY ROOM	65, 932	842, 863	•	·	15, 915	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	16, 819	207, 936	34, 679	·	0	52.00
53.00	05300 ANESTHESI OLOGY	0	63, 706			0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	257, 565	3, 387, 475			35, 734	54.00
60.00	06000 LABORATORY	147, 416	3, 227, 553	538, 275	84, 009	0	60.00
65.00	06500 RESPI RATORY THERAPY	152, 672	1, 651, 727	275, 467		3, 153	65.00
66.00	06600 PHYSI CAL THERAPY	86, 207	946, 203	157, 803	100, 920	3, 603	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	31, 581	257, 326	42, 916	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	15, 007	142, 375	23, 745	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	828, 532	138, 178	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	121, 211	1, 437, 122		·	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	412, 208	4, 266, 984		245, 879	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	222, 559	2, 665, 640		0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	37, 255	411, 892	68, 693	0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	84, 239	896, 408	149, 498			88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	240, 848	2, 478, 905	413, 419	199, 086		88. 05
91.00	09100 EMERGENCY	246, 378	2, 672, 026	445, 627	200, 431	53, 602	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	111, 213	394, 803	65, 843	183, 296		93.00
93. 01	04951 SHAFER MEDICAL CENTER	339, 773	1, 042, 033			0	93. 01
93. 02		98, 411	119, 031	19, 851	13, 003	0	93. 02
	SPECIAL PURPOSE COST CENTERS						
	D 11300 INTEREST EXPENSE						113. 00
118.00	3 /	4, 064, 584	55, 562, 121	7, 928, 259	3, 535, 700	219, 059	118. 00
	NONREI MBURSABLE COST CENTERS			,			
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	12, 470	2, 080	0		192. 00
	1 19201 FCMC	0	0	0	0		192. 01
	2 19202 ARGOS MEDICAL CENTER	0	0	0	0		192. 02
	3 19203 AKRON MEDICAL CENTER	0	0	0	0		192. 03
	D 19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 ADVERTI SI NG	11, 577	557, 744	93, 018	0	0	194. 00
200.00			0				200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 076, 161	56, 132, 335	8, 023, 357	3, 535, 700	219, 059	202. 00

Peri od: Worksheet B From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/26/2022 11:35 am

			'	0 12/31/2021	5/26/2022 11:	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
				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 BUI LDI NG						1.03
1. 04 00101 CLAYS BUILDING						1.04
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG	812, 068					9. 00
10. 00 01000 DI ETARY	920	576, 549				10.00
11. 00 01100 CAFETERI A	10, 953	0	556, 140			11.00
13. 00 O1300 NURSING ADMINISTRATION	460	0	16, 361			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	C	-	0	14.00
15. 00 01500 PHARMACY	7, 870	0	15, 819		0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	2, 434	0	22, 104	36, 988	0	16.00
INPATIENT ROUTINE SERVICE COST CENTER						
30. 00 03000 ADULTS & PEDI ATRI CS	204, 988	502, 200	68, 993		0	30.00
31.00 03100 INTENSIVE CARE UNIT	37, 430	74, 349	21, 508		0	31.00
43. 00 04300 NURSERY	0	0	13, 679	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 0PERATI NG ROOM	103, 673	0	46, 537		0	50.00
51. 00 05100 RECOVERY ROOM	62, 743	0	19, 314		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	3, 928		0	52.00
53. 00 05300 ANESTHESI OLOGY	70.457	0	70. ((2	_	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	79, 457	0	78, 662		0	54.00
60. 00 06000 LABORATORY	30, 912	0	51, 304		0	60.00
65. 00 06500 RESPIRATORY THERAPY	24, 908	0	43, 557		0	65.00
66. 00 06600 PHYSI CAL THERAPY	17, 254	0	25, 029	1	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	6, 826		0	67.00
68. 00 06800 SPEECH PATHOLOGY	U ENT	0	3, 332	1	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATE 72.00 07200 IMPL. DEV. CHARGED TO PATEENTS		0	C	-	0	71. 00 72. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0 0	0	C	1	0	72.00
OUTPATIENT SERVICE COST CENTERS	J O	U	<u> </u>	ıj Uj	0	/3.00
88. 00 08800 RURAL HEALTH CLINIC	33, 589	0	C	O	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC I	50, 357	0	59, 729		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	30, 337	0	37, 727		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		0		0	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V		0			0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI		0			0	88. 05
91. 00 09100 EMERGENCY	93, 385	0	42, 311	154, 535	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT I		Ŭ	12,011	101,000	Ü	92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	17, 200	0	9, 806	0	0	93.00
93. 01 04951 SHAFER MEDI CAL CENTER	33, 373	0	7,000	0	0	93. 01
93. 02 04040 NTERNAL MEDI CI NE	0	0	4, 903	0	0	93. 02
SPECIAL PURPOSE COST CENTERS		<u> </u>	.,,,,,	<u> </u>		70.02
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through	gh 117) 811, 906	576, 549	553, 702	938, 207	0	118.00
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			· · · · ·		
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	TEEN 162	0	C	0	0	190.00
192.00 19200 PHYSICIANS PRIVATE OFFICES	o	o	C	o		192.00
192.01 19201 FCMC	o	0	C	o	0	192. 01
192. 02 19202 ARGOS MEDICAL CENTER	o	o	C	ol	0	192. 02
192.03 19203 AKRON MEDICAL CENTER	o	0	C	o	0	192. 03
193. 00 19300 NONPALD WORKERS	o	o	C	ol ol		193. 00
194. 00 07950 ADVERTI SI NG	0	o	2, 438	ol	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	O	C	o		201.00
202.00 TOTAL (sum lines 118 through 20	1) 812, 068	576, 549	556, 140	938, 207	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 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 11:35 am 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 1.00 00100 CAP REL COSTS-BLDG & FIXT 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 5, 495, 721 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1, 890, 889 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 64,652 5, 910, 706 5, 910, 706 30.00 03100 INTENSIVE CARE UNIT 0 1, 386, 228 o 1, 386, 228 31.00 31.00 12, 589 04300 NURSERY 0 3,052 801, 232 0 801, 232 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 223, 326 4, 435, 571 0 4, 435, 571 50.00 05100 RECOVERY ROOM 0 22, 788 51.00 1, 262, 313 0 1, 262, 313 51.00 0 276, 015 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 3, 625 276, 015 52 00 05300 ANESTHESI OLOGY 53.00 27, 081 105, 800 105, 800 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 408, 731 4, 937, 483 0 4, 937, 483 54.00 06000 LABORATORY 60.00 0000 361, 774 4, 293, 827 0 0 4, 293, 827 60.00 06500 RESPIRATORY THERAPY 2, 249, 426 2, 249, 426 65 00 117 410 65 00 66.00 06600 PHYSI CAL THERAPY 24,698 1, 275, 510 1, 275, 510 66.00 06700 OCCUPATI ONAL THERAPY 10, 730 317, 798 0 317, 798 67.00 67.00 0 6, 075 68.00 06800 SPEECH PATHOLOGY 175, 527 175, 527 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71 00 0 0 o 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 24, 284 990, 994 990, 994 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 495, 721 5, 769, 267 73.00 273, 546 5, 769, 267 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 1, 908, 572 1, 908, 572 08800 RURAL HEALTH CLINIC 17, 739 0 88 00 0 88.01 08801 RURAL HEALTH CLINIC II 0 50, 899 5, 385, 474 0 5, 385, 474 88.01 88 02 08802 RURAL HEALTH CLINIC III 0 0 31, 126 3, 141, 328 0 3, 141, 328 88 02 08803 RURAL HEALTH CLINIC IV 0 486, 813 486, 813 88.03 6, 228 88.03 08804 RURAL HEALTH CLINIC V 9, 555 1, 147, 061 88 04 1, 147, 061 88 04 0 88.05 08805 RURAL HEALTH CLINIC VI 34, 992 3, 126, 402 0 3, 126, 402 88.05 0 09100 EMERGENCY 3, 740, 940 3, 740, 940 91.00 79,023 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 14, 434 685, 382 0 685, 382 93.00 93 01 04951 SHAFER MEDICAL CENTER 0 45, 652 1, 481, 086 0 1, 481, 086 93.01 04040 INTERNAL MEDICINE 0 16, 880 93.02 93.02 173, 668 173, 668 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00

118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	5, 495, 721	1, 890, 889	55, 464, 423	o	55, 464, 423 118. 00
NONRE	IMBURSABLE COST CENTERS					
190. 00 19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	162	0	162 190. 00
192. 00 19200	PHYSICIANS PRIVATE OFFICES	0	0	14, 550	0	14, 550 192. 00
192. 01 1920	FCMC	0	0	0	0	0 192. 01
192. 02 19202	ARGOS MEDICAL CENTER	0	0	0	0	0 192. 02
192. 03 19203	B AKRON MEDICAL CENTER	0	0	0	0	0 192. 03
193. 00 19300	NONPALD WORKERS	0	0	0	0	0 193.00
194. 00 07950	ADVERTI SI NG	0	0	653, 200	0	653, 200 194. 00
200. 00	Cross Foot Adjustments			0	0	0 200. 00
201. 00	Negative Cost Centers	0	0	0	0	0 201.00
202. 00	TOTAL (sum lines 118 through 201)	5, 495, 721	1, 890, 889	56, 132, 335	0	56, 132, 335 202. 00

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				CAPITAL REL	ATED COSTS		
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	AKRON BUI LDI NG	ARGOS BUI LDI NG	CLAYS BUI LDI NG	
		0	1.00	1. 02	1. 03	1. 04	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 02	00102 AKRON BUILDING						1.02
1.03	00103 ARGOS BUILDING						1.03
1.04	00101 CLAYS BUILDING						1.04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	250, 186	5, 553	8, 769	127	5.00
7.00	00700 OPERATION OF PLANT	0	225, 779	3, 332	9, 996	36, 863	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	6, 842	0	0	0	8. 00
9. 00	00900 HOUSEKEEPI NG	0	25, 856	0	0	340	9. 00
10.00	01000 DI ETARY	0	84, 347	0	0	0	10.00
11. 00	01100 CAFETERI A	0	28, 841	0	0	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	58, 363	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
	01500 PHARMACY	0	29, 544	0	0	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	28, 137	0	0	33, 633	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				al.		
30.00	03000 ADULTS & PEDIATRICS	0	321, 809	0	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	0	43, 868	0	0	0	31.00
43. 00	04300 NURSERY	0	3, 986	0	0	0	43.00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	173, 235	0	0		 EO OO
50. 00 51. 00	05100 RECOVERY ROOM	0	173, 235	0	0	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	17, 202	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	2, 920	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 920 254, 556	0	0	0	54.00
60.00	06000 LABORATORY	0	55, 912	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	88, 653	0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	67, 167	0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	07, 107	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	o	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS		-1		-1		
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	44, 596	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	163, 643	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	o	0	O	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	o	39, 706	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	0	0	90, 845	0	88. 05
91.00	09100 EMERGENCY	0	133, 396	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	0	121, 991	0	0	0	93.00
	04951 SHAFER MEDICAL CENTER	0	1	0	0		93. 01
93. 02	04040 I NTERNAL MEDICINE	0	8, 654	0	0	0	93. 02
	SPECIAL PURPOSE COST CENTERS	T					
	11300 INTEREST EXPENSE	_					113.00
118. 00	, , ,	0	2, 300, 124	48, 591	109, 610	161, 589	118. 00
100.00	NONREI MBURSABLE COST CENTERS				- I		100.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSICIANS PRIVATE OFFICES	0	12, 470	0	0		192.00
	19201 FCMC	0		0	0		192.01
	19202 ARGOS MEDICAL CENTER	0		0	0		192.02
	19203 AKRON MEDI CAL CENTER			0	o o		192.03
	19300 NONPALD WORKERS 07950 ADVERTISING		7 50	0	ol		193. 00 194. 00
200.00			7, 525	U	٩	Ü	200.00
200.00	1 1					0	200.00
201.00		0	2, 320, 119	48, 591	109, 610	161, 589	
202.00	1 TOTAL (Sum TITIES TTO THEOUGH 201)	1	2, 320, 117	40, 371	107,010	101, 307	1202.00

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						5/26/2022 11:	35 am_
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		2A	4. 00	5. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS	ZN	4.00	3.00	7.00	0.00	
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						1.03
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	264, 635	0	264, 635			5.00
7. 00	00700 OPERATION OF PLANT	275, 970	0				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	6, 842	0			8, 677	8.00
9. 00	00900 HOUSEKEEPI NG	26, 196	0			1, 433	9. 00
10.00	01000 DI ETARY	84, 347	0			202	10.00
11. 00	01100 CAFETERI A	28, 841	0			0	11.00
13. 00	01300 NURSING ADMINISTRATION	58, 363	0	3, 931	7, 258	Ö	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0			Ö	14.00
15. 00	01500 PHARMACY	29, 544	0		_	Ö	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	61, 770	0			Ö	16.00
10.00	I NPATIENT ROUTINE SERVICE COST CENTERS	01, 770		7, 704	14, 703		10.00
30.00	03000 ADULTS & PEDIATRICS	321, 809	0	18, 349	40, 021	1, 867	30.00
31.00	03100 I NTENSI VE CARE UNI T	43, 868	Ö			226	31.00
43. 00		3, 986	0	1		0	43.00
10.00	ANCILLARY SERVICE COST CENTERS	0, 700		0,070	170		10.00
50.00	05000 OPERATING ROOM	173, 235	0	17, 863	21, 544	511	50.00
51. 00	05100 RECOVERY ROOM	105, 237	0			630	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	17, 202	0	1		0	52.00
53. 00	05300 ANESTHESI OLOGY	2, 920	0	1		Ō	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	254, 556	0	1		1, 415	54.00
60.00	06000 LABORATORY	55, 912	0			0	60.00
65.00	06500 RESPI RATORY THERAPY	88, 653	0			125	65.00
66.00	06600 PHYSI CAL THERAPY	67, 167	0			143	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	0	1, 416	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	o	0	783	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	4, 558	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	44, 596	0	7, 906	14, 935	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	163, 643	0	23, 473	20, 351	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0			0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0			0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	39, 706	0	4, 931		0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	90, 845	0				88. 05
91.00	09100 EMERGENCY	133, 396	0	14, 699	16, 589	2, 125	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	121, 991	0			0	93.00
93. 01	04951 SHAFER MEDICAL CENTER	46, 030	0	1			93. 01
93. 02		8, 654	0	655	1, 076	0	93. 02
440.0	SPECIAL PURPOSE COST CENTERS			_			
	0 11300 NTEREST EXPENSE	0 (40 044		0/4 400	000 (40	0 (77	113.00
118.00	3 /	2, 619, 914	0	261, 498	292, 640	8,6//	118. 00
100.00	NONREI MBURSABLE COST CENTERS	ا		J 0			100 00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	12 470	0	1			190. 00 192. 00
		12, 470	0		1		192.00
	1 19201 FCMC 2 19202 ARGOS MEDICAL CENTER		0		0		192.01
192.0	3 19203 AKRON MEDICAL CENTER		0		0		192. 02
	19203 ARRON MEDICAL CENTER 19300 NONPALD WORKERS		0				192.03
	07950 ADVERTI SI NG	7, 525	0	3, 068			194. 00
200.00		7, 525	U	3,000		l	200.00
200.00			0		٥	0	201.00
202.00		2, 639, 909	0		292, 640	8 677	202.00
_32.00	1.57.12 (55 1.1.55 116 till 64gil 201)	_, 557,707	0	201,000	2,2,040	. 0,011	

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				'	0 12/31/2021	5/26/2022 11:	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	•				ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		9. 00	10. 00	11. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS	T T			T		
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 02	00102 AKRON BUILDING						1.02
1. 03	00103 ARGOS BUILDING						1.03
1. 04	00101 CLAYS BUILDING						1.04
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG	34, 426					9.00
10. 00	01000 DI ETARY	39	97, 169				10.00
11. 00	01100 CAFETERI A	464	0	35, 258			11.00
13. 00	01300 NURSING ADMINISTRATION	19	0	1, 037			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	C	1	0	14.00
15. 00	01500 PHARMACY	334	0	1, 003		0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	103	0	1, 401	2, 784	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 691	84, 639	4, 374		0	1
31.00	03100 INTENSIVE CARE UNIT	1, 587	12, 530	1, 364		0	31.00
43. 00	04300 NURSERY	0	0	867	0	0	43.00
F0 00	ANCILLARY SERVICE COST CENTERS	4 005	ام	0.050			F0 00
50.00	05000 OPERATING ROOM	4, 395	0	2, 950	1	0	50.00
51.00	05100 RECOVERY ROOM	2, 660	0	1, 224	1	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	249	1	0	52.00
53.00		0	U	4 003	1	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	3, 368	U O	4, 987	1	0	54.00
60.00		1, 310	0	3, 253	1		60.00
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 056	0	2, 761		0	65.00
66.00	l l	731	0	1, 587		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	433 211		0	67.00
68. 00 71. 00	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	211	1	0	68. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		ol	C	1 71	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0	C		0	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		, o _l		73.00
88. 00	08800 RURAL HEALTH CLINIC	1, 424	ol	C	ol	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 135	o	3, 787		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	2, 100	0	0, 707		0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	Ö	C		0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0	Č		0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI		0	Č		0	88. 05
91. 00	09100 EMERGENCY	3, 959	o	2, 682	11, 630	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART]	_	_, -,	,	_	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	729	o	622	el ol	0	93.00
93. 01	04951 SHAFER MEDICAL CENTER	1, 415	O	C	1	0	93. 01
93. 02	04040 I NTERNAL MEDICINE	0	o	311	0	0	93. 02
	SPECIAL PURPOSE COST CENTERS		,				1
113.00	11300 I NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	34, 419	97, 169	35, 103	70, 608	0	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	7	0	C	0	0	190. 00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0	0	C	0	0	192. 00
192. 01	1 19201 FCMC	0	0	C	0		192. 01
192. 02	2 19202 ARGOS MEDICAL CENTER	0	0	C	0		192. 02
	3 19203 AKRON MEDICAL CENTER	0	0	C	0		192. 03
	19300 NONPALD WORKERS	0	0	C	1		193. 00
	07950 ADVERTI SI NG	0	0	155	0	0	194. 00
200.00							200. 00
201.00		0	0	C	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	34, 426	97, 169	35, 258	70, 608	0	202. 00

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 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/26/2022 11:35 am 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 60, 133 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 88, 605 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 3,028 531, 489 531, 489 30.00 03100 INTENSIVE CARE UNIT 0 o 78, 144 31.00 590 78, 144 31.00 04300 NURSERY 0 9, 162 43.00 43.00 143 9, 162 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 10, 461 230, 959 0 230, 959 50.00 05100 RECOVERY ROOM 0 51.00 1,067 128, 542 0 128, 542 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 170 20.904 20, 904 52 00 05300 ANESTHESI OLOGY 53.00 1, 269 4, 902 4, 902 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 19, 176 333, 793 0 333, 793 54.00 06000 LABORATORY 60.00 0 0 16, 946 102, 129 0 0 102, 129 60.00 06500 RESPIRATORY THERAPY 65 00 5,500 118 206 118, 206 65 00 66.00 06600 PHYSI CAL THERAPY 1, 157 84, 343 84, 343 66.00 0 06700 OCCUPATI ONAL THERAPY 503 2, 352 0 67.00 67.00 2.352 0 0 1, 279 68.00 06800 SPEECH PATHOLOGY 285 1, 279 68.00 o 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71 00 C 0 0 o 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 138 5,696 5, 696 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 60, 133 12,813 72, 946 72, 946 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 69, 692 0 69, 692 88 00 0 831 88.01 08801 RURAL HEALTH CLINIC II 0 2, 384 215, 773 0 215, 773 88.01 88 02 08802 RURAL HEALTH CLINIC III 0 1, 458 16, 122 0 16, 122 88 02 0 08803 RURAL HEALTH CLINIC IV 0 292 2.558 2.558 88.03 88.03 08804 RURAL HEALTH CLINIC V 88.04 448 52, 666 52,666 88 04 88.05 08805 RURAL HEALTH CLINIC VI 0 1,639 122, 598 0 122, 598 88.05 0 09100 EMERGENCY 0 91.00 188, 782 91.00 3, 702 188, 782 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 676 141, 361 0 141, 361 93.00 93. 01 04951 SHAFER MEDICAL CENTER 0 2, 138 70, 730 0 70, 730 93.01 04040 INTERNAL MEDICINE 11, 487 791 11, 487 93.02 93.02 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 60, 133 88, 605 2, 616, 615 0 2, 616, 615 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 7 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 12, 539 0 12, 539 192. 00 0 0 192. 01 19201 FCMC 0 192.01 0 C 0 0 192. 02 19202 ARGOS MEDICAL CENTER 0 192. 02 0 0 0 192. 03 19203 AKRON MEDICAL CENTER 0 0 0 0 192.03 193. 00 19300 NONPALD WORKERS 0 o 0 193.00 0 0 194. 00 07950 ADVERTI SI NG 0 0 10. 748 194. 00 10.748

0

88, 605

60, 133

0 200.00

0 201.00

2, 639, 909 202. 00

0

2, 639, 909

0

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-1313

				T	0 12/31/2021	Date/Time Pre 5/26/2022 11:	
			CAPI TAL RE	LATED COSTS		372072022 11.	JJ alli
	Cost Contor Description	BLDG & FIXT	AKRON	ARGOS	CLAYS	EMPLOYEE	
	Cost Center Description	(SQUARE FEET)	BUI LDI NG	BUI LDI NG	BUI LDI NG	BENEFI TS	
		(,	(SQUARE FEET)		(SQUARE FEET)	DEPARTMENT	
						(GROSS	
		1. 00	1. 02	1. 03	1. 04	SALARI ES) 4. 00	
GE	NERAL SERVICE COST CENTERS	1.00	1.02	1.00	1.01	1. 00	
	100 CAP REL COSTS-BLDG & FIXT	108, 844					1.00
	102 AKRON BUILDING	0	3, 500	1			1.02
	103 ARGOS BUILDING 101 CLAYS BUILDING	0	0	7, 500 0	20, 414		1. 03 1. 04
	400 EMPLOYEE BENEFITS DEPARTMENT	0	Ö		0	27, 881, 482	4.00
	500 ADMINISTRATIVE & GENERAL	11, 737	400			3, 585, 682	1
	700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE	10, 592 321	240		4, 657 0	385, 378	1
	900 HOUSEKEEPI NG	1, 213			43	21, 653 345, 911	1
	000 DI ETARY	3, 957	o		0	167, 649	1
	100 CAFETERI A	1, 353		0	0	273, 880	1
	300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY	2, 738	0	0	0	475, 254 0	13. 00 14. 00
	500 PHARMACY	1, 386			0	406, 696	1
	600 MEDICAL RECORDS & LIBRARY	1, 320	0	0	4, 249	370, 224	1
	PATIENT ROUTINE SERVICE COST CENTERS	45.007			٥	4 770 (05	00.00
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	15, 097 2, 058	0			1, 772, 605 390, 224	1
	300 NURSERY	187				400, 044	1
	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM 100 RECOVERY ROOM	8, 127	0			825, 640	1
	200 DELIVERY ROOM & LABOR ROOM	4, 937 807	0		0	450, 985 115, 043	
	300 ANESTHESI OLOGY	137	Ö		Ö	0	1
	400 RADI OLOGY-DI AGNOSTI C	11, 942	0	0	0	1, 761, 780	1
	000 LABORATORY 500 RESPI RATORY THERAPY	2, 623 4, 159	0		0	1, 008, 348 1, 044, 297	1
	600 PHYSI CAL THERAPY	3, 151		0	0	589, 670	
	700 OCCUPATI ONAL THERAPY	0	0	0	0	216, 018	
	800 SPEECH PATHOLOGY	0	0	0	0	102, 649	1
	100 MEDICAL SUPPLIES CHARGED TO PATIENT 200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	1
	300 DRUGS CHARGED TO PATIENTS	0			-	0	1
OU	TPATIENT SERVICE COST CENTERS						
	800 RURAL HEALTH CLINIC 801 RURAL HEALTH CLINIC II	0 7 477	0			829, 101	1
	802 RURAL HEALTH CLINIC III	7, 677		0	0	2, 819, 560 1, 522, 332	
	803 RURAL HEALTH CLINIC IV	Ö	Ö	Ö	Ö	254, 831	1
1	804 RURAL HEALTH CLINIC V	0	2, 860		0	576, 204	1
	805 RURAL HEALTH CLINIC VI 100 EMERGENCY	0 6, 258	0	6, 216 0		1, 647, 429 1, 685, 260	
	200 OBSERVATION BEDS (NON-DISTINCT PART	0, 230			O	1, 003, 200	92.00
93. 00 04	950 WOODLAWN MEDICAL PROFESSIONALS	5, 723	0	0	0	760, 713	1
	951 SHAFER MEDICAL CENTER	0	0		·		
	040 INTERNAL MEDICINE ECIAL PURPOSE COST CENTERS	406	0	0	0	673, 141	93. 02
	300 INTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	107, 906	3, 500	7, 500	20, 414	27, 802, 292	118. 00
	NREI MBURSABLE COST CENTERS				0	0	100.00
	000 GIFT FLOWER COFFEE SHOP & CANTEEN 200 PHYSICIANS PRIVATE OFFICES	0 585					190. 00 192. 00
192. 01 19		0	Ö	Ō	Ö		192. 01
	202 ARGOS MEDICAL CENTER	0	0	0	0		192. 02
	203 AKRON MEDICAL CENTER	0	0	0	0		192.03
1	300 NONPALD WORKERS 950 ADVERTISING	353		0	0		193. 00 194. 00
200.00	Cross Foot Adjustments					,	200.00
201.00	Negative Cost Centers	0.000.1:5	40 ===	400 455	4/4 ===	4 07/ 4:-	201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 320, 119	48, 591	109, 610	161, 589	4, 076, 161	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	21. 316003	13. 883143	14. 614667	7. 915597	0. 146196	203.00
204.00	Cost to be allocated (per Wkst. B,						204. 00
20E 00	Part II)					0.00000	205 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)		l				I

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der C		Peri od:	Worksheet B-1	
		From 01/01/2021 To 12/31/2021			Date/Time Pre 5/26/2022 11:	pared: 35 am	
			CAPITAL REI	_ATED COSTS			
Cost Center Descr	ption	BLDG & FIXT	AKRON	ARGOS	CLAYS	EMPLOYEE	
		(SQUARE FEET)	BUI LDI NG	BUI LDI NG	BUI LDI NG	BENEFITS	
			(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT	
						(GROSS	
						SALARI ES)	
		1. 00	1. 02	1.03	1. 04	4. 00	
207.00 NAHE unit cost mu Parts III and IV)	ltiplier (Wkst. D,						207. 00

| Peri od: | Worksheet B-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

			T	0 12/31/2021	Date/Time Pre 5/26/2022 11:	
Cost Center Description	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (HOURS OF S ERVIC)	33 dili
	5A	5. 00	7. 00	LAUNDR) 8.00	9. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT 1. 02 00102 AKRON BUILDING 1. 03 00103 ARGOS BUILDING 1. 04 00101 CLAYS BUILDING						1. 00 1. 02 1. 03 1. 04
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT	-8, 023, 357 0	3, 030, 319	110, 394			4. 00 5. 00 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0 0	178, 936 630, 504 380, 355	1, 256	1, 459 241 34	150, 135 170	8. 00 9. 00 10. 00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	430, 120	1, 353	0	2, 025 85	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 15. 00 01600 PHARMACY 15. 00 01600 PHARMACY 15. 00 0160	0	4, 651, 845	1, 386	0	0 1, 455	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	1, 415, 011	5, 569	0	450	16. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0	916, 463	2, 058	314 38	37, 898 6, 920	30. 00 31. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	667, 234	187	0	0	43.00
50. 00 05000 0PERATING ROOM 051. 00 05100 RECOVERY ROOM	0			86 106	19, 167 11, 600	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	207, 936 63, 706	137	0	0 0	52.00 53.00 54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0		2, 623	238 0 21	14, 690 5, 715 4, 605	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	946, 203	3, 151	24	3, 190	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0 0			0	0	67. 00 68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0		1	0	0	72.00 73.00
88. 00 08800 RURAL HEALTH CLINIC	0			0	6, 210	88. 00
88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III	0			0	9, 310 0	88. 01 88. 02
88.03 08803 RURAL HEALTH CLINIC IV	Ö	411, 892	0	0	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V 88. 05 08805 RURAL HEALTH CLINIC VI	0 0			0	0	88. 04 88. 05
91. 00 09100 EMERGENCY	0	2, 478, 903			17, 265	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS		204 902	E 722	0	2 100	92. 00 93. 00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.01 04951 SHAFER MEDICAL CENTER	0 0			Ŭ	3, 180 6, 170	
93. 02 04040 I NTERNAL MEDI CI NE SPECI AL PURPOSE COST CENTERS	0	119, 031	406	0	0	93. 02
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-8, 023, 357	47, 538, 764	110, 394	1, 459	150, 105	113.00 118.00
NONREI MBURSABLE COST CENTERS					·	
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS PRIVATE OFFICES	0 0		0	0		190. 00 192. 00
192. 01 19201 FCMC	0		ō	0	0	192. 01
192. 02 19202 ARGOS MEDICAL CENTER 192. 03 19203 AKRON MEDICAL CENTER	0 0	0	0	0		192. 02 192. 03
193. 00 19300 NONPALD WORKERS	0	Ö	ő	0	0	193. 00
194.00 07950 ADVERTISING 200.00 Cross Foot Adjustments	0	557, 744	0	0	0	194. 00 200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)		8, 023, 357			812, 068	
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II)		0. 166775 264, 635	1		5. 408919 34, 426	
205.00 Unit cost multiplier (Wkst. B, Part		0. 005501	2. 650869	5. 947224	0. 229300	205. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Heal th	Financial Systems	WOODLAWN H	OSPI TAL		In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre 5/26/2022 11:	pared:
	Cost Center Description	DI ETARY (PATI ENT DA YS)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	33 aiii
				(DI RECT NRS ING HR)	(COSTED REQUIS.)		
		10. 00	11. 00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT			1			1.00
1. 02 1. 03 1. 04 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00	OO102 AKRON BUILDING OO103 ARGOS BUILDING OO1010 CLAYS BUILDING OO400 EMPLOYEE BENEFITS DEPARTMENT OO500 ADMINISTRATIVE & GENERAL OO700 OPERATION OF PLANT OO8000 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING O11000 DIETARY O11000 CAFETERIA	2, 939 0 0	20, 531 604				1. 02 1. 03 1. 04 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0) c	0	l	14.00
	D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY	0	584 816	1	0	1	1
	INPATIENT ROUTINE SERVICE COST CENTERS	0	010	2,720	0	0	10.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	2, 560 379	2, 547 794				
43.00	04300 NURSERY	0	505			l	
-	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	1, 718		0	0	50.00
	D5100 RECOVERY ROOM	0	713				51.00
	D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESIOLOGY	0	145			1	
	D5400 RADI OLOGY-DI AGNOSTI C	0	2, 904			ő	1
	06000 LABORATORY	0	1, 894	•		1	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	1, 608 924	1	-	1	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	0	252	•	0	0	67.00
	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	123 0		0	0	68. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			•	
	07300 DRUGS CHARGED TO PATIENTS DUTPATIENT SERVICE COST CENTERS	0	0) C	0	100	73.00
	D8800 RURAL HEALTH CLINIC	0	0			l	
	D8801 RURAL HEALTH CLINIC II D8802 RURAL HEALTH CLINIC III	0	2, 205 0		0	l	88. 01 88. 02
	D8803 RURAL HEALTH CLINIC IV	0	0		0	0	88. 03
	D8804 RURAL HEALTH CLINIC V D8805 RURAL HEALTH CLINIC VI	0	0		0	0	88. 04 88. 05
91. 00	D9100 EMERGENCY	0	1, 562	11, 385	0	0	1 / 1. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 WOODLAWN MEDICAL PROFESSIONALS	0	362		0	0	92. 00 93. 00
93. 01	04951 SHAFER MEDICAL CENTER	0	0) c		•	93. 01
	04040 I NTERNAL MEDICINE SPECIAL PURPOSE COST CENTERS	0	181	C	0	0	93.02
113.00	11300 INTEREST EXPENSE				_		113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 939	20, 441	69, 120	0	100	118. 00
190. 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	C		l	190. 00
	19200 PHYSICIANS PRIVATE OFFICES 19201 FCMC	0	0				192. 00 192. 01
192. 02	19202 ARGOS MEDICAL CENTER	0	0	C	0	0	192. 02
	19203 AKRON MEDICAL CENTER 19300 NONPALD WORKERS	0	0		0		192. 03 193. 00
194. 00	07950 ADVERTI SI NG	O	90	o c	Ö	•	194. 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B,	576, 549	556, 140	938, 207	0	5, 495, 721	
203. 00 204. 00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	196. 171827 97, 169	27. 087818 35, 258			54, 957. 210000 60, 133	203. 00 204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	33. 061926	1. 717306	1. 021528	0. 000000	601. 330000	205. 00
206. 00	 NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1313 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 11:35 am 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 BUILDING 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 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 160, 748, 340 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 496, 249 30.00 03100 INTENSIVE CARE UNIT 1,070,247 31.00 31.00 259, 488 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 18, 985, 498 50.00 05100 RECOVERY ROOM 51.00 1, 937, 277 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 308, 192 52 00 05300 ANESTHESI OLOGY 53.00 2, 302, 244 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 34, 746, 361 54.00 06000 LABORATORY 60.00 30, 755, 233 60.00 06500 RESPIRATORY THERAPY 65 00 9, 981, 267 65 00 66.00 06600 PHYSI CAL THERAPY 2, 099, 654 66.00 06700 OCCUPATI ONAL THERAPY 912, 214 67.00 67.00 516, 408 68.00 06800 SPEECH PATHOLOGY 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,064,429 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 23, 254, 788 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1,508,033 88 00 88. 01 08801 RURAL HEALTH CLINIC II 4, 327, 003 88.01 88.02 08802 RURAL HEALTH CLINIC III 2, 646, 125 88 02 08803 RURAL HEALTH CLINIC IV 529, 476 88.03 88.03 08804 RURAL HEALTH CLINIC V 88.04 812, 280 88 04 88.05 08805 RURAL HEALTH CLINIC VI 2, 974, 761 88.05 09100 EMERGENCY 6, 717, 948 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 1, 227, 109 93.00 93. 01 04951 SHAFER MEDICAL CENTER 3, 881, 008 93.01 04040 INTERNAL MEDICINE 93.02 93.02 1, 435, 048 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 160, 748, 340 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 0 192. 01 19201 FCMC 192.01 192. 02 19202 ARGOS MEDICAL CENTER 0 192.02 192. 03 19203 AKRON MEDICAL CENTER 0 192.03 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 ADVERTI SI NG 0 194. 00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 890, 889 202.00 Part I) 203 00 203 00 Unit cost multiplier (Wkst. B, Part I) 0.011763 204.00 Cost to be allocated (per Wkst. B, 88, 605 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000551 205.00 II)206. 00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00

Parts III and IV)

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1313	Period: Worksheet C From 01/01/2021 Part I		

12/31/2021 Date/Time Prepared: To 5/26/2022 11:35 am Title XVIII Hospi tal Cost Costs Total Cost Cost Center Description Therapy Limit Total Costs RCE Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 2.00 4. 00 5. 00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 910, 706 5, 910, 706 0 0 30.00 03100 INTENSIVE CARE UNIT 1, 386, 228 1, 386, 228 0 0 31.00 31.00 43.00 04300 NURSERY 801, 232 801, 232 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 435, 571 4, 435, 571 0 50.00 51.00 05100 RECOVERY ROOM 1, 262, 313 1, 262, 313 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 52.00 52.00 276, 015 276, 015 0 05300 ANESTHESI OLOGY 53.00 105,800 105, 800 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 937, 483 4, 937, 483 0 54.00 60.00 06000 LABORATORY 4, 293, 827 4, 293, 827 0 60.00 06500 RESPIRATORY THERAPY 2, 249, 426 65.00 2, 249, 426 0 65.00 1, 275, 510 66.00 06600 PHYSI CAL THERAPY 1, 275, 510 C 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 317, 798 317, 798 0 67.00 68.00 06800 SPEECH PATHOLOGY 175, 527 175, 527 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 990, 994 990, 994 0 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 769, 267 5, 769, 267 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 1, 908, 572 1, 908, 572 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.01 08801 RURAL HEALTH CLINIC II 5, 385, 474 5, 385, 474 0 88.01 08802 RURAL HEALTH CLINIC III 3, 141, 328 88.02 3, 141, 328 0 0 0 88.02 88 03 08803 RURAL HEALTH CLINIC IV 486, 813 486, 813 Ω 88.03 08804 RURAL HEALTH CLINIC V 88.04 1, 147, 061 1, 147, 061 0 88.04 0 88.05 08805 RURAL HEALTH CLINIC VI 3, 126, 402 3, 126, 402 0 88.05 ol 91.00 09100 EMERGENCY 3, 740, 940 3, 740, 940 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 442, 717 92.00 92.00 1, 442, 717 0 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 685, 382 685, 382 0 0 93.00 04951 SHAFER MEDICAL CENTER 0 93.01 93.01 1, 481, 086 1, 481, 086 0 93.02 04040 INTERNAL MEDICINE 173, 668 173, 668 0 0 93.02 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 56, 907, 140 56, 907, 140 0 200. 00 200.00 Subtotal (see instructions) 0 ol 201.00 1, 442, 717 0 201.00 Less Observation Beds 1, 442, 717 202.00 Total (see instructions) 55, 464, 423 55, 464, 423 0 0 0 202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1313

-			Ti +Lo	XVIII	Hospi tal	Cost	<u>55 diii</u>
			Charges	AVIII	поѕрі таі	COST	
	Cost Center Description	Inpati ent	Outpati ent	Total (ool (Cost or Other	TEFRA	
	cost center bescription	inpatrent	outpatrent		Ratio	Inpatient	
				+ col. 7)	Ratio	Ratio	
		4 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7.00	8.00	9.00	10.00	
30. 00		3, 400, 643		3, 400, 643	,		30.00
31. 00	· · · · · · · · · · · · · · · · · · ·	1, 070, 247		1, 070, 247		I	31.00
	04300 NURSERY	259, 488		259, 488		I	43.00
43.00	ANCILLARY SERVICE COST CENTERS	239, 400		239, 400			43.00
50.00		4, 057, 547	14, 927, 951	18, 985, 498	0. 233629	0. 000000	50.00
51. 00	· · · · · · · · · · · · · · · · · · ·	354, 027	1, 583, 250			0.000000	
51.00						0.000000	
	1	224, 045	84, 147			0.000000	
53. 00 54. 00		283, 085	2, 019, 159				
		1, 242, 823	33, 503, 538			0.000000	
60.00		2, 920, 752	27, 834, 481				
65.00	06500 RESPI RATORY THERAPY	3, 443, 281	6, 537, 986			0. 000000	
66. 00		289, 653	1, 810, 001			0. 000000	
67.00		95, 694	816, 520			0. 000000	
68. 00		24, 280	492, 128				
71. 00		0	0				
72. 00		1, 253, 532	810, 897				
73. 00		5, 067, 247	18, 187, 541	23, 254, 788	0. 248089	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00		0	1, 508, 033			I	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	17	4, 326, 986			I	88. 01
88. 02		0	2, 646, 125			I	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	529, 476			ı	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	812, 280			I	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	2, 974, 761			I	88. 05
91.00		234, 392	6, 483, 556				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	315, 893	1, 779, 713				
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	0	1, 227, 109			0.000000	
93. 01	04951 SHAFER MEDICAL CENTER	0	3, 881, 008	3, 881, 008	0. 381624	0.000000	93. 01
93. 02	04040 I NTERNAL MEDICINE	0	1, 435, 048	1, 435, 048	0. 121019	0. 000000	93. 02
	SPECIAL PURPOSE COST CENTERS						
113.00	0 11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	24, 536, 646	136, 211, 694	160, 748, 340		I	200.00
201.00	Less Observation Beds					I	201.00
202.00	Total (see instructions)	24, 536, 646	136, 211, 694	160, 748, 340)	I	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	From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 11:35 am	

				10 12/31/2021	5/26/2022 11:35 am
-			Title XVIII	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11. 00			
	IPATIENT ROUTINE SERVICE COST CENTERS				
	3000 ADULTS & PEDIATRICS				30.00
	3100 INTENSIVE CARE UNIT				31.00
	1300 NURSERY				43.00
	ICILLARY SERVICE COST CENTERS				
	OOOO OPERATING ROOM	0. 000000			50.00
	5100 RECOVERY ROOM	0. 000000			51.00
	5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
	300 ANESTHESI OLOGY	0. 000000			53.00
	7400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
	5000 LABORATORY	0. 000000			60.00
	5500 RESPI RATORY THERAPY	0. 000000			65.00
	6600 PHYSI CAL THERAPY	0. 000000			66.00
	5700 OCCUPATI ONAL THERAPY	0. 000000			67.00
	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
	ITPATIENT SERVICE COST CENTERS				
	8800 RURAL HEALTH CLINIC				88. 00
	RURAL HEALTH CLINIC II				88. 01
	8802 RURAL HEALTH CLINIC III				88. 02
	8803 RURAL HEALTH CLINIC IV				88. 03
	8804 RURAL HEALTH CLINIC V				88. 04
	8805 RURAL HEALTH CLINIC VI				88. 05
	2100 EMERGENCY	0. 000000			91. 00
	2200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
	1950 WOODLAWN MEDICAL PROFESSIONALS	0. 000000			93. 00
	1951 SHAFER MEDI CAL CENTER	0. 000000			93. 01
	1040 I NTERNAL MEDI CI NE	0. 000000			93. 02
	PECIAL PURPOSE COST CENTERS				110.00
4	300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201. 00
202. 00	Total (see instructions)	1			202.00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1313	Peri od: From 01/01/2021	Worksheet C Part I	

12/31/2021 Date/Time Prepared: To 5/26/2022 11:35 am 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, 910, 706 5, 910, 706 5, 910, 706 30.00 03100 INTENSIVE CARE UNIT 1, 386, 228 1, 386, 228 0 1, 386, 228 31.00 31.00 43.00 04300 NURSERY 801, 232 801, 232 0 801, 232 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 435, 571 4, 435, 571 4, 435, 571 50.00 51.00 05100 RECOVERY ROOM 1, 262, 313 1, 262, 313 0 1, 262, 313 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 276, 015 276, 015 276, 015 52.00 05300 ANESTHESI OLOGY 53.00 105,800 105, 800 105, 800 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 937, 483 4, 937, 483 0 4, 937, 483 54.00 60.00 06000 LABORATORY 4, 293, 827 4, 293, 827 0 0 4, 293, 827 60.00 06500 RESPIRATORY THERAPY 2, 249, 426 2, 249, 426 65.00 2, 249, 426 65.00 1, 275, 510 66.00 06600 PHYSI CAL THERAPY 1, 275, 510 C 1, 275, 510 66.00 67.00 06700 OCCUPATIONAL THERAPY 317, 798 317, 798 0 317, 798 67.00 0 68.00 06800 SPEECH PATHOLOGY 175, 527 175, 527 175, 527 68.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 0 Ω 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 990, 994 990, 994 0 990, 994 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 769, 267 5, 769, 267 0 73.00 5, 769, 267 73.00 OUTPATIENT SERVICE COST CENTERS 1, 908, 572 1, 908, 572 88.00 08800 RURAL HEALTH CLINIC 1, 908, 572 0 88.00 88.01 08801 RURAL HEALTH CLINIC II 5, 385, 474 5, 385, 474 0 5, 385, 474 88.01 3, 141, 328 3, 141, 328 o 88.02 08802 RURAL HEALTH CLINIC III 3, 141, 328 88.02 0 88 03 08803 RURAL HEALTH CLINIC IV 486, 813 486, 813 486, 813 88 03 08804 RURAL HEALTH CLINIC V 0 88.04 1, 147, 061 1, 147, 061 1, 147, 061 88.04 88.05 08805 RURAL HEALTH CLINIC VI 3, 126, 402 3, 126, 402 0 3, 126, 402 88.05 91.00 09100 EMERGENCY 3, 740, 940 3, 740, 940 ol 3, 740, 940 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 442, 717 92.00 1, 442, 717 1, 442, 717 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 685, 382 685, 382 685, 382 93.00 04951 SHAFER MEDICAL CENTER 93.01 1, 481, 086 1, 481, 086 0 1, 481, 086 93.01 93.02 04040 INTERNAL MEDICINE 173, 668 173, 668 0 173, 668 93.02 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 56, 907, 140 200. 00 200.00 Subtotal (see instructions) 56, 907, 140 0 56, 907, 140 ol 201.00 1, 442, 717 201. 00 Less Observation Beds 1, 442, 717 1, 442, 717 202.00 Total (see instructions) 55, 464, 423 0 55, 464, 423 0 55, 464, 423 202. 00

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/26/2022 11:35 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 400, 643 3, 400, 643 30.00 31.00 03100 INTENSIVE CARE UNIT 1,070,247 1,070,247 31.00 04300 NURSERY 259, 488 259, 488 43.00 43.00 ANCILLARY SERVICE COST CENTERS 4, 057, 547 50.00 14, 927, 951 18, 985, 498 0 233629 0.000000 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 354, 027 1, 583, 250 1, 937, 277 0.651591 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 224, 045 84, 147 308, 192 0.895594 0.000000 52.00 05300 ANESTHESI OLOGY 2,019,159 0.045955 283.085 2.302.244 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 1, 242, 823 33, 503, 538 34, 746, 361 0.142101 54 00 60.00 06000 LABORATORY 2, 920, 752 27, 834, 481 30, 755, 233 0.139613 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 3, 443, 281 6, 537, 986 9, 981, 267 0. 225365 0.000000 65.00 06600 PHYSI CAL THERAPY 2, 099, 654 0.607486 66.00 289, 653 1,810,001 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 95, 694 816, 520 912, 214 0.348381 0.000000 67.00 06800 SPEECH PATHOLOGY 0.339900 68.00 24, 280 492, 128 516, 408 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.000000 0.000000 71.00 0 C 07200 IMPL. DEV. CHARGED TO PATIENTS 810, 897 2, 064, 429 72 00 1, 253, 532 0.480033 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 5, 067, 247 23, 254, 788 0.248089 73.00 18, 187, 541 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 1,508,033 1,508,033 1.265604 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 17 4, 326, 986 4, 327, 003 1. 244620 0.000000 88.01 88.02 08802 RURAL HEALTH CLINIC III 0 2, 646, 125 2, 646, 125 1.187143 0.000000 88.02 08803 RURAL HEALTH CLINIC IV 0 529, 476 529, 476 0. 919424 0.000000 88.03 88.03 08804 RURAL HEALTH CLINIC V 88 04 0 812, 280 812, 280 1.412150 0.000000 88 04 88.05 08805 RURAL HEALTH CLINIC VI 0 2, 974, 761 2, 974, 761 1.050976 0.000000 88.05 09100 EMERGENCY 6, 483, 556 6, 717, 948 0. 556858 91.00 234, 392 0.000000 91.00 1, 779, 713 09200 OBSERVATION BEDS (NON-DISTINCT PART 315.893 2,095,606 0.688449 0.000000 92.00 92.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.558534 93.00 0 1, 227, 109 1, 227, 109 0.000000 93.00 93.01 04951 SHAFER MEDICAL CENTER 0 3, 881, 008 3, 881, 008 0.381624 0.000000 93.01

0

24, 536, 646

24, 536, 646

1, 435, 048

136, 211, 694

136, 211, 694

1, 435, 048

160, 748, 340

160, 748, 340

0.121019

0.000000

93.02

113.00

200.00

201.00

202.00

04040 INTERNAL MEDICINE

113.00 11300 INTEREST EXPENSE

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

93.02

200.00

201.00

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: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 11:35 am	

				10 12/31/2021	Date/IIMe Prep 5/26/2022 11:3	oared: 85 am
			Title XIX	Hospi tal	Cost	, , , , , , , , , , , , , , , , , , ,
Cost Center Des	scription	PPS Inpatient				
		Ratio				
		11. 00				
INPATIENT ROUTINE SE						
30. 00 03000 ADULTS & PEDIA						30.00
31. 00 03100 I NTENSI VE CARE	UNI T					31.00
43. 00 04300 NURSERY						43.00
ANCILLARY SERVICE CO	ST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 000000				50.00
51.00 05100 RECOVERY ROOM		0. 000000				51.00
52. 00 05200 DELIVERY ROOM 8	& LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY		0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGI	NOSTIC	0. 000000				54.00
60. 00 06000 LABORATORY		0. 000000				60.00
65. 00 06500 RESPI RATORY THI		0. 000000				65.00
66. 00 06600 PHYSI CAL THERAI		0. 000000				66.00
67. 00 06700 0CCUPATI ONAL TI		0. 000000				67. 00
68. 00 06800 SPEECH PATHOLO		0. 000000				68.00
71. 00 07100 MEDI CAL SUPPLI I		0. 000000				71. 00
72. 00 07200 I MPL. DEV. CHAI		0. 000000				72.00
73. 00 07300 DRUGS CHARGED		0. 000000				73.00
OUTPATIENT SERVICE C		1				
88. 00 08800 RURAL HEALTH CI		0. 000000				88. 00
88. 01 08801 RURAL HEALTH CI		0. 000000				88. 01
88. 02 08802 RURAL HEALTH CI		0. 000000				88. 02
88. 03 08803 RURAL HEALTH CI		0. 000000				88. 03
88. 04 08804 RURAL HEALTH CI		0. 000000				88. 04
88. 05 08805 RURAL HEALTH CI	LINIC VI	0. 000000				88. 05
91. 00 09100 EMERGENCY		0. 000000				91.00
92. 00 09200 0BSERVATI ON BEI		0. 000000				92.00
93. 00 04950 WOODLAWN MEDICA		0. 000000				93.00
93. 01 04951 SHAFER MEDI CAL		0. 000000				93. 01
93. 02 04040 I NTERNAL MEDI C		0. 000000				93. 02
SPECIAL PURPOSE COST						110 00
113. 00 11300 INTEREST EXPENS						113.00
200.00 Subtotal (see	,					200. 00 201. 00
201.00 Less Observation						
202.00 Total (see ins	tructions)	1			-	202. 00

Health Financial Systems WOODLAWN HOSPITAL					In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	Provider CCN: 15-1313		Peri od:	Worksheet D			
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narad:	
				10 12/31/2021	5/26/2022 11:	pareu. 35 am	
			XVIII	Hospi tal	Cost		
Cost Center Description		Total Charges			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	1						
50. 00 05000 OPERATI NG ROOM	230, 959	18, 985, 498					
51. 00 05100 RECOVERY ROOM	128, 542	1, 937, 277			5, 673		
52. 00 05200 DELI VERY ROOM & LABOR ROOM	20, 904	308, 192			257	52.00	
53. 00 05300 ANESTHESI OLOGY	4, 902	2, 302, 244			175		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	333, 793	34, 746, 361					
60. 00 06000 LABORATORY	102, 129	30, 755, 233			2, 950		
65. 00 06500 RESPIRATORY THERAPY	118, 206	9, 981, 267			13, 569	65.00	
66. 00 06600 PHYSI CAL THERAPY	84, 343	2, 099, 654				66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 352	912, 214			83	67.00	
68. 00 06800 SPEECH PATHOLOGY	1, 279				30	68.00	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71.00	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 696	2, 064, 429		·		72.00	
73. 00 07300 DRUGS CHARGED TO PATIENTS	72, 946	23, 254, 788	0. 00313	7 1, 312, 241	4, 117	73.00	
OUTPATIENT SERVICE COST CENTERS	(0.400	4 500 000	0.04/04	4 0		00.00	
88. 00 08800 RURAL HEALTH CLINIC	69, 692	1, 508, 033			0	00.00	
88.01 08801 RURAL HEALTH CLINIC II 88.02 08802 RURAL HEALTH CLINIC III	215, 773	4, 327, 003			0	88. 01 88. 02	
88. 03 08803 RURAL HEALTH CLINIC IV	16, 122 2, 558	2, 646, 125 529, 476			0	88. 02	
88. 04 08804 RURAL HEALTH CLINIC TV					0	88. 04	
88. 05 08805 RURAL HEALTH CLINIC V	52, 666	812, 280 2, 974, 761			0	88. 05	
91. 00 09100 EMERGENCY	122, 598 188, 782	2, 974, 761 6, 717, 948			88	91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	129, 729	2, 095, 606			2, 485		
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	129, 729	1, 227, 109			2, 485	93.00	
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 93. 01 04951 SHAFER MEDICAL CENTER	70, 730	3, 881, 008			0	93.00	
93. 02 04040 INTERNAL MEDICINE	11, 487	1, 435, 048			0	93.01	
200.00 Total (lines 50 through 199)	2, 127, 549			5, 694, 561	•		
200.00 10tal (111163 30 till ough 177)	2, 127, 347	130,017,702	I	3, 074, 301	55, 176	1200.00	

Health Financial Systems		WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10		
	ADDODEL ONMENT OF LANDATI ENT COLUMN THE ENT	ANCILLIADY SERVICE OTHER DASS Drovi don CCN: 15 1212	Dari ad. Waskahaat D		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Peri od: From 01/01/2021 To 12/31/2021 Worksheet D Part IV THROUGH COSTS Date/Time Prepared: 5/26/2022 11:35 am Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st Program Post-Stepdown Program Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0 0 0 000000000000 0 0 51.00 05100 RECOVERY ROOM 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 0 0 60.00 06000 LABORATORY 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0 66.00 0 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 0 72.00 0 0 72.00

07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0 0 88.01 08801 RURAL HEALTH CLINIC II 0 88.01 0 88.02 08802 RURAL HEALTH CLINIC III 0 0 88.02 08803 RURAL HEALTH CLINIC IV 0 0 0 88.03 88.03 0 0 0 0 08804 RURAL HEALTH CLINIC V 0 88.04 88.04 0 0 08805 RURAL HEALTH CLINIC VI 0 88.05 0 88.05 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 0 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 0 0 Ω 93.00 0 04951 SHAFER MEDICAL CENTER 0 93.01 93.01 0 93. 02 04040 INTERNAL MEDICINE 0 0 93.02 0 200.00 200.00 Total (lines 50 through 199)

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 01/01/2021 To 12/31/2021 Part IV THROUGH COSTS Date/Time Prepared: 5/26/2022 11:35 am Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges (sum of cols. to Charges Medi cal 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 18, 985, 498 0.000000 50.00 05100 RECOVERY ROOM 0 0 1, 937, 277 0.000000 51.00 51.00 00000000000 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 308, 192 05300 ANESTHESI OLOGY 0 0 2, 302, 244 53.00 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 34, 746, 361 0.000000 54.00 60.00 06000 LABORATORY 0 30, 755, 233 0.000000 60.00 9, 981, 267 06500 RESPIRATORY THERAPY 65.00 0 0 0.000000 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 2, 099, 654 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 912, 214 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 516, 408 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, 064, 429 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 23, 254, 788 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 1, 508, 033 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 0 0 4, 327, 003 0.000000 88.01 08802 RURAL HEALTH CLINIC III 88.02 0000000000 0 0 2, 646, 125 0.000000 88.02 08803 RURAL HEALTH CLINIC IV 0 0 529, 476 0.000000 88 03 88 03 0 88.04 08804 RURAL HEALTH CLINIC V 0 812, 280 0.000000 88.04 88.05 08805 RURAL HEALTH CLINIC VI 2, 974, 761 0.000000 88.05 0 91.00 09100 EMERGENCY 6, 717, 948 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 0 0 2, 095, 606 0.000000 92.00

0

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1, 227, 109

3, 881, 008

1, 435, 048

156, 017, 962

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0.000000

0.000000

0.000000

93.00

93.01

93.02

200.00

93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS

Total (lines 50 through 199)

04951 SHAFER MEDICAL CENTER

93. 02 | 04040 | I NTERNAL MEDICINE

93.01

200.00

Health Financial Systems	WOODLAWN HOSPITAL		In Lieu of Form CMS-2552-10		
ADDODEL ONMENT OF LAIDATIENT (OUTDATIENT	ANOLLI ADV. CEDVILOE OTHER DACC	D 1 L . OON 45 4040	D	Wasalsalaa - + D	

Period: From 01/01/2021 To 12/31/2021 Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Date/Time Prepared: 5/26/2022 11:35 am Title XVIII Hospi tal Cost Outpati ent Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Charges Pass-Through Charges Pass-Through (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col. 10) x col. 12) 13.00 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 50 00 05000 OPERATING ROOM 1, 188, 208 0 51.00 05100 RECOVERY ROOM 0.000000 85, 501 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 3, 784 0 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 0.000000 82, 271 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.000000 408, 863 0 54.00 60.00 06000 LABORATORY 0.000000 888, 147 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 1, 145, 707 0 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.000000 107, 159 0 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 32, 116 0 67.00 06800 SPEECH PATHOLOGY 0.000000 12, 122 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 385, 150 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1, 312, 241 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II 0.000000 C 0 88.01 08802 RURAL HEALTH CLINIC III 0.000000 0 0 88.02 88.02 0 0 0 0 0 0 0 0 08803 RURAL HEALTH CLINIC IV 0.000000 88.03 88.03 0 0 0 08804 RURAL HEALTH CLINIC V 88.04 0.000000 0 0 88.04 88.05 08805 RURAL HEALTH CLINIC VI 0.000000 C 0 88.05 09100 EMERGENCY 0 91.00 0.000000 3, 144 0 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 40, 148 Ω 92.00 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.000000 0 93.00 C 0 93. 01 04951 SHAFER MEDICAL CENTER 0.000000 0 93.01 93. 02 04040 INTERNAL MEDICINE 0 0 93.02 0.000000 0

5, 694, 561

0

0 200.00

200.00

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 01/01/2021 Part V 12/31/2021 Date/Time Prepared: 5/26/2022 11:35 am 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. Ded. & Coins. Part I, col. 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, 057, 020 50.00 0. 233629 05100 RECOVERY ROOM 0 0.651591 175, 585 51.00 51.00 0 0 0. 895594 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1, 160 0 52.00 53.00 05300 ANESTHESI OLOGY 0.045955 341, 681 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.142101 7, 437, 854 0 54.00 06000 LABORATORY 60.00 0.139613 5, 885, 082 0 60.00 06500 RESPIRATORY THERAPY 65.00 0. 225365 0 1, 654, 153 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.607486 487, 877 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.348381 0 258, 481 0 67.00 06800 SPEECH PATHOLOGY 0.339900 0 68.00 68.00 10, 529 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 480033 115, 714 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 248089 5, 649, 946 73.00 73 00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88.01 08802 RURAL HEALTH CLINIC III 88 02 88 02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 08804 RURAL HEALTH CLINIC V 88.04 88.04 08805 RURAL HEALTH CLINIC VI 88.05 88.05 09100 EMERGENCY 91 00 0.556858 1, 123, 936 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.688449 342, 186 1,800 0 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.558534 0 93.00 0 04951 SHAFER MEDICAL CENTER 0. 381624 93.01 93.01 0 0 0 93. 02 | 04040 | I NTERNAL MEDICINE 0.121019 0 93.02 Ω 200.00 Subtotal (see instructions) 0 25, 541, 204 1,800 0 200.00

0

25, 541, 204

1, 800

201.00

0 202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Health Financial Systems	WOODLAWN HOSI	PITAL	In Lieu	of Form CMS-2552-10
APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1313	Peri od: From 01/01/2021	Worksheet D Part V

12/31/2021 Part / Date/Time Prepared: 5/26/2022 11:35 am Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 480, 580 50.00 05100 RECOVERY ROOM 114, 410 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 1,039 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 15, 702 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 056, 926 54.00 60.00 06000 LABORATORY 0 821, 634 60.00 06500 RESPIRATORY THERAPY 0 65.00 372, 788 65.00 66.00 06600 PHYSI CAL THERAPY 296, 378 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 90,050 67.00 06800 SPEECH PATHOLOGY 3, 579 0 68.00 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 55, 547 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73 00 1, 401, 689 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88.01 08802 RURAL HEALTH CLINIC III 88. 02 88 02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 88.04 08804 RURAL HEALTH CLINIC V 88.04 08805 RURAL HEALTH CLINIC VI 88.05 88.05 91 00 09100 EMERGENCY 625, 873 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 235, 578 1, 239 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.00 93. 01 04951 SHAFER MEDICAL CENTER 93.01 0 0 93. 02 | 04040 | I NTERNAL MEDICINE 93.02 200.00 Subtotal (see instructions) 5, 571, 773 1, 239 200.00 Less PBP Clinic Lab. Services-Program

5, 571, 773

1, 239

201.00

202.00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Syst	ems WO	ODLAWN HOSE	PLTAL	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATI	ENT OPERATING COST		Provider CCN: 15-1313	Peri od: From 01/01/2021	Worksheet D-1		
				To 12/31/2021	Date/Time Prep 5/26/2022 11:3		
			Title XVIII	Hospi tal	Cost		
Cost Cent	er Description						
	·				1. 00		
PART I - ALL PI	ROVI DER COMPONENTS						
INPATIENT DAYS							
1.00 Inpatient days	(including private room days and swi	ng-bed days	s, excluding newborn)		3, 237	1.00	

1. 00 2. 00 3. 00 4. 00 5. 00	Cost Center Description PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	1.00	
1. 00 2. 00 3. 00 4. 00 5. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 237	
1. 00 2. 00 3. 00 4. 00 5. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 237	
2. 00 3. 00 4. 00 5. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 23/	1 .
3. 00 4. 00 5. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 112	1. C
1. 00 5. 00 6. 00	do not complete this line.	0	3. 0
5. 00	Semi-private room days (excluding swing-bed and observation bed days)	2, 329	4.0
	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	92	
	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.0
	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	33	7.0
	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.0
	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	815	9. (
	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	92	10.0
	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.0
	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.0
	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	
	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0	
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	
7. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.
	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.
	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216. 95	19.
0.00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216. 95	20.
1.00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	5, 910, 706 0	21. 22.
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.
4. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	7, 159	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.
- 1	Total swing-bed cost (see instructions)	176, 675	26.
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	5, 734, 031	27.
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
- 1	Private room charges (excluding swing-bed charges)	0	
1	Semi-private room charges (excluding swing-bed charges)	0	•
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	•
1	Average private room per diem charge (line 29 ÷ line 3)	0.00	
1	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	•
. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.
5. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.
. 00	Private room cost differential adjustment (line 3 x line 35)	0	36
. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5, 734, 031	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM I NPATI ENT OPERATI NG COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 040 5	1 00
- 1	Adjusted general inpatient routine service cost per diem (see instructions)	1, 842. 56	
	Program general inpatient routine service cost (line 9 x line 38) Medically processary private room cost applicable to the Program (line 14 x line 35)	1, 501, 686	
	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 1, 501, 686	40. 41

	Financial Systems	WOODLAWN HO				u of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST		Provi der CC	F	Period: From 01/01/2021	Worksheet D-1	
					To 12/31/2021	Date/Time Pre 5/26/2022 11:	pared: 35 am_
	Cost Center Description	Total	Ti tl e Total	XVIII Average Per	Hospital Program Days	Cost Program Cost	
		I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		1.00	Days 2. 00	÷ col. 2) 3.00	4. 00	col . 4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0. 00	0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 386, 228	379	3, 657. 59	120	438, 911	43.00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44.00
45. 00 46. 00							45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			>		1, 401, 017	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	see instruction	ons)		3, 341, 614	49. 00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sum	of Parts I and	0	50. 00
51. 00		atient ancillary	/ services (fr	om Wkst. D, s	um of Parts II	О	51.00
F2 00	and IV)	FO F1)	•				F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-phy	ysician anesth	etist, and	0	
	medical education costs (line 49 minus line	52)		,	·		
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	ı
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions)	norting ported a	andina 1004 .	undated and a	maguaded by the	0	
59.00	Lesser of lines 53/54 or 55 from the cost re market basket	portring period e	endring 1996, t	updated and co	ilipounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
61.00	which operating costs (line 53) are less tha	n expected costs					81.00
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)							62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	nber 31 of the	e cost reporti	ng period (See	169, 516	64 00
	instructions)(title XVIII only)	Ü		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	55)(title XVII	I only). For	169, 516	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	porting period	0	67. 00
40.00	(line 12 x line 19)	a accta often Da	noombor 21 of	the east rand	nting ported		40.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after be	ecember 31 of	the cost repo	rting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70.00	Skilled nursing facility/other nursing facil						70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic	abĺe to Program	•	•			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			art II column		74. 00 75. 00
	26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minu	,		4-3			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	, ,		,	us line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
82. 00 83. 00	Reasonable inpatient routine service costs (see instructions					83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ne)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	•					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					783	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 842. 55	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 442, 717	89.00

Health Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
			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	531, 489	5, 910, 706	0. 08992	0 1, 442, 717	129, 729	90.00
91.00 Nursing Program cost	0	5, 910, 706	0.00000	0 1, 442, 717	0	91.00
92.00 Allied health cost	0	5, 910, 706	0.00000	0 1, 442, 717	0	92.00
93.00 All other Medical Education	0	5, 910, 706	0. 00000	0 1, 442, 717	0	93. 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: From 01/01/2021	Worksheet D-1			
		To 12/31/2021	Date/Time Pre 5/26/2022 11:	pared: 35 am		
	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 da	1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 3,237					
2 00 Innatient days (including private room da	ave excluding swing-hed and newhorn days)		3 112	2 00		

	Cost Contar Decement on	LOST	
	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, 237	1
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 112 0	
	do not complete this line.		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	2, 329 92	
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	33	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	46	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15.00	Total nursery days (title V or XIX only)	311	1
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT	0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216. 95	19.00
20. 00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	216. 95	20.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	5, 910, 706 0	1
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	7, 159	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	176, 675 5, 734, 031	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	5, 734, 031	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	1
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	1
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	1
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	1
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		ł
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 842. 56	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	84, 758	1
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	84, 758	41.00

	Financial Systems	WOODLAWN H				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2021	Worksheet D-1	
				1	o 12/31/2021	Date/Time Pre 5/26/2022 11:	
			_	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42 00	NURSERY (title V & XIX only)	1. 00 801, 232	2. 00	3. 00 2, 576. 31	4. 00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units		311	2,370.3	0		1 42.00
43. 00 44. 00	INTENSIVE CARE UNIT	1, 386, 228	379	3, 657. 59	0	0	
45.00	BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	<u> </u>					1. 00	
48.00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			one)		55, 582 140, 340	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 (111 Ough 46) (see mstructri	JIIS)		140, 340	49.00
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sum	of Parts I and	0	50.00
51. 00	<pre> </pre>	atient ancillar	v services (f	rom Wkst. D. s	um of Parts II	0	51.00
	and IV)		J (
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non-nh	usician anosth	atist and	0	
55.00	medical education costs (line 49 minus line		rated, non-pri	ysi ci aii allestii	etist, and		33.00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	line 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, i	updated and co	mpounded by the		
60. 00	market basket	cost report un	dated by the i	markat haskat		0.00	60.00
	50.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 51.00 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) 62.00 Relief payment (see instructions)							62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	na period (See	0	64.00
.	instructions)(title XVIII only)	· ·		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reporting	period (See	0	65.00
66.00	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	e costs through	December 31 (nf the cost re	norting period	0	67.00
07.00	(line 12 x line 19)	o .					
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service c	•		• •			71.00
72.00	Program routine service cost (line 9 x line	,	(line 14 v li	ino 3E)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv		7				73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient	,			art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi der recor	46)			78. 00 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		,				81. 00 82. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82.00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			783 1, 842. 55	1
	Observation bed cost (line 87 x line 88) (se					1, 442, 717	

Health Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
			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	531, 489	5, 910, 706	0. 08992	0 1, 442, 717	129, 729	90.00
91.00 Nursing Program cost	0	5, 910, 706	0.00000	0 1, 442, 717	0	91.00
92.00 Allied health cost	0	5, 910, 706	0.00000	0 1, 442, 717	0	92.00
93.00 All other Medical Education	0	5, 910, 706	0. 00000	1, 442, 717	0	93. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1313	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Pre 5/26/2022 11:	pared:
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
INDATIENT DOUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			1, 112, 934	I	30.00
31. 00 03100 ADDETS & PEDIATRICS			344, 060		31.00
43. 00 04300 NURSERY			·		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 0PERATING ROOM		0. 23362			
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 65159 0. 89559		55, 712 3, 389	
53. 00 05200 DELI VERY ROUM & LABOR ROUM 53. 00 05300 ANESTHESI OLOGY		0. 89559		3, 389	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14210			
60. 00 06000 LABORATORY		0. 13961	·	123, 997	1
65. 00 06500 RESPIRATORY THERAPY		0. 22536			
66.00 06600 PHYSI CAL THERAPY		0. 60748	107, 159	65, 098	66.0
67. 00 06700 OCCUPATI ONAL THERAPY		0. 34838		11, 189	67.0
58. 00 06800 SPEECH PATHOLOGY		0. 33990	·	4, 120	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000		0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 48003			
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 24808	1, 312, 241	325, 553	73.0
B8. 00 08800 RURAL HEALTH CLINIC		0.00000	00	Ο	88. 0
B8. 01 08801 RURAL HEALTH CLINIC II		0.00000		l o	
38. 02 08802 RURAL HEALTH CLINIC III		0.00000		0	88. 0
38.03 08803 RURAL HEALTH CLINIC IV		0.00000	00	0	88. C
38.04 08804 RURAL HEALTH CLINIC V		0.00000	00	0	88.0
38. 05 08805 RURAL HEALTH CLINIC VI		0.00000		0	1
91. 00 09100 EMERGENCY		0. 55685	·		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 68844			
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS		0. 55853		-	
93. 01 04951 SHAFER MEDICAL CENTER		0. 38162		0	
93.02 04040 INTERNAL MEDICINE 200.00 Total (sum of lines 50 through 94 and 96	through 00)	0. 12101		0 1, 401, 017	
201.00 Less PBP Clinic Laboratory Services-Progr			5, 694, 561	1, 401, 017	200. 0
Net charges (line 200 minus line 201)	am only charges (Title 01)	1	5, 694, 561	l	201. 0

ealth Financial Systems NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	WOODLAWN HOSPITAL Provider 0	CN: 15-1313	Peri od:	u of Form CMS-: Worksheet D-3	
THE PROPERTY OF THE PROPERTY O			From 01/01/2021		
	Component	CCN: 15-Z313	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
	Title	e XVIII	Swing Beds - SNF		JJ all
Cost Center Description		Ratio of Cos		Inpatient	
·		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
0.00 03000 ADULTS & PEDIATRICS		1			30.
1. 00 03100 NTENSI VE CARE UNI T					31.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS					1
0. 00 05000 OPERATING ROOM		0. 23362	29 408	95	50.
1.00 05100 RECOVERY ROOM		0. 65159	91 2	1	51.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 89559		1	1
3. 00 05300 ANESTHESI OLOGY		0. 04595			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14210			
0. 00 06000 LABORATORY		0. 13961			
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY		0. 2253 <i>6</i> 0. 60748		3, 112 19, 461	65. 66.
7. 00 06700 OCCUPATI ONAL THERAPY		0. 34838		6, 118	
8. 00 06800 SPEECH PATHOLOGY		0. 33990		l '	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000		· -	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 48003		l	1
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 24808	31, 022	7, 696	73.
OUTPATIENT SERVICE COST CENTERS					
8.00 08800 RURAL HEALTH CLINIC		0.00000		0	
3. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	
3. 02 08802 RURAL HEALTH CLINIC		0.00000		0	
B. 03 08803 RURAL HEALTH CLINIC IV B. 04 08804 RURAL HEALTH CLINIC V		0.00000		0	88. 88.
8.05 08805 RURAL HEALTH CLINIC V		0.00000			
1.00 09100 EMERGENCY		0. 55685		2	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 68844		l	
3. 00 04950 WOODLAWN MEDICAL PROFESSIONALS		0. 55853		l	
3. 01 04951 SHAFER MEDI CAL CENTER		0. 38162			
3. 02 04040 I NTERNAL MEDI CI NE		0. 12101			1
00.00 Total (sum of lines 50 through 94 and 96			114, 270	39, 262	200.
201.00 Less PBP Clinic Laboratory Services-Prog	gram only charges (line 61)		0		201.
Net charges (line 200 minus line 201)		1	114, 270		202.

		DDLAWN HOSPITAL	ON 45 4040		u of Form CMS-2	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
					col . 2)	
	LABORT FAT DOUTLAS OFFICE OF COOT OFFITEDO		1.00	2. 00	3. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			F4 400		00.00
30.00	03000 ADULTS & PEDIATRICS			51, 199		30.00
31.00	03100 INTENSIVE CARE UNIT			11, 382		31.00
43. 00	04300 NURSERY			23, 731		43.00
F0 00	ANCILLARY SERVICE COST CENTERS		0.00040	50.040	40.450	F0 00
	05000 OPERATING ROOM		0. 23362		12, 159	
	05100 RECOVERY ROOM		0. 65159		3, 435	1
	05200 DELIVERY ROOM & LABOR ROOM		0. 89559			
53.00	05300 ANESTHESI OLOGY		0. 04595			
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 14210		1, 837	54.00
60.00	06000 LABORATORY		0. 13961		5, 544	1
65.00	06500 RESPI RATORY THERAPY		0. 22536		5, 863	1
66. 00	06600 PHYSI CAL THERAPY		0. 60748		602	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 34838		98	67.00
68. 00	06800 SPEECH PATHOLOGY		0. 33990		24	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 00000		0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 48003		1, 100	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 24808	9 50, 493	12, 527	73.00
	OUTPATIENT SERVICE COST CENTERS			_		
	08800 RURAL HEALTH CLINIC		1. 26560		0	
88. 01	08801 RURAL HEALTH CLINIC II		1. 24462		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III		1. 18714		0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV		0. 91942		0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V		1. 41215		0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI		1. 05097		0	88. 05
91.00	09100 EMERGENCY		0. 55685	9, 866	5, 494	91.00

0. 688449

0. 558534 0. 381624

0. 121019

93.00

93.01 0

0 92.00

0 93.02

55, 582 200. 00 201. 00 202. 00

92.00 09200 OBSERVATION 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

93.02 04040 INTERNAL MEDICINE
200.00 Total (sum of line
Less PBP Clinic La

202.00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	5/26/2022 11: Cost	35 am
		ΠΕΙΘΑΝΙΙΙ	nospi tai		
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			5, 573, 012	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions	ıs)		0, 0, 0, 0, 0	1
3. 00	OPPS payments	,		0	
4. 00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)	una)		0 000	1
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	ns)		0.000	1
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	
	Organ acqui si ti ons			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			5, 573, 012	11.00
	Reasonable charges				1
12. 00	Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15 00	Customary charges			0	1 1 5 00
	Aggregate amount actually collected from patients liable for paym Amounts that would have been realized from patients liable for pa			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	yment for services c	on a chargebasi's	0	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
	Total customary charges (see instructions)			0	
19. 00	Excess of customary charges over reasonable cost (complete only i	f line 18 exceeds li	ne 11) (see	0	19.00
20. 00	instructions) Figure of responsible cost over sustanary charges (complete only in	flino 11 ovecode li	no 10) (coo	0	20.00
20.00	Excess of reasonable cost over customary charges (complete only instructions)	i iiile ii exceeus ii	ne ro) (see	U	20.00
21. 00	Lesser of cost or charges (see instructions)			5, 628, 742	21.00
22. 00	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instructi	i ons)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			71, 366	25. 00
	Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see instr	ructions)	3, 942, 762	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			1, 614, 614	
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 1, 614, 614	
	Primary payer payments			265	1
	Subtotal (line 30 minus line 31)			1, 614, 349	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			342, 138 222, 390	
	Allowable bad debts for dual eligible beneficiaries (see instructi	ions)		282, 053	
37. 00	Subtotal (see instructions)	,		1, 836, 739	1
38. 00	MSP-LCC reconciliation amount from PS&R			0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced (devices (see instru	ctions)	0	1
	RECOVERY OF ACCELERATED DEPRECIATION	devices (see mistrae	2013)	Ö	1
	Subtotal (see instructions)			1, 836, 739	
	Sequestration adjustment (see instructions)			0	1
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs			2 571 510	40.03
	Interim payments Interim payments-PARHM			2, 571, 510	41.00
	Tentative settlement (for contractors use only)			0	1
	Tentative settlement-PARHM (for contractor use only)				42. 01
	Balance due provider/program (see instructions)			-734, 771	
	Balance due provider/program-PARHM (see instructions)	' II ONO D ' 45 5		_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance v	with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				1
,	TO BE COMMITTED BY CONTINUOUS			0	90.00
90. 00 i	Original outlier amount (see instructions)				
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	91.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0. 00	92.00
91. 00 92. 00 93. 00	Outlier reconciliation adjustment amount (see instructions)			0. 00 0	92.00

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/26/2022	11:35 am Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1313

				10 12/01/2021	5/26/2022 11: 3	35 am
		Title	: XVIII	Hospi tal	Cost	
		I npati en	it Part A	Par	rt 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, 786, 93	6	2, 571, 510	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,			0	0	2. 00
3. 00	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					3. 00
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		<u> </u>			
3. 01	ADJUSTMENTS TO PROVIDER	12/14/2021	254, 30	0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51				0	0	3. 51
3. 52			•	0	0	3. 52
3. 53				0	0	3. 53
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		254, 30	0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		3, 041, 23	6	2, 571, 510	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after		I			5. 00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	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
	Provider to Program					
5. 50	TENTATIVE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		59, 72	8	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	734, 771	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 100, 96		1, 836, 739	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(0			8. 00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2021 | Part | | Date/Time Prepared: | 5/26/2022 | 11: 35 am | | Provider CCN: 15-1313 Component CCN: 15-Z313

		T: +1 o	XVIII Sv	ui na Dodo CNI	5/26/2022 II:	35 am
				ving Beds - SNF		
		Inpatien	t 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		198, 618		0	1.00
2.00	Interim payments payable on individual bills, either		0		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)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3.04
3. 05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		198, 618		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			T		
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)					
F 04	Program to Provider TENTATIVE TO PROVIDER					F 04
5. 01	TENTATIVE TO PROVIDER		0		0	5. 01
5. 02			0		0	5. 02 5. 03
5. 03	Provi der to Program		0		0	5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51	TENTATIVE TO PROGRAM		0			5. 51
5. 52			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
J. 77	5. 50-5. 98)		0		O O	3.77
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		10, 949		o	6. 01
6. 02	SETTLEMENT TO PROGRAM		10, 747			6. 02
7. 00	Total Medicare program liability (see instructions)		209, 567		0	
,. 00	10 tal mode out o program frability (see first detroits)		207, 307	Contractor	NPR Date	7.00
				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	Provider CCN: 15-1313	Peri od: From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	••			
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst				1.00
2. 00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and		for cost		2. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines		d plus for cost		4. 00
	reporting periods beginning on or after 10/01/2013, line 32)				
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				6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HII technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

		component CCN: 15-2313	10 12/31/2021	5/26/2022 11:	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
	COMPUTATION OF NET COCT OF CONTENED CERVILORS		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		171, 211	0	1.00
2. 00	Inpatient routine services - swing bed-5M (see instructions)		1/1, 211	U	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A. and sum of Wkst. D.	39, 655	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin				
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4.00
5. 00	instructions) Program days		92	0	5.00
6. 00	Interns and residents not in approved teaching program (see i	nstructions)	72	0	
7. 00	Utilization review - physician compensation - SNF optional me		0	_	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	3	210, 866	0	8.00
9. 00	Primary payer payments (see instructions)		0	0	
10. 00	Subtotal (line 8 minus line 9)		210, 866	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11.00
12 00	professional services) Subtotal (line 10 minus line 11)		210, 866	0	12.00
12. 00 13. 00	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	1, 299	0	
13.00	for physician professional services)	(exertace corristration	1,277	O	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
15. 00	Subtotal (see instructions)		209, 567	0	15.00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18.00
19. 00	Total (see instructions)		209, 567	0	19.00
19. 01	Sequestration adjustment (see instructions)		0	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs			0	19. 03
19. 25 20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		198, 618	0	19. 25 20. 00
20. 00	Interim payments Interim payments-PARHM		170,010	U	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	10, 949	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2	sation) Adiustment			-
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per				200. OC
200. 00	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod under the 213t			200.00
	Cost Reimbursement				1
201. 00	Medicare swing-bed SNF inpatient routine service costs (from \	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202. 00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lin	Э		202.00
202 00	200 (title XVIII swing-bed SNF))				203. 00
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				204.00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demons	tration	204.00
	period)	st year or the earlie	re o your domone		
205. 00	Medicare swing-bed SNF target amount				205.00
206. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see inst	•			207.00
208. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208.00
000 00	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
	Reserved for future use	on ons,			210.00
	Comparision of PPS versus Cost Reimbursement				1 . 5. 50
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	From 01/01/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 11:35 am
	Title XVIII	Hospi tal	Cost

				5/26/2022 11:	35 am_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services			3, 341, 614	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			3, 341, 614	4.00
5.00	Primary payer payments			1, 761	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 373, 269	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for			0	
12.00	Amounts that would have been realized from patients liable for		on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e	e)			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14.00	Total customary charges (see instructions)			0	
15. 00	Excess of customary charges over reasonable cost (complete or	nly if line 14 exceeds li	ne 6) (see	0	15.00
4, 00	instructions)		442 (4, 00
16. 00	Excess of reasonable cost over customary charges (complete or	nly if line 6 exceeds lir	ne 14) (see	0	16. 00
17 00	instructions)			0	17. 00
17. 00	Cost of physicians' services in a teaching hospital (see inst	.ructrons)		0	17.00
18. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet E-	4 Line 40)		0	18.00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	4, TITIE 49)		3, 373, 269	
20. 00	Deductibles (exclude professional component)			290, 636	
21. 00	Excess reasonable cost (from line 16)			270,030	
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 082, 633	
23. 00	Coi nsurance			0,002,033	
24. 00	Subtotal (line 22 minus line 23)			3, 082, 633	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		28, 201	
26. 00	Adjusted reimbursable bad debts (see instructions)	000) (000 11.01. 401. 01.0)		18, 331	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		22, 493	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	40 (1 0.1.5)		3, 100, 964	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0, 100, 701	
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		Ö	
29. 98	Recovery of accelerated depreciation.	,		0	
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			3, 100, 964	
30. 01	Sequestration adjustment (see instructions)			0	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30.03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			3, 041, 236	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, 30.0	02, 31, and 32)		59, 728	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m				33. 01
34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2				[

Health Financial Systems	cial Systems WOODLAWN HOSPITAL		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: Worksheet E-3 From 01/01/2021 Part VII	
		To 12/31/2021 Date/Time Prepared:	

			To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	S FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		140, 340		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)		140, 340	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)		140, 340	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		86, 312		8. 00
9. 00	Ancillary service charges		211, 556	0	
10. 00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		297, 868	0	12. 00
40.00	CUSTOMARY CHARGES	· · · · · · · · · · · · · · · · · · ·	1 0		
13. 00	Amount actually collected from patients liable for payment for services	vices on a charge	0	0	13.00
14 00	basis	mont for corvince of		0	14.00
14. 00	Amounts that would have been realized from patients liable for payla charge basis had such payment been made in accordance with 42 CFI		' "	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	K 9413. 13(e)	0. 000000	0. 000000	15.00
			297, 868	0.000000	16.00
		Fline 16 exceeds	157, 528	0	ı
17.00	line 4) (see instructions)	Title to exceeds	137, 320	U	17.00
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)		O	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruction	ons)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	•	140, 340	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	leted for PPS provid	lers.		
22.00	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		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	27. 00
			0	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		140, 340	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
	Excess of reasonable cost (from line 18)		140 240	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		140, 340	0	
33. 00			0	0	33.00
				0	34.00
35. 00	, , ,			U	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		140, 340	0	•
			0	0	1
	Subtotal (line 36 ± line 37)		140, 340	0	1
39. 00	, , , , , , , , , , , , , , , , , , ,		0	Ü	39.00
	0 Total amount payable to the provider (sum of lines 38 and 39)		140, 340	0	1
41. 00	Interim payments		126, 868	0	
42. 00	Balance due provider/program (line 40 minus line 41)		13, 472	0	1
	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub 15-2,	0	0	
	chapter 1, §115.2	•]		
			·		

Health Financial Systems 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 only)

Provider CCN: 15-1313 Period: From 01

Period: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 11: 35 am

	oni y)				, 12,01,2021	5/26/2022 11:	35 am
CURRENT ASSETS 1,000 2,000 3,000 4,000			General Fund			Plant Fund	
Cosh on hand in banks			1.00			4. 00	
Temporary Investments	1 00		15 577 170		0	0	1 00
Notes receit value 0			15,577,170		0		1.00 2.00
Accounts receivable 24, 389, 232			0	-	0		3.00
All owances for uncollect bile notes and accounts receivable -14, 741, 561 0 0 0 0 0 0 0 0 0			24, 389, 232	0	0		
1.00 Inventorry	5.00	Other receivable	1, 098, 866	0	0		
Prepaid expensess				0	0		
Other current assets				0	0		7.00
10.00 Due from other Funds		' '	207,666		0		8. 00 9. 00
Total current assets (sum of lines 1-10)			0	1	0		10.00
IXED_ASSETS			27, 686, 044		0		11.00
13.00 Land improvements				·			1
14.00 Accumulated depreciation	12.00	Land			0	-	
15.00 Buil dings					-		
16.00 Accumul ated depreciation					0		14.00
17.00 Leasehold Improvements					0		15. 00 16. 00
18.00 Accumulated depreciation 0 0 0 0 0 0 0 0 0			- 15, 045, 659 0		0		17.00
19.00 Calcumulated depreciation 0 0 0 0 0 0 0 0 0		·	0	-	0		18.00
21.00 Automobiles and trucks 0 0 0 0 0 0 0 0 0			Ö	Ö	0		19.00
22.00 Accumul ated depreciation 0 0 0 0 0 0 0 0 0	20.00	Accumulated depreciation	0	0	0	0	20.00
23.00 Waj or movable equi pment 11, 394, 525 0 0 0 0 0 0 0 0 0	21.00	Automobiles and trucks	0	0	0	0	21.00
24.00 Accumulated depreciation			0	-	0		22.00
25.00 Minor equipment depreciable 0 0 0 0 0 0 0 0 0		'			0		23.00
26.00 Accumul ated depreciation		•	-7, 420, 082		0		24.00
27. 00 HIT designated Assets 0 0 0 0 0 0 0 0 0			0	0	0		25. 00 26. 00
28. 00 Accumulated depreciation				0	0		27.00
29. 00			0	0	0		28.00
30. 00 Total fixed assets (sum of lines 12-29) 17, 120, 007 0 0 0		· · · · · · · · · · · · · · · · · · ·	Ö	1	0		
31.00 Investments	30.00		17, 120, 007	0	0	0	30.00
32.00 Deposits on leases 0 0 0 0 0 0 0 0 0							
1.00			8, 664, 210		0		31.00
34,00 Other assets			0	1	0	-	32.00
35.00 Total other assets (sum of lines 31-34) 9,231,509 0 0 0 0 0 0 0 0 0			E47 200	1	0		33. 00 34. 00
Total assets (sum of lines 11, 30, and 35) 54, 037, 560 0 0 0					0		35.00
CURRENT LIABILITIES		· · · · · · · · · · · · · · · · · · ·			0		36.00
38.00 Salaries, wages, and fees payable 2,967,316 0 0 0 39.00 Payroll taxes payable 0 0 0 0 40.00 Notes and loans payable (short term) 1,206,969 0 0 0 41.00 Deferred income 0 0 0 0 0 42.00 Accelerated payments 0 0 0 0 0 43.00 Due to other funds 0 0 0 0 0 44.00 Other current liabilities 600,000 0 0 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 10,918,879 0 0 0 0 46.00 Mortgage payable 0 0 0 0 0 0 0 46.00 Mortgage payable 8,442,141 0 0 0 0 0 0 47.00 Notes payable 8,442,141 0 0 0 0 0 0 0 0 0 0 0 0 0 0<		CURRENT LI ABI LI TI ES		,	-		
39.00 Payroll taxes payable 0 0 0 0 0 0 0 0 0	37.00		6, 144, 594	0	0		37.00
40.00 Notes and Loan's payable (short term) 1,206,969 0 0 0 0 0 0 0 0 0			2, 967, 316		0		38.00
41.00 Deferred income 0 0 0 0 0 0 0 0 0			0		0		39.00
Accelerated payments 0			1, 206, 969	0	0		40.00 41.00
43.00 Due to other funds 44.00 Other current liabilities 500 Other current liabilities 600,000 O 600 O			0	١	U	U	41.00
44.00 Other current liabilities 600,000 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 10,918,879 0 0 46.00 Mortgage payable 0 0 0 0 46.00 Notes payable 0 0 0 0 48.00 Unsecured loans 0 0 0 0 49.00 Other long term liabilities 0 0 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 8,442,141 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 19,361,020 0 0 0 52.00 General fund balance 34,676,540 0 0 53.00 Specific purpose fund 0 0 54.00 Donor created - endowment fund balance - unrestricted 0 0 55.00 Governing body created - endowment fund balance 0 0 57.00 Plant fund balance - invested in plant 0 0 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 0 59.00 Total liabilities and fund balances (sum of lines 52 thru 58) 34,676,540 0 0 60.00 <td></td> <td> </td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td>			0	0	0	0	
LONG TERM LIABILITIES			600, 000	Ö	0		
46.00 Mortgage payable 0 0 0 0 47.00 Notes payable 8,442,141 0 0 0 48.00 Unsecured Loans 0 0 0 0 0 49.00 Other Long term Liabilities 0 0 0 0 0 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 8,442,141 0 0 0 51.00 Total Liabilities (sum of Lines 45 and 50) 19,361,020 0 0 0 6eneral fund bal ance 34,676,540 0 0 0 52.00 Specific purpose fund 0 0 0 54.00 Donor created - endowment fund balance - restricted 0 0 55.00 Donor created - endowment fund balance 0 0 57.00 Plant fund balance - invested in plant 0 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 59.00 Total fund balances (sum of Lines 52 thru 58) 34,676,540 0 0 0 60.00 Total Liabilities and fund balances (sum of Lines 51 an					0	0	
47.00 Notes payable		LONG TERM LIABILITIES					
48.00 Unsecured Loans 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	-	-		
49.00 Other long term liabilities		' '	8, 442, 141		-		
50.00 Total long term liabilities (sum of lines 46 thru 49) 8, 442, 141 0 0 0 51.00 Total liabilities (sum of lines 45 and 50) 19, 361, 020 0 0 0 CAPITAL ACCOUNTS 52.00 General fund balance 34, 676, 540 34, 676, 540 0 53.00 Specific purpose fund 0			0	-			48.00
51.00 Total liabilities (sum of lines 45 and 50)			0 442 141		_		49. 00 50. 00
CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 59.00 Total liabilities and fund balances (sum of lines 51 and 54,037,560) 34,676,540 0 0 0 0 0 0 0 0 0 0 0 0		,			-		
52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 78.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 Total fund balances (sum of lines 52 thru 58) 70 Total liabilities and fund balances (sum of lines 51 and sum of 154,037,560) 34,676,540 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	01.00		17,001,020	<u> </u>	<u> </u>		01.00
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 78.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 Total fund balances (sum of lines 52 thru 58) 70 Total liabilities and fund balances (sum of lines 51 and sale) 70 Donor created - endowment fund balance - restricted 70 Donor created - endowment fund balance	52.00		34, 676, 540				52.00
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Flant fund balance - invested in plant Flant fund balance - reserve for plant improvement, replacement, and expansion For all fund balances (sum of lines 52 thru 58) Total fund balances (sum of lines 51 and 34,676,540 Total liabilities and fund balances (sum of lines 51 and 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	53.00	Specific purpose fund		0			53.00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 54,037,560 0 0					0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 54,037,560 0 0					0		55.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 54,037,560 0 0 0					0		56.00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 54,037,560 0 0 0		· ·					
59.00 Total fund balances (sum of lines 52 thru 58) 34,676,540 0 0 60.00 Total liabilities and fund balances (sum of lines 51 and 54,037,560 54,037,560 0 0	30.00						58.00
60.00 Total liabilities and fund balances (sum of lines 51 and 54,037,560 0 0 0	59.00		34, 676, 540	0	O	ი	59.00
					Ö		60.00
		59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES WOODLAWN HOSPITAL

Provider CCN: 15-1313

					То	12/31/2021	Date/Time Pre 5/26/2022 11:	
		General	Fund	Speci al	Purpos	se Fund	Endowment Fund	
1 00		1. 00	2.00	3. 00		4. 00	5. 00	1.00
1.00	Fund balances at beginning of period		30, 442, 237	1		0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		4, 234, 303 34, 676, 540	1		0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)		34, 676, 340		0	٩	C	
5. 00	Additions (credit adjustments) (specify)				0			1
6. 00					Ö		C	
7. 00		o			O		C	
8.00		o			0		C	8.00
9.00		o			0		C	9.00
10.00	Total additions (sum of line 4-9)		0			O		10.00
11. 00	Subtotal (line 3 plus line 10)		34, 676, 540			0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0		C	
13.00		0			0		C	
14. 00 15. 00		0			0		C	
16. 00		U			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		34, 676, 540			ő		19.00
	sheet (line 11 minus line 18)							
		Endowment	PI ant	Fund				
		Fund		ı				
		6. 00	7. 00	8.00				
1.00	Fund balances at beginning of period	0			0			1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	_			_			2.00
3.00	Total (sum of line 1 and line 2)	0			0			3.00
4. 00 5. 00	Additions (credit adjustments) (specify)		0					4. 00 5. 00
6. 00			0					6.00
7. 00			0					7.00
8. 00			0					8.00
9. 00			0					9.00
10.00	Total additions (sum of line 4-9)	o			0			10.00
11.00	Subtotal (line 3 plus line 10)	o			0			11.00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14.00			0					14.00
15. 00			0					15.00
16.00			0					16.00
17.00	T-t-1 deductions (com of lines 12 17)		0					17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance				0			18. 00 19. 00
17.50	sheet (line 11 minus line 18)							' ' ' ' '

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

		Τ̈́	0 12/31/2021	Date/Time Pre 5/26/2022 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	JJ dili
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	4, 220, 944		4, 220, 944	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	C		0	5.00
6.00	Swing bed - NF	c		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)	4, 220, 944		4, 220, 944	10.00
	Intensive Care Type Inpatient Hospital Services	·			
11.00	INTENSIVE CARE UNIT	1, 208, 773		1, 208, 773	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lin	nes 1, 208, 773		1, 208, 773	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5, 429, 717		5, 429, 717	17.00
18.00	Ancillary services	19, 261, 076	122, 032, 760	141, 293, 836	18.00
19.00	Outpati ent servi ces	l		19, 822	19.00
20.00	RURAL HEALTH CLINIC	l c	1, 508, 033	1, 508, 033	20.00
20. 01	RURAL HEALTH CLINIC II	17	4, 326, 986	4, 327, 003	20. 01
20. 02	RURAL HEALTH CLINIC III	l c		2, 646, 125	20. 02
20. 03	RURAL HEALTH CLINIC IV			529, 476	20. 03
20. 04	RURAL HEALTH CLINIC V			812, 280	20. 04
20. 05	RURAL HEALTH CLINIC VI	l c		2, 974, 761	20. 05
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY			ŭ	22. 00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER OUTPATIENT		1, 227, 109	1, 227, 109	27. 00
27. 01	PROFESSI ONAL FEES		4, 071, 754	4, 071, 754	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 24, 690, 810		164, 839, 916	28. 00
20.00	G-3, line 1)	21,070,010	110, 117, 100	101,007,710	20.00
	PART II - OPERATING EXPENSES	<u> </u>			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		66, 183, 288		29. 00
30.00	ADD (SPECIFY)	l c			30.00
31. 00	(6. 25)	l c			31.00
32. 00		1 0			32.00
33. 00					33.00
34. 00		l c			34.00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		-		37. 00
38. 00	(6. 25.1.1)				38. 00
39. 00					39. 00
40. 00					40. 00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)		n		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	transfer	66, 183, 288		43. 00
10. 00	to Wkst. G-3, line 4)		00, 100, 200		.0.00
	1	1	'		1

Heal th	Financial Systems WOODLAWN HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	FATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1313 Period:				
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		164, 839, 916	1.00
2.00	Less contractual allowances and discounts on patients' accounts	nts		103, 916, 862	2.00
3.00	Net patient revenues (line 1 minus line 2)			60, 923, 054	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		66, 183, 288	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-5, 260, 234	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			17, 959	7.00
8.00	Revenues from telephone and other miscellaneous communication	0	8.00		
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			129, 137	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			5	21.00
22. 00	Rental of hospital space			3, 888	22.00
23.00	Governmental appropriations			0	23.00
24. 00	OTHER OPERATING INCOME			531, 295	
24. 01	LTC REVENUE			3, 840, 357	24. 01
24. 02	GAIN/LOSS DISP ASSET-MISC			0	24. 02
24. 03				913, 724	
	DONATIONS FROM FOUNDATION			60, 327	
24 50	COVED 10 DUE Frankling			2 007 045	1 24 50

3, 997, 845 9, 494, 537

4, 234, 303

0 28.00 4,234,303 29.00

24.50

25.00 26.00

27.00

24. 04 DONATIONS FROM FOUNDATION 24. 50 COVI D-19 PHE Funding

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES

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

	Financial Systems	WOODLAWN F		ON 45 4040		u of Form CMS-1	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 01/01/2021	Worksheet M-1	
			Component	CCN: 15-8551	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi ficat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00	0.00		col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS	454 404		454.40		454 404	1 00
1.00	Physi ci an	451, 424	0	451, 42	0 0	451, 424	
2.00	Physician Assistant	1/0 //1	0	1/0 //	0	0	2.00
3.00	Nurse Practitioner	168, 441	0	168, 44	0 0	168, 441	1
4.00	Visiting Nurse	41 244	0	41 24	٥	0	4.00
5.00	Other Nurse Clinical Psychologist	41, 266	0	41, 26	0	41, 266 0	5. 00 6. 00
6. 00 7. 00	Clinical Social Worker	0	0				
7. 00 8. 00	Laboratory Techni ci an	0	0			0	8.00
9. 00	Other Facility Health Care Staff Costs	113, 614	0	113, 61	4	113, 614	
10.00	Subtotal (sum of lines 1 through 9)	774, 745	0			774, 745	
11. 00	Physician Services Under Agreement	774,745	503, 704			503, 704	
12. 00	Physician Supervision Under Agreement	0	303, 704	303, 70	0 0	0 303, 704	12.00
13. 00	Other Costs Under Agreement	0	0			0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	503, 704	503, 70	0	503, 704	
15. 00	Medical Supplies	0	14, 237			14, 237	
16. 00	Transportation (Health Care Staff)	0	11, 237	11,20	n n	0	
17. 00		0	0		0 0	Ö	
18. 00	Professional Liability Insurance	0	0		0 0	0	18.00
19. 00		0	0		0 0	o o	
20. 00	Allowable GME Costs	-	_			_	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	14, 237	14, 23	0	14, 237	21.00
22.00	Total Cost of Health Care Services (sum of	774, 745	517, 941			1, 292, 686	
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23. 00
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		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	28. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	4, 927				
30. 00	Administrative Costs	27 560	172.042	199.60	26 796	226, 398	1 30, 00

27, 560

802, 305

4, 927 172, 042 176, 969

694, 910

4, 927 199, 602

204, 529

1, 497, 215

4, 737 226, 398 231, 135

1, 523, 821

30.00

31.00

32.00

26, 796

26, 606

26, 606

30.00 Administrative Costs

31.00

32.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1313	Peri od: From 01/01/2021	Worksheet M-1		
	Component CCN: 15-8551	To 12/31/2021	Date/Time Prepared: 5/26/2022 11:35 am		
		RHC I	Cost		

Adjustments
FACILITY HEALTH CARE STAFF COSTS
Allocation (col. 5 + col. 6) 6.00 7.00
Cool 5 + col 6 6 6 6 6 6 6 6 6
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician -252,369 199,055 1.00 2.00 3.00 Nurse Practitioner -137 168,304 3.00 4.00 Visiting Nurse 0 0 0 4.00 5.00 Clinical Psychologist 0 0 0 6.00 7.00 Clinical Social Worker 0 0 0 0 8.00 0.00
FACILITY HEALTH CARE STAFF COSTS 1.00 Physician Assistant 0 0 0 2.00 0 0 0 0 0 0 0 0 0
FACILITY HEALTH CARE STAFF COSTS
1. 00 Physician -252, 369 199, 055 1.00 2. 00 Physician Assistant 0 0 2.00 3. 00 Nurse Practitioner -137 168, 304 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 41, 266 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 0 113, 614 9.00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10.00 11. 00 Physician Services Under Agreement 0 503, 704 11.00 12. 00 Physician Supervision Under Agreement 0 0 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 503, 704 14.00 15. 00 Medical Supplies 0 14, 237 15.00 16. 00 Transportation (Health Care Staff)
2. 00 Physici an Assistant 0 0 0 3. 00 Nurse Practitioner -137 168, 304 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 41, 266 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 0 113, 614 9.00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10.00 11. 00 Physician Services Under Agreement 0 503, 704 11.00 12. 00 Other Costs 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) 0 503, 704 14.00 15. 00 Medical Supplies 0 14, 237 15.00 16. 00 Transportation (Health Care Staff)
3. 00 Nurse Practitioner -137 168, 304 3.00 4. 00 Visiting Nurse 0 0 4.00 5. 00 Other Nurse 0 41, 266 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 0 113, 614 9.00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10.00 11. 00 Physician Services Under Agreement 0 503, 704 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) 0 503, 704 14.00 15. 00 Medical Supplies 0 14, 237 15.00 16. 00 Transportation (Health Care Staff) 0 14, 237 16.00
4. 00 Visiting Nurse 0 0 4. 00 5. 00 Other Nurse 0 41, 266 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 0 113, 614 9. 00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10. 00 11. 00 Physician Services Under Agreement 0 503, 704 11. 00 12. 00 Other Costs Under Agreement 0 0 13. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 503, 704 14. 00 15. 00 Medical Supplies 0 14, 237 15. 00 16. 00 Transportation (Health Care Staff) 0 0 16. 00
5. 00 Other Nurse 0 41, 266 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 0 113, 614 9. 00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10. 00 11. 00 Physician Services Under Agreement 0 503, 704 11. 00 12. 00 Other Costs Under Agreement 0 0 12. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 503, 704 13. 00 15. 00 Medical Supplies 0 14, 237 15. 00 16. 00 Transportation (Health Care Staff) 0 0 16. 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 0 113, 614 9.00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10.00 11. 00 Physician Services Under Agreement 0 503, 704 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) 0 503, 704 14.00 15. 00 Medical Supplies 0 14, 237 15.00 16. 00 Transportation (Health Care Staff) 0 16.00
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 0 113, 614 9. 00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10. 00 11. 00 Physician Services Under Agreement 0 503, 704 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) 0 503, 704 14. 00 15. 00 Medical Supplies 0 14, 237 15. 00 16. 00 Transportation (Health Care Staff) 0 0 16. 00
8. 00 Laboratory Technician 0 0 8. 00 9. 00 Other Facility Health Care Staff Costs 0 113, 614 9. 00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10. 00 11. 00 Physician Services Under Agreement 0 503, 704 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) 0 503, 704 14. 00 15. 00 Medical Supplies 0 14, 237 15. 00 16. 00 Transportation (Health Care Staff) 0 0 16. 00
9. 00 Other Facility Health Care Staff Costs 0 113, 614 9.00 10. 00 Subtotal (sum of lines 1 through 9) -252, 506 522, 239 10.00 11. 00 Physician Services Under Agreement 0 503, 704 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) 0 503, 704 14.00 15. 00 Medical Supplies 0 14, 237 15.00 16. 00 Transportation (Health Care Staff) 0 16.00
10.00 Subtotal (sum of lines 1 through 9) -252,506 522,239 10.00 11.00 Physician Services Under Agreement 0 503,704 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) 0 503,704 14.00 15.00 Medical Supplies 0 14,237 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
11.00 Physician Services Under Agreement 0 503,704 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) 0 503,704 14.00 15.00 Medical Supplies 0 14,237 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
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) 0 503,704 14.00 15.00 Medical Supplies 0 14,237 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
13.00 Other Costs Under Agreement 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 503,704 14.00 15.00 Medical Supplies 0 14,237 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
14.00 Subtotal (sum of lines 11 through 13) 0 503,704 14.00 15.00 Medical Supplies 0 14,237 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
15.00 Medical Supplies 0 14,237 15.00 16.00 Transportation (Health Care Staff) 0 0 16.00
16.00 Transportation (Health Care Staff) 0 0 16.00
17.00 Depressing at on Modical Equipment
17.00 Depired at on-weardar Equipment
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 14,237 21.00
22.00 Total Cost of Health Care Services (sum of -252,506 1,040,180 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 27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00
through 27)
FACILITY OVERHEAD
29. 00 Facility Costs 0 4, 737 29. 00
30. 00 Admi ni strati ve Costs 0 226, 398 30. 00
31.00 Total Facility Overhead (sum of lines 29 and 0 231,135 31.00
30)
32.00 Total facility costs (sum of lines 22, 28 -252,506 1,271,315 32.00
and 31)

	Financial Systems	WOODLAWN H				u 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 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	pared: 35 am
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		4.00	0.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFE COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	2 042 025	04 224	2 127 0/	20.040	2 155 007	1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	2, 042, 825	84, 224	2, 127, 04	19 28, 048	2, 155, 097 0	1.00
3. 00	Nurse Practitioner	148, 842	0	148, 84	0	148, 842	
4. 00	Visiting Nurse	140, 042	0	140, 04	0	140, 042	
5.00	Other Nurse	240, 865	0	240, 86	5 0	240, 865	
6. 00	Clinical Psychologist	240, 603	0	240, 60	0	240, 803	
7. 00	Clinical Social Worker	0	0			0	
8. 00	Laboratory Techni ci an	0	0			0	1
9. 00	Other Facility Health Care Staff Costs	0	0			0	
10.00	Subtotal (sum of lines 1 through 9)	2, 432, 532	84, 224	2, 516, 75	56 28, 048	2, 544, 804	
11. 00	Physician Services Under Agreement	2, 432, 332	04, 224	2, 310, 73	0 20,040	2, 344, 604	
12. 00	Physician Supervision Under Agreement	0	0			0	1
13. 00	Other Costs Under Agreement	0	0			0	
14. 00	Subtotal (sum of lines 11 through 13)	0	o n			0	
15. 00	Medical Supplies	0	456, 319	456, 31	0	456, 319	
16. 00	Transportation (Health Care Staff)	0	100,017	100,01	, o	0	1
17. 00		0	o o		0 0	Ö	
18. 00	Professional Liability Insurance	0	0		0 0	0	
	Other Health Care Costs	0	0		0 0	0	
20.00	Allowable GME Costs	-					20.00
21.00	Subtotal (sum of lines 15 through 20)	0	456, 319	456, 31	9 0	456, 319	21.00
22.00	Total Cost of Health Care Services (sum of	2, 432, 532	540, 543	2, 973, 07	75 28, 048	3, 001, 123	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0	0	24.00
25.00	Optometry	0	0		0	0	
25. 01	Tel eheal th	0	0		0	0	
25.02	9	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28.00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0			•		29. 00
30 00	Administrative Costs	535 394	507 753	1 043 14	17 - 173 872	869 275	1 20 00

535, 394

2, 967, 926

525, 959 507, 753

1, 033, 712

1, 574, 255

-525, 959 -173, 872

-699, 831

-671, 783

1, 043, 147

1, 569, 106

4, 542, 181

29. 00 30. 00

31.00

32.00

869, 275

869, 275

3, 870, 398

30.00 Administrative Costs

31.00

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1313	Peri od: From 01/01/2021	Worksheet M-1
	Component CCN: 15-8552	To 12/31/2021	Date/Time Prepared: 5/26/2022 11:35 am
		RHC II	Cost

S/26/2022 RHC I Co:	1.00
Adjustments Net Expenses for Allocation (col. 5 +	1.00
for Allocation (col. 5 +	
Allocation (col. 5 +	
(col. 5 +	
col . 6)	
6.00 7.00	
FACILITY HEALTH CARE STAFF COSTS	
1. 00 Physi ci an -179, 048 1, 976, 049	
2.00 Physician Assistant 0 0	2.00
3. 00 Nurse Practitioner -217 148, 625	3.00
4.00 Vi si ti ng Nurse 0 0	4.00
5. 00 Other Nurse 0 240, 865	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 0	9.00
10.00 Subtotal (sum of lines 1 through 9)	10.00
11. 00 Physician Services Under Agreement 0 0	11.00
	12.00
	13.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
14.00 Subtotal (sum of lines 11 through 13) 0 0	14.00
15. 00 Medi cal Suppli es 0 456, 319	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) 0 456,319	21.00
22.00 Total Cost of Health Care Services (sum of -179,265 2,821,858	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	27. 00
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0	28. 00
through 27)	
FACILITY OVERHEAD	
29.00 Facility Costs 0 0	29. 00
30.00 Administrative Costs 0 869, 275	30.00
31.00 Total Facility Overhead (sum of lines 29 and 0 869,275	31.00
[30]	
32.00 Total facility costs (sum of lines 22, 28 -179,265 3,691,133	32.00
and 31)	1

Heal th	Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-1313	Peri od:	Worksheet M-1	
			Component	CCN: 15-8550	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	pared: 35 am
					RHC III	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
		·		+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	994, 242	6, 906	1, 001, 14	18 0	1, 001, 148	1.00
2.00	Physician Assistant	0	0		0	0	2.00
3.00	Nurse Practitioner	148, 610	0	148, 61	10 0	148, 610	3.00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	98, 075	0	98, 07	75 0	98, 075	5.00
6.00	Clinical Psychologist	0	0		0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	
8.00	Laboratory Techni ci an	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0	0	
10.00	Subtotal (sum of lines 1 through 9)	1, 240, 927	6, 906	1, 247, 83	33 0	1, 247, 833	
11. 00	Physician Services Under Agreement	0	0		0	0	
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15. 00	Medical Supplies	0	144, 757	144, 75	57 0	144, 757	
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		0	0		0	0	19.00
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	144, 757			144, 757	
22. 00	Total Cost of Health Care Services (sum of	1, 240, 927	151, 663	1, 392, 59	90 0	1, 392, 590	22.00
	lines 10, 14, and 21)						-
	COSTS OTHER THAN RHC/FQHC SERVICES					_	
	Pharmacy	0	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	0	
25. 02	9	0	0		0	0	
26.00	All other nonreimbursable costs	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) FACILITY OVERHEAD						1
20 00	FACILITY OVERHEAD Facility Costs	0	182, 390	182, 39	-35, 299	147, 091	29.00
	Administrative Costs	228, 516	· ·				
	Total Facility Overhead (sum of lines 29 and	228, 516	· ·				

228, 516

1, 469, 443

Total Facility Overhead (sum of lines 29 and

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

182, 390 640, 426 822, 816

974, 479

1, 051, 332

2, 443, 922

17, 590

17, 590

1, 068, 922

2, 461, 512

31.00

32.00

31.00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1313	From 01/01/2021			
	Component CCN: 15-8550	10 12/31/2021	5/26/2022 11:35 am		

			Component	CCN: 15-8550	То	12/31/2021	Date/Time Pro 5/26/2022 11	epared: ·35 am
						RHC III	Cost	
		Adjustments	Net Expenses	5				
		,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	-18, 362	982, 78	36				1.00
2.00	Physician Assistant	0		0				2.00
3.00	Nurse Practitioner	-69	148, 54	41				3.00
4.00	Visiting Nurse	0		0				4. 00
5.00	Other Nurse	0	98, 07	75				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		0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	-18, 431	1, 229, 40	02				10.00
11.00	Physician Services Under Agreement	o		o				11.00
12.00	Physician Supervision Under Agreement	0		o				12.00
13.00	Other Costs Under Agreement	0		o				13.00
14.00	Subtotal (sum of lines 11 through 13)	o		o				14.00
15.00	Medical Supplies	o	144, 75	57				15. 00
16.00	Transportation (Health Care Staff)	o		o				16.00
17.00	Depreciation-Medical Equipment	o		o				17.00
18.00	Professional Liability Insurance	o		o				18. 00
19.00	Other Health Care Costs	o		o				19.00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	o	144, 75	57				21.00
22.00	Total Cost of Health Care Services (sum of	-18, 431	1, 374, 15	59				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0		0				23. 00
24.00	Dental	o		o				24.00
25.00	Optometry	o		o				25. 00
25. 01	Tel eheal th	o		o				25. 01
25.02	Chronic Care Management	o		o				25. 02
26.00	All other nonreimbursable costs	o		o				26.00
27.00	Nonallowable GME costs							27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	o		o				28. 00
	through 27)							
	FACILITY OVERHEAD			•				
29. 00	Facility Costs	0	147, 09	91				29. 00
30.00	Administrative Costs	О	921, 83	31				30.00
31.00	Total Facility Overhead (sum of lines 29 and	o	1, 068, 92					31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	-18, 431	2, 443, 08	31				32. 00
	and 31)							
	,			•				•

Heal th	Financial Systems	WOODLAWN F	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1313	Peri od:	Worksheet M-1	
			Component	CCN: 15-8549	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
					RHC IV	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2. 00	3.00	4.00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1. 00	Physi ci an	180, 066	3, 968	184, 03	84 0	184, 034	1.00
2. 00	Physician Assistant	0	0, 700		0 0	10.700.	2.00
3. 00	Nurse Practitioner	12, 269	0	12, 26	59 0	12, 269	3.00
4.00	Visiting Nurse	0	0	,	0 0	0	4.00
5.00	Other Nurse	29, 854	0	29, 85	54 0	29, 854	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	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	
10.00	Subtotal (sum of lines 1 through 9)	222, 189	3, 968	226, 15	57 0	226, 157	
11. 00	Physician Services Under Agreement	0	0		0	0	1
12.00	Physician Supervision Under Agreement	0	0		0	0	
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	20 102	20.10	0 0	0 30, 182	14.00
15. 00 16. 00	Transportation (Health Care Staff)	0	30, 182	30, 18	0	30, 182	15. 00 16. 00
17. 00	Depreciation-Medical Equipment	0	0		0	0	
18. 00	Professional Liability Insurance	0	0		0 0	0	18.00
19. 00	Other Health Care Costs	0	0		0 0	o o	19.00
20.00	Allowable GME Costs	Ü	· ·				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	30, 182	30, 18	32 0	30, 182	21.00
22.00	Total Cost of Health Care Services (sum of	222, 189	34, 150	256, 33	39 0	256, 339	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0		
24. 00	Dental	0	0		0		24.00
25. 00	Optometry	0	0		0	0	25.00
25. 01	Tel eheal th	0	0		0 0	0	25. 01 25. 02
25. 02	Chronic Care Management All other nonreimbursable costs	0	0		0 0	0	
26. 00 27. 00	Nonallowable GME costs	U	Ü		0	0	26. 00 27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28.00
20.00	through 27)	U	0			٥	20.00
	FACILITY OVERHEAD			'			1
29. 00	Facility Costs	0	11, 703	11, 70	35, 299	47, 002	29. 00
30.00	Administrative Costs	19, 678	38, 654			71, 296	1
31.00	Total Facility Overhead (sum of lines 29 and	19, 678	50, 357	70, 03	48, 263	118, 298	31.00
	30)						

241, 867

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

84, 507

326, 374

32.00

374, 637

48, 263

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der	CCN: 15-1313	Peri od: From 01/01/2021	Worksheet M-1	
		Component	CCN: 15-8549	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
				RHC IV	Cost	
	Adiustments	Not Evnances				

						5/26/2022 11:	35 am
					RHC IV	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	184, 03	4			1.00
2.00	Physician Assistant	0		0			2.00
3.00	Nurse Practitioner	0	12, 26	9			3.00
4.00	Visiting Nurse	0		0			4.00
5.00	Other Nurse	0	29, 85	4			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		0			9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	226, 15	7			10.00
11.00	Physician Services Under Agreement	0		ol			11.00
12.00	Physician Supervision Under Agreement	0		ol			12.00
13.00		0		ol			13.00
14.00	Subtotal (sum of lines 11 through 13)	0		ol			14.00
15. 00	Medical Supplies	0	30, 18	2			15. 00
16. 00		0		o l			16.00
	Depreciation-Medical Equipment	0		ol			17. 00
	Professional Liability Insurance	0					18. 00
	Other Health Care Costs	0					19.00
20.00	Allowable GME Costs	ū		1			20.00
21. 00		0	30, 18	2			21.00
22. 00	Total Cost of Health Care Services (sum of	0	256, 33				22.00
22.00	lines 10, 14, and 21)	Ö	200, 00	^			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23. 00	Pharmacy	0					23.00
24. 00	, ,	0					24.00
25. 00	4	0					25. 00
25. 01	Tel eheal th	0					25. 01
25. 02		0					25. 02
26. 00	All other nonreimbursable costs	0					26.00
27. 00	Nonallowable GME costs	ū		1			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0					28. 00
20.00	through 27)	· ·		1			20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	47, 00	2			29. 00
30.00	Administrative Costs	0	71, 29				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	n	118, 29				31.00
5 00	30)	J	110, 27				00
32.00	Total facility costs (sum of lines 22, 28	0	374, 63	7			32.00
	and 31)	J	2, 00				
		'		1			•

	Figure 1 at 1 a	WOODL AWALL	IOCDI TAI		1 - 11 -	C. F OHC.	0550 40
	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	WOODLAWN I	Provider C	^N· 15_1313	In Lie Period:	u of Form CMS-2 Worksheet M-1	
AIVALIS	NO OF THOSE TIME BASED KNOT QUO GGSTS				From 01/01/2021		
			Component	CCN: 15-8547	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
					RHC V	Cost	33 alli
		Compensation	Other Costs	Total (col.	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	FACULTY USALTH CARE OTAES COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	2/2 275	40.07/	070.05	1	070 054	1 00
1. 00 2. 00	Physician Assistant	363, 075 0	10, 276 0		0 0	373, 351 0	1.00 2.00
3.00	Physician Assistant Nurse Practitioner	102, 383	0	102, 38	٠	102, 383	
4. 00	Visiting Nurse	102, 303	0	102, 30	0 0	102, 363	1
5. 00	Other Nurse	1, 368	0	1, 36	٠	1, 368	1
6. 00	Clinical Psychologist	1, 300	0		0	0	1
7. 00	Clinical Social Worker	0	0		0 0	Ö	
8. 00	Laboratory Techni ci an	0	Ö		o o	Ö	
9. 00	Other Facility Health Care Staff Costs	0	0		0	0	1
10.00	Subtotal (sum of lines 1 through 9)	466, 826	10, 276	477, 10	2 0	477, 102	10.00
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	
15. 00	Medical Supplies	0	1, 809			1, 809	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	
19.00	Other Health Care Costs	0	0		0	0	
20. 00 21. 00	Allowable GME Costs Subtotal (sum of lines 15 through 20)	0	1, 809	1, 80	9 0	1, 809	20. 00 21. 00
21.00	Total Cost of Health Care Services (sum of	466, 826	12, 085			478, 911	1
22.00	lines 10, 14, and 21)	400, 020	12,003	470, 71		470, 711	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	30, 829	30, 82	9 0	30, 829	23. 00
24.00	Dental	0	0		0	0	24.00
25.00	Optometry	0	0		0 0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	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	30, 829	30, 82	9 0	30, 829	28. 00
	through 27)						-
20.00	FACILITY OVERHEAD		14 700	14.70		14 700	20.00
29. 00 30. 00	Facility Costs Administrative Costs	0 91, 092	14, 792 158, 590			14, 792	1
30.00	Total Facility Overhead (sum of lines 29 and	91, 092 91, 092	158, 590		·	253, 176 267, 968	
51.00	30)	71, 092	173,302	204, 47	3, 494	207, 700	31.00

557, 918

216, 296

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

777, 708

3, 494

774, 214

32.00

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 01/01/2021	Worksheet M-1
	Component CCN: 15-8547	To 12/31/2021	Date/Time Prepared: 5/26/2022 11:35 am
		RHC V	Cost

			Component C	CN: 15-8547	10	12/31/2021	5/26/2022 11:	
						RHC V	Cost	. 55 am
		Adjustments	Net Expenses		<u> </u>	1110	0001	
		riaj do timorreo	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	-1, 046	372, 305					1.00
2.00	Physi ci an Assi stant	0	o					2.00
3.00	Nurse Practitioner	-4, 199	98, 184					3.00
4.00	Visiting Nurse	0	0					4.00
5. 00	Other Nurse	0	1, 368					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	0					9.00
10.00	Subtotal (sum of lines 1 through 9)	-5, 245	471, 857					10.00
11. 00	Physician Services Under Agreement	0,	0					11.00
12. 00	Physician Supervision Under Agreement	0	0					12.00
	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	1, 809					15.00
16. 00	Transportation (Health Care Staff)	0	0					16.00
17. 00		0	o					17.00
18. 00	Professional Liability Insurance	0	0					18.00
	Other Health Care Costs	0						19.00
20. 00	Allowable GME Costs	Ö	J					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	1, 809					21.00
22. 00	Total Cost of Health Care Services (sum of	-5, 245	473, 666					22. 00
22.00	lines 10, 14, and 21)	0,2.0	.,,,,,,,,					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	30, 829					23.00
24. 00	Dental	0	O					24.00
25. 00	Optometry	0	o					25.00
25. 01	Tel eheal th	0	o					25. 01
25. 02	4	0	o					25. 02
26.00	All other nonreimbursable costs	0	o					26.00
27. 00	Nonallowable GME costs	-						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	30, 829					28.00
	through 27)		,					
	FACILITY OVERHEAD		· · · · · · · · · · · · · · · · · · ·					
29. 00	Facility Costs	0	14, 792					29. 00
30.00	Administrative Costs	0	253, 176					30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	267, 968					31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	-5, 245	772, 463					32.00
	and 31)							
			•					

	Financial Systems	WOODLAWN H				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 01/01/2021	Worksheet M-1	
			Component		To 12/31/2021	Date/Time Pre 5/26/2022 11:	
					RHC VI	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(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, 173, 744	13, 121			1, 186, 865	
2.00	Physician Assistant	0	0		0	0	2.00
3. 00	Nurse Practitioner	178, 143	0	178, 14	3 0	178, 143	
4.00	Visiting Nurse	0	0		0	0	4. 00
5. 00	Other Nurse	42, 510	0	42, 51	0	42, 510	
6. 00	Clinical Psychologist	0	0		0	0	
7. 00	Clinical Social Worker	0	0		0	0	
8. 00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0	4 407 54	0	0	
10.00	Subtotal (sum of lines 1 through 9)	1, 394, 397	13, 121	1, 407, 51	8 0	1, 407, 518	
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	101 170	404 47	0	0	14.00
15.00	Medical Supplies	0	121, 172	121, 17	2	121, 172	1
16.00	Transportation (Health Care Staff)	U	0		0	0	
17. 00	Depreciation-Medical Equipment	U	0		0	0	
18. 00 19. 00	Professional Liability Insurance Other Health Care Costs	U O	0		0	0	18. 00 19. 00
20.00		۷	Ü		U U	U	20.00
21.00	Allowable GME Costs Subtotal (sum of lines 15 through 20)		121, 172	121, 17	2 0	121, 172	1
21.00	Total Cost of Health Care Services (sum of	1, 394, 397	134, 293			1, 528, 690	
22.00	lines 10, 14, and 21)	1, 374, 377	134, 273	1, 320, 09	o o	1, 320, 090	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			l .			
23. 00	Pharmacy Pharmacy	O	0		0 0	0	23. 00
24. 00	Dental	o	0		0 0	Ö	
25. 00	Optometry	o	0		0 0	0	
25. 01	Tel eheal th	ol	0		0 0	0	
25. 02	Chronic Care Management	ol	0		ol o	0	
26. 00	All other nonreimbursable costs	ol	0		0 0	0	1
27. 00	Nonal I owable GME costs	Ĭ	0				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	o	0		0	0	
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	36, 272			36, 272	29. 00
30.00	Administrative Costs	187, 553	387, 087			603, 847	
31 00	Total Facility Overhead (sum of lines 29 and	187 553	423 359	610 91	29 207	640 119	31 00

1, 581, 950

423, 359

557, 652

610, 912

2, 139, 602

29, 207

29, 207

31.00

32.00

640, 119

2, 168, 809

Total Facility Overhead (sum of lines 29 and

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

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1313	Peri od: From 01/01/2021	Worksheet M-1
	Component CCN: 15-8548		

			Component	JCIN. 15-6546	10	12/31/2021	5/26/2022 11	
						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	-19, 710	1, 167, 155					1.00
2.00	Physician Assistant	0	0					2.00
3.00	Nurse Practitioner	-1, 887	176, 256					3.00
4.00	Visiting Nurse	0	0					4.00
5.00	Other Nurse	0	42, 510					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	0					9. 00
10.00	Subtotal (sum of lines 1 through 9)	-21, 597	1, 385, 921					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	121, 172					15. 00
16. 00	Transportation (Health Care Staff)	0	0					16. 00
17. 00	, · · · · · · · · · · · · · · · · · · ·	0	0					17. 00
18. 00	1	0	0					18. 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	121, 172					21.00
22. 00	Total Cost of Health Care Services (sum of	-21, 597	1, 507, 093					22. 00
	lines 10, 14, and 21)							_
00.00	COSTS OTHER THAN RHC/FQHC SERVICES	ام						
23.00	1 -	0	0					23.00
24. 00	Dental	U	0					24. 00
25. 00	Optometry	U	0					25. 00
25. 01	Tel eheal th	U	0					25. 01 25. 02
25. 02 26. 00	Chronic Care Management All other nonreimbursable costs	0	0					26.00
27.00	Nonallowable GME costs	U	۷					27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0					28.00
26.00	through 27)	U	١					20.00
	FACILITY OVERHEAD							-
29 00	Facility Costs	0	36, 272					29. 00
30.00	Administrative Costs	0	603, 847					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	640, 119					31.00
31. 30	30)	Ĭ	0.10, 117					01.00
32.00	1 /	-21, 597	2, 147, 212					32.00
	and 31)	,	, , , - , - , - , - , - ,					
	,			•				•

	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		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:		
					RHC I	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							
	Positions		T	T				
1. 00	Physi ci an	0. 34		l .	1 0		1.00	
2.00	Physician Assistant	0.00			1 0		2.00	
3. 00	Nurse Practitioner	0. 60			1 1	3, 037	3. 00 4. 00	
4.00								
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)					0.007		
8. 00	Total FTEs and Visits (sum of lines 4	0. 94	3, 037			3, 037	8. 00	
0.00	through 7)		2 412			2 412	0.00	
9. 00	Physician Services Under Agreements		3, 412			3, 412	9. 00	
						1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HUSDITAL BASI	ED DUC/EDUC SEI	DVI CES		1.00		
10.00	Total costs of health care services (from Wk			(VI CLS		1, 040, 180	10.00	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	1	
12.00	Cost of all services (excluding overhead) (s	· ·	,			1, 040, 180	1	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1, 000000		
14. 00				ine 31)		231, 135		
15. 00								
16. 00								
17. 00	Allowable GME overhead (see instructions)					868, 392 0		
18. 00						868, 392		
19. 00		HC services (ine 13 x line	18)		868, 392		
	Total allowable cost of hospital-based RHC/F					1, 908, 572		
20.00	1. Stal. al. Shabi o Goot of Hoopi tal based Mio/1	2 301 VI 003 (Ca 01 111103 1	5 a.ia 17)		1,700,072	0.00	

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC SERVICES Provider CCN: 15-1313 Form Oil/01/2021 To 12/31/2021 To 13/31/2021 To 13		Financial Systems	WOODLAWN I				u of Form CMS-2	<u> 2552-10</u>	
Component CCN: 15-8552 To	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2		
Number of FTE Personnel Total Visits Productivity Minimum Greater of col. 2 or col. 4				Component					
Personnel						RHC II	Cost		
VISITS AND PRODUCTIVITY				Total Visits			Greater of		
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)	Visits (col.	col. 2 or		
VISITS AND PRODUCTIVITY									
Positions			1. 00	2.00	3. 00	4. 00	5. 00		
1.00 Physician									
2. 00 Physician Assistant 0. 00 0 1 0 0 1 0 0 3. 00 Nurse Practitioner 0. 67 2,076 1 1 1 1 1 1 1 1 1									
3.00 Nurse Practitioner 0.67 2,076 1 1 4.00 Subtotal (sum of lines 1 through 3) 4.72 15,799 5 15,799 5 15,799 5 15,799 5 15,799 5 15,799 5 15,799 6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 0 0		1 3				1 4		1.00	
4. 00 Subtotal (sum of lines 1 through 3)						1 0		2.00	
Solid Visiting Nurse						1 1		3.00	
6.00 Clinical Psychologist 0.00 0 7.00 Clinical Social Worker 0.00 0 7.01 Medical Nutrition Therapist (FQHC only) 0.00 0 7.02 Diabetes Self Management Training (FQHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			15, 799						
7. 00 Clinical Social Worker 0. 00 0 7. 01 Medical Nutrition Therapist (FQHC only) 0. 00 0 7. 02 Diabetes Self Management Training (FQHC 0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				5.00					
7. 01 Medical Nutrition Therapist (FQHC only) 0.00 0 7. 02 Diabetes Self Management Training (FQHC 0.00 0.00 0 0.01 0) 8. 00 Total FTEs and Visits (sum of lines 4 4.72 15,799 15,799 15,799 15,799 15,799 15,799 15,799 15,799 15,799 15,799 15,799 16,799 15,799 16			1	l .			_	6. 00	
7. 02 Di abetes Self Management Training (FOHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	l .			_	7. 00 7. 01	
onl y) 8. 00 Total FTEs and Visits (sum of lines 4 4.72 15,799 9. 00 Physician Services Under Agreements 0 15,799 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10. 00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 2,821,858 11. 00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 12. 00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,821,858 13. 00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 14. 00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 869,275 15. 00 Parent provider overhead allocated to facility (see instructions) 1,694,341									
8.00 Total FTEs and Visits (sum of lines 4 4.72 15,799 15,799 15,799 9.00 Physician Services Under Agreements 0 1.00 1.00 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 2,821,858 0 0 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,821,858 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 869,275 15.00 Parent provider overhead allocated to facility (see instructions) 1,694,341	7. 02		0.00	C			0	7. 02	
through 7) Physician Services Under Agreements DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,821,858 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,821,858 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 869,275 15.00 Parent provider overhead allocated to facility (see instructions) 1,694,341	8 00		1 72	15 700			15 700	8.00	
9.00 Physician Services Under Agreements 0 1.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 2,821,858 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,821,858 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 869,275 15.00 Parent provider overhead allocated to facility (see instructions) 1,694,341	0.00		4.72	13,777			15, 777	0.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 1.00 1.00 1.00 2,821,858 2,821,858 1.00 3,821,858 4,858 5,821,858 6,821,858 7,821,858 7,822,823 8,823,858 9,823,858 1,000	9 00						0	9.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 2,821,858 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,821,858 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 869,275 15.00 Parent provider overhead allocated to facility (see instructions) 1,694,341	7.00	Triyarerum services onder high coments			1		Ü	7.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 2,821,858 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,821,858 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 869,275 15.00 Parent provider overhead allocated to facility (see instructions) 1,694,341							1. 00		
Total costs of health care services (from Wkst. M-1, col. 7, line 22) Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) Parent provider overhead allocated to facility (see instructions) 2,821,858 0 1.000000 1.000000 869,275		DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES				
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 2,821,858 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 869,275 15.00 Parent provider overhead allocated to facility (see instructions) 1,694,341	10.00						2, 821, 858	10.00	
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 1.000000 869, 275 1, 694, 341									
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 1.000000 869, 275 1, 694, 341	12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			2, 821, 858	12.00	
14.00Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)869, 27515.00Parent provider overhead allocated to facility (see instructions)1,694, 341									
15.00 Parent provider overhead allocated to facility (see instructions) 1,694,341	14.00								
	15.00			1, 694, 341	15.00				
	16.00		<i>,</i>	,			2, 563, 616	16.00	
17.00 Allowable GME overhead (see instructions)	17.00							1	
18.00 Enter the amount from line 16 2,563,616							2, 563, 616		
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 2,563,616	19.00	Overhead applicable to hospital-based RHC/FC	MC services (I	ine 13 x line	18)		2, 563, 616	19.00	
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 5,385,474									

	Financial Systems	WOODLAWN H				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		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:		
					RHC III	Cost		
		Number of FTE	Total Visits	Producti vi ty		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. 40 2. 64		1	1 0		3.00	
4.00	Subtotal (sum of lines 1 through 3)	12, 729						
5.00	Visiting Nurse	0	5.00					
6.00	Clinical Psychologist	0	6.00					
7.00	Clinical Social Worker	0	7. 00 7. 01					
7. 01	Medical Nutrition Therapist (FQHC only)	al Nutrition Therapist (FQHC only) 0.00 0						
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	2. 64	12, 729	'		12, 729	8. 00	
	through 7)		_			_		
9. 00	Physician Services Under Agreements		C)		0	9.00	
	DETERMINATION OF ALLOWARIE COOT ARRIVAGABLE T	0 1100D1 T41 D40	ED DUG (EQUID OF	D) // 050		1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		4 074 450	10.00	
	Total costs of health care services (from Wk					1, 374, 159		
	Total nonreimbursable costs (from Wkst. M-1,	·	,			0		
12.00	Cost of all services (excluding overhead) (s					1, 374, 159		
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000 1, 068, 922		
	4.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)							
15.00								
16.00	Total overhead (sum of lines 14 and 15)					1, 767, 169		
17.00	Allowable GME overhead (see instructions)					0		
				10)		1, 767, 169		
	Overhead applicable to hospital-based RHC/FQ					1, 767, 169		
20.00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (sum of lines 1	u and 19)		3, 141, 328	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: 15-8549	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:		
					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							
	Positions	1	1	T				
1.00	Physi ci an	0.44		1	1 0		1.00	
2.00	Physician Assistant	0.00		1	1 0		2.00	
3.00	Nurse Practitioner	0. 40 0. 84			1 0	0.400	3.00	
4.00	Subtotal (sum of lines 1 through 3)	3, 120	4.00					
5.00	Visiting Nurse	0	5.00					
6.00	Clinical Psychologist	0. 00 0. 00				0	6.00	
7.00	Clinical Social Worker	0	7. 00 7. 01					
7. 01 7. 02	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01	
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			U	7.02	
8. 00	Total FTEs and Visits (sum of lines 4	0. 84	3, 120			3, 120	8.00	
0.00	through 7)	0.04	3, 120			3, 120	0.00	
9. 00	Physician Services Under Agreements		0			0	9.00	
7.00	Thysrefall services ender hyreements					Ü	7.00	
						1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEI	RVI CES				
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			256, 339	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)			256, 339	12.00	
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00	
14.00	· · · · · · · · · · · · · · · · · · ·							
15.00								
16.00	Total overhead (sum of lines 14 and 15)					230, 474	16.00	
17.00	Allowable GME overhead (see instructions)					0	17.00	
	Enter the amount from line 16					230, 474		
	Overhead applicable to hospital-based RHC/FQ					230, 474		
20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		486, 813	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: From 01/01/2021	Worksheet M-2	
			Component	CCN: 15-8547	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
					RHC V	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						
	Positions	_					
1. 00	Physi ci an	0. 91			1 1		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	0. 83			1 1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.74			2	4, 398	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			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	1.74	4, 398			4, 398	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			RVICES			
	Total costs of health care services (from Wk					473, 666	
	Total nonreimbursable costs (from Wkst. M-1,					30, 829	1
12.00	Cost of all services (excluding overhead) (s					504, 495	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 938891	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		267, 968	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			374, 598	
16. 00	Total overhead (sum of lines 14 and 15)					642, 566	
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					642, 566	
	Overhead applicable to hospital-based RHC/FQ					603, 299	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (:	sum of lines 1	0 and 19)		1, 076, 965	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		From 01/01/2021 To 12/31/2021	Date/Time Pre	nared·
			ooporrorre	00.11 10 00 10		5/26/2022 11:	
					RHC VI	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
		1.00			1 x col . 3)	col. 4	
	VI CLTC AND DRODUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						
1. 00	Physi ci an	2.04	11, 186	I	1 2		1.00
2. 00	Physician Assistant	0.00			1 0		2.00
3. 00	Nurse Practitioner	0.00			1 1		3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 78			'	15, 759	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	l .			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. 78	15, 759			15, 759	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWARIE COOT ARRULOARIE T	O HOCDITAL DAG	ED DUO (EQUA CEI	DVII 050		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T Total costs of health care services (from Wk			RVICES		1, 507, 093	10 00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					1, 507, 093	
12. 00	Cost of all services (excluding overhead) (s					1, 507, 093	
13. 00	Ratio of hospital-based RHC/FQHC services (I					1, 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		640, 119	
15. 00	Parent provider overhead allocated to facili			1110 01)		979, 190	
16. 00	Total overhead (sum of lines 14 and 15)	., (/			1, 619, 309	
17.00	Allowable GME overhead (see instructions)					0	17.00
18. 00	Enter the amount from line 16					1, 619, 309	18.00
	Overhead applicable to hospital-based RHC/FC					1, 619, 309	19.00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		3, 126, 402	20.00

Heal th	Financial Systems WOODLAWN HOS	ΡΙΤΔΙ	Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI (CES	Component CCN: 15-8551	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title XVIII	RHC I	Cost	00 4111
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			1, 908, 572	1.00
2. 00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			16, 470	1
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		1, 892, 102	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			3, 037	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		3, 412	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5)			6, 449 293. 39	6. 00 7. 00
7.00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on		7.00
			our cur a tr on	01 21 1111 2 (1)	
				Rate Period 2	
			(01/01/2021	(04/01/2021	
			through	through	
			03/31/2021)	12/31/2021) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	264. 14	8. 00
9. 00	Rate for Program covered visits (see instructions)		293. 39	264. 14	9. 00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		349	1, 250	•
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	102, 393	330, 175 0	11. 00 12. 00
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	
15.00	Graduate Medical Education Pass Through Cost (see instruction	s)			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	432, 568	
16. 01	Total program charges (see instructions)(from contractor's re			250, 401	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		2, 933 5, 067	16. 02 16. 03
16. 04	Total Program non-preventive costs ((Time 16.02/Time 16.07) times	*		315, 483	
	(Titles V and XIX see instructions.)			212, 122	
16. 05	Total program cost (see instructions)		0	320, 550	
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		33, 147	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		42, 864	19. 00
	records)	, ,			
20.00	Net Medicare cost excluding vaccines (see instructions)			320, 550	
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		7, 199	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			327, 749 0	22. 00 23. 00
23. 01	` '			Ö	23. 01
24.00	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `	ructions)		0	24.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
25. 99			0		
26. 00 26. 01	, , , , , , , , , , , , , , , , , , ,		327, 749 0	26. 00 26. 01	
26. 01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			0	26. 01
27. 00	, , , , , , , , , , , , , , , , , , , ,			251, 811	27. 00
	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	•		75, 938	•
30. 00		nce with CMS Pub. 15-II	,	0	30. 00
	chapter I, §115.2		I		I

Heal th	Financial Systems WOODLAWN HOS	ΡΙΤΔΙ	Inlie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI C	EES	Component CCN: 15-8552	From 01/01/2021 To 12/31/2021	Date/Time Pre	
		Title XVIII	DHC 11	5/26/2022 11:	35 am_
		II tre xviii	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00				5, 385, 474	1.00
2. 00				176, 208	•
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		5, 209, 266	•
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	1: 20 0)		15, 799	•
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	Tine 9)		0 15, 799	5. 00 6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			329. 72	7.00
7.00	That dister cost per visit (Time 5 divided by Time 6)		Cal cul ati on	of Limit (1)	7.00
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through	through	
			03/31/2021)	12/31/2021) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	0.00		8.00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	329. 72	329. 72	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	contractor records)	160	425	10.00
11.00	Program cost excluding costs for mental health services (line	•	52, 755	140, 131	11.00
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	•	0	0	13.00
14. 00 15. 00	Limit adjustment for mental health services (see instructions Graduate Medical Education Pass Through Cost (see instruction	•	0	0	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	192, 886	ı
16. 01	Total program charges (see instructions) (from contractor's re	•		93, 110	
16. 02	Total program preventive charges (see instructions) (from prov			3, 401	16. 02
16.03	Total program preventive costs ((line 16.02/line 16.01) times	line 16)		7, 046	16. 03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		138, 446	16. 04
4, 05	(Titles V and XIX see instructions.)			4.5 400	4, 65
16. 05	Total program cost (see instructions)		0		1
17. 00 18. 00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0 12, 782	17. 00 18. 00
10.00	records)	(11 oiii contractor		12, 702	10.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		15, 386	19.00
	records)				
20.00	Net Medicare cost excluding vaccines (see instructions)			145, 492	
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		1, 494	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			146, 986	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	23. 00 23. 01
24. 00	, , , , , , , , , , , , , , , , , , , ,	ructions)		0	24.00
25. 00	,	. 401. 5.13)		0	25.00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26. 00	,			146, 986	1
26. 01	Sequestration adjustment (see instructions)			0	1
26. 02	, , , , , , , , , , , , , , , , , , , ,			107 404	1
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			107, 496 0	27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02. 27. and 28)		39, 490	
30.00	, , ,		,	0	30.00
	chapter I, §115.2				

Hoal th	Financial Systems WOODLAWN HOS	DITAI	In Lio	u of Form CMS 1	0552 10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C		Component CCN: 15-8550	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	pared:
		Title XVIII	RHC III	Cost	00 4111
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				1.00
2. 00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			3, 141, 328 109, 701	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		3, 031, 627	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12, 729	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		10,700	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			12, 729 238. 17	6. 00 7. 00
7.00	That district cost per visit (Time 5 divided by Time 6)		Cal cul ati on	of Limit (1)	7.00
				Rate Period 2	
			(01/01/2021	(04/01/2021 through	
			through 03/31/2021)	12/31/2021)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	237. 38	8. 00
9. 00	Rate for Program covered visits (see instructions)		238. 17	237. 38	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	477	1, 329	10.00
11. 00	Program cost excluding costs for mental health services (line		113, 607	315, 478	•
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	,	0	0	13. 00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	429, 085	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re			272, 973	
16. 02	Total program preventive charges (see instructions)(from prov			3, 124	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		4, 910	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		306, 564	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	311, 474	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		40, 970	18. 00
40.00	records)			45 77/	40.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		45, 776	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			311, 474	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		33, 106	
22. 00	, , ,			344, 580	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			22	23. 00 23. 01
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		14	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. 401. 66)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	25. 50
25. 99				0	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			344, 594 0	26. 00 26. 01
26. 01	1 '			0	26. 02
27. 00	Interim payments			209, 633	
	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			134, 961	
30. 00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	ince with CMS Pub. 15-II	'	0	30.00
	10.1ap.co. 17 3110.2		I	ı	ı

	Financial Systems WOODLAWN HOS			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1313	Peri od: From 01/01/2021	Worksheet M-3	
SERVI (ies S	Component CCN: 15-8549	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title XVIII	RHC I V	Cost	
				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)		486, 813	1.00
2.00	Cost of injections/infusions and their administration (from W			17, 584	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	inus line 2)		469, 229 3, 120	3.00
4. 00 5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		3, 120	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 7)		3, 120	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			150. 39	7.00
			Cal cul ati on	of Limit (1)	
			Rate Period 1		
			(01/01/2021	(04/01/2021	
			through 03/31/2021)	through 12/31/2021)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	237. 51	8. 00
9.00	Rate for Program covered visits (see instructions)		150. 39	150. 39	9. 00
10.00	CALCULATION OF SETTLEMENT				10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	•	168 25, 266	502 75, 496	
12. 00	Program covered visits for mental health services (from contr		25, 260	75, 470	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	Graduate Medical Education Pass Through Cost (see instruction			100 7/0	15.00
16. 00 16. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re	•	0	100, 762 100, 073	16. 00 16. 01
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	16.03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		67, 188	16. 04
1/ 05	(Titles V and XIX see instructions.)			/7 100	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	67, 188 0	16. 05 17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		16, 777	ı
	records)	•		•	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		16, 659	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			67, 188	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		7, 387	
22.00	Total reimbursable Program cost (line 20 plus line 21)			74, 575	•
23. 00 23. 01	Allowable bad debts (see instructions)			0	23.00
24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
25. 00	,	r de trons)		0	25.00
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	
26.00	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			74, 575	•
26. 01 26. 02	, ,			0	26. 01 26. 02
27. 00	Interim payments			47, 572	•
	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			27, 003	•
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II	,	0	30.00

	Financial Systems WOODLAWN HOSE		In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1313	Peri od: From 01/01/2021	Worksheet M-3	
SERVI (JE S	Component CCN: 15-8547	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title XVIII	RHC V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			26, 132	
3.00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	inus line 2)		1, 050, 833	
4. 00 5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		4, 398 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	7)		4, 398	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			238. 93	
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through 03/31/2021)	through 12/31/2021)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	. 6 or your contractor)	0.00	287. 67	8. 00
9.00	Rate for Program covered visits (see instructions)		238. 93	238. 93	9. 00
	CALCULATION OF SETTLEMENT		T		
10.00	Program covered visits excluding mental health services (from	•	150	546	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr		35, 840 0	130, 456 0	
13. 00	Program covered cost from mental health services (line 9 x li	,	0	0	
14.00	Limit adjustment for mental health services (see instructions	•	0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction				15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	166, 296	1
16. 01 16. 02	Total program charges (see instructions)(from contractor's re			110, 972 5, 437	1
16. 02	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	*		8, 148	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	*		112, 137	1
	(Titles V and XIX see instructions.)	, ,		·	
16. 05	Total program cost (see instructions)		0	120, 285	
17.00	Primary payer amounts	(6		17.077	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		17, 977	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		17, 512	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			120, 285	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		8, 700	1
22.00				128, 985	1
23.00	Allowable bad debts (see instructions)			66	
23. 01 24. 00	` ` '	rusti ons)		43	
25. 00		ructions)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	1
26.00	Net reimbursable amount (see instructions)			129, 028	
26. 01	Sequestration adjustment (see instructions)			0	
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 70, 027	26. 02 27. 00
	Tentative settlement (for contractor use only)			70, 027	28.00
	,	02 27 and 28)		59, 001	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.				
			,	0	1

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: From 01/01/2021	Worksheet M-3	
SERVI (EES	Component CCN: 15-8548	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title XVIII	RHC VI	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)				1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			84, 115	
3.00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	inus line 2)		3, 042, 287	3.00
4. 00 5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		15, 759 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 7)		15, 759	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			193. 05	
			Cal cul ati on	of Limit (1)	
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through	through	
			03/31/2021)	12/31/2021) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	207. 80	8.00
9.00	Rate for Program covered visits (see instructions)		193. 05	193. 05	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	•	531	1, 605	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr		102, 510 0	309, 845 0	
13. 00	Program covered cost from mental health services (line 9 x li		0	0	
14. 00	Limit adjustment for mental health services (see instructions	*	0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction	s)			15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	412, 355	1
16. 01	Total program charges (see instructions) (from contractor's re			323, 672	
16. 02 16. 03	Total program preventive charges (see instructions)(from prov Total program preventive costs ((line 16.02/line 16.01) times	•		17, 539 22, 345	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	•		275, 568	1
	(Titles V and XIX see instructions.)	,		·	
16. 05	Total program cost (see instructions)		0	297, 913	
17.00	Primary payer amounts	(from contractor		0 45 550	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		45, 550	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		52, 117	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			297, 913	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		24, 627	
22.00	,			322, 540	1
23. 00	Allowable bad debts (see instructions)			144	
23. 01	` ` '			94	1
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99			0	1	
26.00	Net reimbursable amount (see instructions)			322, 634	
26. 01	Sequestration adjustment (see instructions)			0	
26. 02	1 3 3			0	
27.00	Interim payments Tentative settlement (for contractor use only)			205, 989 0	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02. 27. and 28)		116, 645	1
30.00			,	0	1
	chapter I, §115.2				I

	Financial Systems WOODLAWN H	HOSPI TAL			u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od:	Worksheet M-4	
		Component (From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2.00	2. 01	2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	522, 239			522, 239	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000271	0. 00205		0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	142	1, 07	72 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	2, 246	5, 51	6 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2, 388	6, 58	88 0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 040, 180	1, 040, 18	1, 040, 180	1, 040, 180	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	868, 392	868, 39	92 868, 392	868, 392	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 002296	0. 00633	0. 000000	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1, 994	5, 50	00	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	4, 382	12, 08	0	0	10. 00
11.00	Total number of injections/infusions (from your records)	21	15		0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	208. 67	76. (0. 00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	13	į	0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2, 713	4, 48	0	0	14. 00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		16, 47	70		15. 00
16. 00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		7, 19	99		16. 00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of	f Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CCN: 15-1313		rksheet M-4
		From 01/01/2021	
	C CON 15 0550		

COMPU	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1313	Peri od:	Worksheet M-4	
		Component (CCN: 15-8552	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
					PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2, 365, 539		· · ·		
2.00	Ratio of injection/infusion staff time to total health	0. 001853	0. 0030	0. 000000	0. 000000	2.00
	care staff time				_	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	4, 383	7, 1	53 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	52, 833	27, 9	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	57, 216	35, 1	13 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	2, 821, 858	2, 821, 8	58 2, 821, 858	2, 821, 858	6.00
	Worksheet M-1, col. 7, line 22)					
7.00	Total overhead (from Wkst. M-2, line 19)	2, 563, 616	2, 563, 6	16 2, 563, 616	2, 563, 616	7.00
8.00	Ratio of injection/infusion direct cost to total direct	0. 020276	0. 0124	0. 000000	0.000000	8. 00
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	51, 980	31, 8	99 0	0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	109, 196	67, 0	12 0	0	10. 00
11. 00	· · · · · · · · · · · · · · · · · · ·	494	8	06	0	11.00
12.00		221. 04	83.	14 0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program	3		10 0	0	13.00
	benefi ci ari es					
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
	administered to MA enrollees					
14.00		663	8:	31 0	0	14.00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)					
15. 00	J		176, 20	08		15. 00
	administration costs (sum of columns 1, 2, 2.01, and 2.02,					
47.00	line 10) (transfer this amount to Wkst. M-3, line 2)			2.4		1/ 00
16. 00	3		1, 4	74		16. 00
	administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)					
	Title 14) (transfer this amount to wast. W-3, Title 21)	1	I	l	I	I

Heal th	Health Financial Systems WOODLAWN H			In Lieu of Form CMS-2552-10			
COMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1313	Peri od:	Worksheet M-4		
		'	CCN: 15-8550	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:		
			XVIII	RHC III	Cost		
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL		
		VACCI NES	VACCI NES	VACCINES	ANTI BODY		
		1.00	0.00	0.01	PRODUCTS		
1 00	THE THE TOTAL TOTA	1.00	2.00	2. 01	2. 02	4 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 229, 402				1.00	
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001224	0. 00312	0.000000	0. 000000	2.00	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 505	3, 84	6 0	0	3. 00	
4. 00	Injections/infusions and related medical supplies costs (from your records)	23, 315	19, 32	0	0	4. 00	
5.00	Direct cost of injections/infusions (line 3 plus line 4)	24, 820			0	5.00	
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 374, 159	1, 374, 15	1, 374, 159	1, 374, 159	6. 00	
7.00	Total overhead (from Wkst. M-2, line 19)	1, 767, 169	1, 767, 16	9 1, 767, 169	1, 767, 169	7.00	
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 018062	0. 01686	0. 000000	0. 000000	8. 00	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	31, 919	29, 79	4 0	0	9. 00	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	56, 739	52, 96	2 0	0	10.00	
11.00	Total number of injections/infusions (from your records)	218	55	7 0	0	11.00	
12.00	Cost per injection/infusion (line 10/line 11)	260. 27	95.0	0.00	0.00	12.00	
13. 00	Number of injection/infusion administered to Program beneficiaries	64	17	0	0	13. 00	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	16, 657	16, 44	9 0	0	14. 00	
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		109, 70	1		15. 00	
16. 00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		33, 10	06		16. 00	

Heal th	Financial Systems WOODLAWN H	HOSPI TAL			u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od:	Worksheet M-4	
		Component	CCN: 15-8549	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title	XVIII	RHC IV	Cost	
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCINES	ANTI BODY	
		4 00	0.00	0.01	PRODUCTS	
4 00	11 11 10 10 10 10 10 10 10 10 10 10 10 1	1.00	2.00	2. 01	2. 02	1 00
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	226, 157	226, 15		226, 157	
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000859	0. 01373	0.000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	194	3, 10	07 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	963	4, 99	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1, 157	8, 10	0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	256, 339	256, 33	256, 339	256, 339	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	230, 474	230, 47	230, 474	230, 474	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 004514	0. 03160	0. 000000	0.000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1, 040	7, 28	35 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2, 197			0	
11.00	Total number of injections/infusions (from your records)	9	14	4 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	244. 11	106. 8	0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	4	ϵ	0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	976	6, 41	1 0	0	14.00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		17, 58	34		15. 00
16. 00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		7, 38	37		16.00

Heal th	Financial Systems WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1313	Peri od:	Worksheet M-4	
		· ·	CCN: 15-8547	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
			XVIII	RHC V	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	471, 857 0. 000348				1. 00 2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	164	1, 4	42 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	2, 567	7, 3:	20 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	2, 731			0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	473, 666	473, 6	473, 666	473, 666	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	603, 299				
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 005766			0.000000	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	3, 479			0	9. 00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6, 210			0	
11. 00	Total number of injections/infusions (from your records)	24			0	
12.00	Cost per injection/infusion (line 10/line 11)	258. 75				12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	11	'	62 0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2, 846	5, 8	54 0	0	14. 00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		26, 1	32		15. 00
16. 00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		8, 7	00		16. 00

Heal th	Financial Systems WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der C		Peri od:	Worksheet M-4	
		Component		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
			XVIII	RHC VI	Cost	
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 385, 921	1, 385, 92	1 1, 385, 921	1, 385, 921	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 000717	0. 00320	6 0.000000	0.000000	2. 00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	994	4, 44	3 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	14, 331	20, 77	9 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	15, 325	25, 22	2 0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 507, 093	1, 507, 09	3 1, 507, 093	1, 507, 093	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	1, 619, 309	1, 619, 30	9 1, 619, 309	1, 619, 309	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 010169	0. 01673	6 0.000000	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	16, 467	27, 10	1 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31, 792	52, 32	3 0	0	10. 00
11.00	Total number of injections/infusions (from your records)	134	59	9 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	237. 25	87. 3	5 0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	39	17	6 0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	9, 253	15, 37	4 O	0	14. 00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		84, 11	5		15. 00
16. 00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		24, 62	7		16. 00

Health Financial Systems	WOODLAWN HOSF	PI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/ SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-1313 Component CCN: 15-8551	Peri od: From 01/01/2021 To 12/31/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am

		p		5/26/2022 11: 3	35 a
			RHC I	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			251, 811	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				0	3
)5				0	3
	Provider to Program				
0				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	sfer to Worksheet M-3, line		251, 811	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date of	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	5
)2				0	5
)3				0	5
	Provider to Program				
50				0	5
1				0	5
52				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
)1	SETTLEMENT TO PROVIDER			75, 938	6
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			327, 749	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
00	Name of Contractor	0	1.00	2.00	8.

Health Financial Systems	WOODLAWN HOSPITAL			u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARII	ES .	CCN: 15-1313 CCN: 15-8552	From 01/01/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am

		Component CCN: 15-8552	10 12/31/2021	5/26/2022 11: 3	pared 35 am
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1.00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			107, 496	1. C
2. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.0
	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. 0
	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				o	3.
. 05				0	3.
	Provider to Program		<u>'</u>		
. 50				0	3.
51				o	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	sfer to Worksheet M-3, line	е	107, 496	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	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.			0	5.
00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			39, 490	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			146, 986	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2. 00	
		<u> </u>	1.00	2.00	8. (

Health Financial Systems	WOODLAWN HOSPITAL		In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH SERVICES RENDERED TO PROGRAM BENEFICIARIE	S	er CCN: 15-1313 ent CCN: 15-8550	From 01/01/2021	Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am

		Component Con. 13-8330	10 12/31/2021	5/26/2022 11:	
			RHC III	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			209, 633	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	t 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				
1				0	3
2				0	3
3				0	3
)4				0	3
5				0	3
	Provider to Program				
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	e	209, 633	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
1				0	5
2				0	5
3				0	5
	Provider to Program			_	
0				0	5
1				0	5
2		00)		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (I)		404.044	6
1	SETTLEMENT TO PROVIDER			134, 961	6
2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)			344, 594	7
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
	No. of Contraction	0	1. 00	2. 00	
00	Name of Contractor				8

Health Financial Systems	WOODLAWN HOS	PITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provi der CCN: 15-1313 Component CCN: 15-8549	Peri od: From 01/01/2021 To 12/31/2021	
			DUC IV	C+

		Component Con. 13-8349	10 12/31/2021	5/26/2022 11:	
			RHC IV	Cost	
			Pai	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			47, 572	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	•			
0	List separately each retroactive lump sum adjustment amount	t 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		<u> </u>		
1				0	3
2				0	3
3				0	3
4				0	3
5				0	3
	Provider to Program				
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (trans			47, 572	_
	27)			, ,	
	TO BE COMPLETED BY CONTRACTOR		-	•	
00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
1				0	Ę
2				0	5
3				0	Ę
	Provider to Program				
0				0	5
1				0	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
1	SETTLEMENT TO PROVIDER			27, 003	6
2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)			74, 575	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor				8

Health Financial Systems	WOODLAWN HOSE	PI TAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED I SERVICES RENDERED TO PROGRAM BENEFICIAR	I ES	Provider CCN: 15-1313 Component CCN: 15-8547		Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am

		Component Con. 13-8347	10 12/31/2021	5/26/2022 11: 3	
			RHC V	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			70, 027	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				
	"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
)2				0	3
23				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	fer to Worksheet M-3, line	;	70, 027	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		-		_
00	List separately each tentative settlement payment after des	k review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
01	Program to Provider			0	5
)2					5
)2					5
	Provider to Program			<u> </u>	C
50	Frovider to Frogram			0	5
51					5
52				ان ا	5
99	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 cost report. (1)				6
)1	SETTLEMENT TO PROVIDER			59, 001	6
)2	SETTLEMENT TO PROGRAM			37,001	6
00	Total Medicare program liability (see instructions)			129, 028	7
00	Total modicale program Habitity (see Histiactions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	WOODLAWN HOSE	PI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR	IES	Provider CCN: 15-1313 Component CCN: 15-8548		Worksheet M-5 Date/Time Prepared: 5/26/2022 11:35 am

		Component Con. 13-8348	10 12/31/2021	5/26/2022 11: 3	
			RHC VI	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			205, 989	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				
	"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
23				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	fer to Worksheet M-3, line	:	205, 989	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		-	ı	
00	List separately each tentative settlement payment after des	k review. Also show date o	OT		5
	each payment. If none, write "NONE" or enter a zero. (1)				
01	Program to Provider			1 0	5
02					5
)2)3					5
	Provider to Program			0	~
50	11001del to 110gi diii			0	5
51				0	5
52				l ol	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
)1	SETTLEMENT TO PROVIDER			116, 645	6
02	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			322, 634	7
	[[] [] [] [] [] [] [] [] [] [Contractor	NPR Date	É
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	