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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1313 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2023 Ti me: 7:17 pm use only] Manually prepared cost report If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [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. (4) Reopened

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

(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 01/01/2022 and ending 12/31/2022 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	Ala	an Fisher	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	Alan Fisher			2
3	Signatory Title	CEO CEO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-507, 502	-351, 525	0	-1, 050	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	-72, 588	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		10, 884		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-33, 257		0	10.01
10.02	RURAL HEALTH CLINIC III	0		19, 433		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		-21, 790		0	10.03
10.04	RURAL HEALTH CLINIC V	0		-26, 347		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		-21, 087		0	10.05
200.00	TOTAL	0	-580, 090	-423, 689	0	-1, 050	200.00
The ab	ove amounts represent "due to" or "due from"	the annlicable	program for t	he element of	the above compl	ev 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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/26/2023 7:17 pm 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, 0, 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 Hospi tal -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) 01/01/2022 12/31/2022 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 UCPs, including supplemental UCPs, for 22.01 Ν Ν 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 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			ON 4E 4040		n Li e	u of Form		
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENIIFICATION DATA	Pr	rovider CC		Period: From 01/01 To 12/31	/2022	Workshee Part I Date/Tii 5/26/20	me Pre 23 7:1	pared
						1. 00	XVIII 2.00	3. 00	-
7.00 For cost reporting periods beginning is this the first cost reporting per at this facility? Enter "Y" for yes residents start training in the firs "N" for no in column 2. If column 2 complete Wkst. D, Parts III & IV and beginning on or after December 27, 2 which month(s) of the cost report the for yes, enter "Y" for yes in column	od during which resider "N" for no in column to this cost is "Y", complete Wor D-2, Pt. II, if appl D20, under 42 CFR 413 eresidents were on dan do not complete column.	dents i umn 1. reporti ksheet icable. .77(e) uty, if olumn 2	n approve If column ng period E-4. If c For cost (1)(iv) a the resp , and com	ed GME program 1 1 is "Y", di 1? Enter "Y" column 2 is "! creporting per ind (v), regal conse to line aplete Workshe	ns trained d for yes or N", eriods rdless of 56 is "Y" eet E-4.	-			57.
3.00 If line 56 is yes, did this facility defined in CMS Pub. 15-1, chapter 21 2.00 Are costs claimed on line 100 of Worl	§2148? If yes, comp	lete Wk	st. Ď-5.		s as	N N			58. 59.
	_	•		NAHE 413.85 Y/N	Workshe Li ne		Pass-Th Qualific Criter Code	ation ion	
				1.00	2. 0	0	3. 0	0	
Are you claiming nursing and allied any programs that meet the criterial instructions) Enter "Y" for yes or is "Y", are you impacted by CR 11642 adjustment? Enter "Y" for yes or "N"	under 42 CFR 413.85? 'N" for no in column (or subsequent CR) N	(see 1. If	column 1	N					60.
jady distillente. Enter i 161 yes of iv	Y/N		IME	Direct GME	I ME		Di rect	GME	
1 00 Did your best tel seed to STE at a	1.00)	2. 00	3. 00	4. 0		5. 0		61.
1.00 Did your hospital receive FTE slots of section 5503? Enter "Y" for yes or "I column 1. (see instructions) 1.01 Enter the average number of unweighted FTEs from the hospital's 3 most received.	N" for no in ed primary care					0. 00		0. 00	61.
ending and submitted before March 23 instructions) .02 Enter the current year total unweigh FTE count (excluding OB/GYN, general	ted primary care surgery FTEs,								61.
and primary care FTEs added under set ACA). (see instructions) .03 Enter the base line FTE count for pri and/or general surgery residents, while determining compliance with the 75% of the set of th	mary care								61.
instructions) .04 Enter the number of unweighted primal surgery allopathic and/or osteopathic	ry care/or c FTEs in the								61.
current cost reporting period (see in Enter the difference between the base and/or general surgery FTEs and the primary care and/or general surgery (61.04 minus line 61.03). (see instru	eline primary current year's FTE counts (line								61.
I. 06 Enter the amount of ACA \$5503 award used for cap relief and/or FTEs that care or general surgery. (see instru	that is being are nonprimary ctions)								61.
	F	Program		Program Cod	IME FTE	Count	Unweigh Direct FTE Co	GME ount	
1.10 Of the FTEs in line 61.05, specify ea	ach new program	1. 0	J	2.00	3. 0	0. 00	4. 0	0. 00	61
specialty, if any, and the number of for each new program. (see instruction column 1, the program name. Enter in program code. Enter in column 3, the unweighted count. Enter in column 4, FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify exprogram specialty, if any, and the number of the following special ty, if any,	FTE residents ons) Enter in column 2, the IME FTE the direct GME ach expanded umber of FTE (see program name. Enter in column					0. 00		0. 00	

	Financial Systems		DLAWN HOSPITA				u of Form CMS-	
IOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Pro	vider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/26/2023 7:1	pared
							1.00	
	ACA Provisions Affecting the Hea Enter the number of FTE resident	s that your hospital	trained in t			eriod for which		62.0
2. 01	your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe	s that rotated from	a Teaching He			o your hospital	0.00	62.
. 00	Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col	esidents in Nonprovid ents in nonprovider s	er Settings ettings durin	g this co	ost reportino		N	63.
	TO YES OF IN TOUR HO THE COL	umir i. II yes, compri	ete iiiles 04	in ough	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te 1. 00	2. 00	3.00	1
	Section 5504 of the ACA Base Yea					_		
. 00	period that begins on or after of Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the	s yes, or your facili aber of unweighted no otations occurring in a number of unweighte	ty trained res n-primary car all nonprovid d non-primary	sidents e der care	0. (0.00	0. 000000	64.
	resident FTEs that trained in your of (column 1 divided by (column							
		Program Name	Program (code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2.00		Si te 3. 00	4. 00	5. 00	1
	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)				Unwei ghted	Unwei ghted	Ratio (col.	
					FTEs Nonprovi der Si te	FTES in Hospital	1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovi der	Setti ng	1.00 sEffective	2.00 for cost report	3.00 ing periods	
. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima occurring in all nonp unweighted non-prima al. Enter in column	rovider setti ry care resid 3 the ratio o	ngs. ent	0. (0. 00	0. 000000	66.
		Program Name	Program (code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
					51 10			

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPI			F	Period: Trom 01/01/2022 To 12/31/2022		pared:
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2.00	3. 00	4. 00	5. 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			0.00	0.0	0. 000000	67. U
	4)). (see instructions)						
	Direct CME in Accordance will I	o EV 2022 LDDC E:	Dul o 07 FD 400/F 4	10072 (10072	2022)	1.00	
8. 00	Direct GME in Accordance with th For a cost reporting period begi MAC to apply the new DGME formul (August 10, 2022)?	nning prior to Octob	er 1, 2022, did you	obtain permissi	on from your	N	68.00
					4.6	20 00 00 00	-
	Inpatient Psychiatric Facility P	PS			1. (00 2.00 3.00	
	Is this facility an Inpatient Ps		IPF), or does it con	tain an IPF sub	provi der? N		70.0
1.00	Enter "Y" for yes or "N" for no. 0 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS						
5. 00	Is this facility an Inpatient Re	habilitation Facilit	y (IRF), or does it	contain an IRF	N		75.0
6. 00	subprovider? Enter "Y" for yes If line 75 is yes: Column 1: Did recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	the facility have a ing on or before Nov train residents in a r "Y" for yes or "N"	rember 15, 2004? Ente new teaching progra for no. Column 3: I	r "Y" for yes o m in accordance f column 2 is \	or "N" for e with 42 /,	0	76.00
						1.00	
	Long Term Care Hospital PPS					1.00	
0. 00 1. 00	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				g period? Ente	- N N	80. 00 81. 00
5. 00 5. 00	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider	(excluded unit) unde			N	85. 00 86. 00
	Is this hospital an extended neo 1886(d)(1)(B)(vi)? Enter "Y" for		hospital classified	under section		N	87.0
					Approved for Permanent Adjustment (Y/N) 1.00	Approved Permanent Adjustments 2.00	-
	Column 1: Is this hospital appro amount per discharge? Enter "Y" 89. (see instructions)				=	0	88.0

ealth Financial Systems WOODLAWN HO	_	ON 45 4040		u of Form CMS-	
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	JN: 15-1313	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/26/2023 7:1	epared
		Wkst. A Lir No.	ne Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1. 00	2. 00	3. 00	
9.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A I on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA taper discharge. Column 3: Enter the amount of the approved permanent adjustment tages. TEFRA target amount per discharge.	s based. g period arget amount	0.	00	C	89.
			V 1,00	XIX	-
Title V and XIX Services			1. 00	2. 00	
Does this facility have title V and/or XIX inpatient hospital	al services? E	nter "Y" for	· N	Y	90. (
yes or "N" for no in the applicable column. 1.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applicable.			N	Y	91.
2.00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applica		ion)? (see		N	92.
B. 00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		nd XIX? Enter	N	N	93.
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for r	no in the	N	N	94.
applicable column. Old If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the				0. 00 N	95. 96.
applicable column. Output Discourse In the applicable of its "Y", enter the reduction percentage in the applicable of the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for the instead of the stepdown adjustments on Wkst. B, Pt. I, col. 25?	nterns and res	sidents post	0. 00 Y	0. 00 Y	97. 98.
column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.				Y	98.
.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes a for title V, and in column 2 for title XIX.			Y	Y	98.
.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				N	98.
.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ir in column 2 for title XIX.			N N	N	98.
.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in a column 2 for title XIX.				Y	98.
.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.
Rural Providers 5.00 Does this hospital qualify as a CAH?			Υ		105.
6.00 of this facility qualifies as a CAH, has it elected the all-	-inclusive met	hod of payme			106.
for outpatient services? (see instructions) 7.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF	n 1. (see ins you train I&F PF and/or IRF	structions) Rs in an	N		107.
Enter "Y" for yes or "N" for no in column 2. (see instructi 18.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		edul e? See 4	2 N		108.
	Physi cal	Occupation		Respiratory	-
09.00 f this hospital qualifies as a CAH or a cost provider, are	1. 00 N	2. 00 N	3. 00 N	4. 00 N	109.
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					

Health Financial Systems WOODLAWN HOSPI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA F	TAL Provider CC	F	In Lieu Period: From 01/01/2022 To 12/31/2022	worksheet S- Part I Date/Time Pr 5/26/2023 7:	-2 repared:
				1. 00	
10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" complete Worksheet E, Part A, lines 200 through 218, and Workshapplicable.	for yes or	"N" for no.	f yes,	N N	110.0
			1. 00	2. 00	
I11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colum integration prong of the FCHIP demo in which this CAH is partic Enter all that apply: "A" for Ambulance services; "B" for addit for tele-health services.	reporting pain 1 is Y, or cipating in	period? Enter enter the column 2.	N		111.0
		1. 00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost repor period? Enter "Y" for yes or "N" for no in column 1. If colum "Y", enter in column 2, the date the hospital began participati demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. 113.00 Did this hospital participate in the Community Health Access an Transformation (CHART) model for any portion of the current cos reporting period? Enter "Y" for yes or "N" for no.	nting nn 1 is ng in the i	N			112. 0
Miscellaneous Cost Reporting Information 15.00 st this an all-inclusive rate provider? Enter "Y" for yes or "N	l" for no	N			0115. C
in column 1. If column 1 is yes, enter the method used (A, B, o in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (inc psychiatric, rehabilitation and long term hospitals providers)	or E only) percent cludes	IV			0113.0
the definition in CMS Pub.15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for	yes or	N			116.0
"N" for no. 17.00 s this facility legally-required to carry malpractice insuranc "Y" for yes or "N" for no.	ce? Enter	Υ			117.0
118.00 Is the malpractice insurance a claims-made or occurrence policy if the policy is claim-made. Enter 2 if the policy is occurrence			1		118.0
in the portey 13 crum made. Effect 2 11 the portey 13 decurrent	,	Premi ums	Losses	Insurance	
		1. 00	2.00	3. 00	
18.01 List amounts of malpractice premiums and paid losses:		1. 00 282, 84			0118.0
		282, 84	1.00		
I18.02 Are malpractice premiums and paid losses reported in a cost cen Administrative and General? If yes, submit supporting schedule and amounts contained therein.		282, 84 than the	5 0		0118.0
18.02 Are malpractice premiums and paid losses reported in a cost cen Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments?	e listing co armless pro blumn 1, "Y fies for th	282,84 than the ost centers vision in ACA for yes or he Outpatient	1.00 N		118. 0
18.02 Are mal practice premiums and paid losses reported in a cost cen Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implanta	e listing of armless problumn 1, "Y fies for the (see inst	282,84 than the ost centers vision in ACA " for yes or he Outpatient ructions)	1.00 N	2.00	118. C
18.02 Are mal practice premiums and paid losses reported in a cost cen Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha \$3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA \$3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is	e listing of armless problem 1, "Y fies for the content of the con	than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to (w)(3) of the	1.00 N N	2.00	118. (119. (120. (
18.02 Are mal practice premiums and paid losses reported in a cost cen Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha \$3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA \$3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purcha services, e.g., legal, accounting, tax preparation, bookkeeping management/consulting services, from an unrelated organization? for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., gr professional services expenses, for services purchased from unr located in a CBSA outside of the main hospital CBSA? In column "N" for no.	e listing of armless proportion 1, "Y fies for the control of the	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 ional and/or 1, enter "Y" 50% of total anizations	1.00 N N	2.00	118. (119. (120. (121. (122. (
18.02 Are mal practice premiums and paid losses reported in a cost cen Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purcha services, e.g., legal, accounting, tax preparation, bookkeeping management/consulting services, from an unrelated organization? for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., gr professional services expenses, for services purchased from unr located in a CBSA outside of the main hospital CBSA? In column "N" for no. Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant cent	e listing of armless problumn 1, "Y fies for the control (see instable devices ed in §1903 s "Y", enter ase profess, payroll, of in column related org. 2, enter ""	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or	1.00 N N	2.00	118. C 119. C 120. C
Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) purcha services, e.g., legal, accounting, tax preparation, bookkeeping management/consulting services, from an unrelated organization? for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., gr professional services expenses, for services purchased from unr located in a CBSA outside of the main hospital CBSA? In column "N" for no. Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant cent and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy	e listing of armless proportion of the control of t	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes	N N N	2.00	118. 0 119. 0 120. 0 121. 0 122. 0 123. 0
Are mal practice premiums and paid losses reported in a cost cen Administrative and General? If yes, submit supporting schedule and amounts contained therein. 19.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha \$3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purcha services, e.g., legal, accounting, tax preparation, bookkeeping management/consulting services, from an unrelated organization? for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., gr professional services expenses, for services purchased from unr located in a CBSA outside of the main hospital CBSA? In column "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant cent and "N" for no. If yes, enter certification date(s) (mm/dd/yyyyy in column 1 and termination date, if applicable, in column 2.	e listing of armless proportion of the control of t	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 ional and/or 1, enter "Y" 50% of total anizations Y" for yes or "Y" for yes ification data	N N N	2.00	118. C 119. C 120. C 121. C 122. C 123. C
and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Ha \$3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that qualifies hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchas services, e.g., legal, accounting, tax preparation, bookkeeping management/consulting services, from an unrelated organization? for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., gr professional services expenses, for services purchased from unrelocated in a CBSA outside of the main hospital CBSA? In column "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) 126.00 If this is a Medicare-certified kidney transplant program, enter	e listing of armless problems 1, "Y fies for the certification of the ce	than the ost centers vision in ACA "for yes or he Outpatient ructions) s charged to (w)(3) of the rin column 2 ional and/or 1, enter "Y" 50% of total and yer for yes or "Y" for yes ification date fication date	N N N	2.00	

In Lieu of Form CMS-2552-10 Health Financial Systems WOODLAWN HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1313 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/26/2023 7:17 pm 1. 00 2.00 129.00 If this is a Medicare-certified lung transplant program, enter the certification date 129.00 in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare-certified intestinal transplant program, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00|If this is a Medicare-certified islet transplant program, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 134.00 If this is a hospital-based organ procurement organization (0P0), enter the 0P0 number 134.00 in column 1 and termination date, if applicable, in column 2 All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. N 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 3.00 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: Contractor's Name: Contractor's Number: 141.00 142.00 Street: PO Box 142.00 143.00 Ci ty: State: Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 1. 00 2.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. Ν 148.00 for yes or "N" for no 149.00 Was there a change to the simplified cost finding method? Enter "Y" N 149. 00 Part A Part B Title XIX Title V 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N 155.00 Ν Ν Ν 156.00 Subprovi der - IPF Ν Ν Ν Ν 156. 00 157.00 Subprovi der - IRF N Ν N N 157 00 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY Ν Ν 160.00 N Ν 161.00 CMHC N N Ν 161.00 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. N 165.00 FTE/Campus CBSA Name County State Zi p Code 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4. FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.
168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the Υ 167 00 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions)

Health Financial Systems	ealth Financial Systems WOODLAWN HOSPITAL			u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		Peri od:	Worksheet S-2	
			From 01/01/2022 To 12/31/2022		narod:
			10 12/31/2022	5/26/2023 7: 1	
			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 section 1876 Medicare cost plans repo	N	0	171. 00		
"Y" for yes and "N" for no in column 1876 Medicare days in column 2. (see		nter the number of secti	on		

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1313 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/26/2023 7:17 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 03/22/2023 Υ 03/22/2023 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 17.00 N N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 18.00 Ν N 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. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems WOODLAWN H	HOSPI TAL		In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-1313	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part II Date/Time F 5/26/2023 7	repared:
			iption	Y/N	Y/N	
20.00	If Line 14 or 17 is yes were adjustments made to DCOD		0	1.00	3. 00	20, 00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	,	Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23.00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ing the cost	N	23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases enterollifyes, see instructions	ed into during	this cost re	eporting period?	N	24.00
25. 00	Have there been new capitalized leases entered into during	Plf ves see	N	25. 00		
20.00	instructions.	0001 . 000	. tring portou	1. 300, 000		20.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost report	ing period?	f yes, see	N	26.00
	instructions.					
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	yes, submit	N	27. 00
	Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cos	t reporting	Υ	28. 00
	period? If yes, see instructions.		•			
29. 00	Did the provider have a funded depreciation account and/or	Reserve Fund)	N	29. 00		
20.00	treated as a funded depreciation account? If yes, see install Has existing debt been replaced prior to its scheduled mate		. dob+2 l.f. vo.		N	20.00
30. 00	instructions.	urity with new	debt? If yes	s, see	N	30.00
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see	N	31.00
	i nstructi ons.					
	Purchased Servi ces					
32. 00	Have changes or new agreements occurred in patient care se		ied through c	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instruction of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the second section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied to the section of Sec. 2135.2 applied		na to competi	tive hidding? If	N	33.00
00.00	no, see instructions.	pri ou por turin	g to compet.	tivo bi daing. ii		00.00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-l	pased physicians?	Y	34.00
	If yes, see instructions.					
35. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in		ents with the	provi der-based	N	35.00
	physicians during the cost reporting period: if yes, see if	iisti ucti olis.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36. 00	Were home office costs claimed on the cost report?	·		N		36.00
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office	?		37.00
20.00	If yes, see instructions.	eloo diee	from that	-		20.00
38. UU	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end					38. 00
39. 00	If line 36 is yes, did the provider render services to other			s,		39.00
	see instructions.					
40.00	If line 36 is yes, did the provider render services to the	home office?	If yes, see			40. 00
	i nstructi ons.	1				
		1	. 00	2.	00	
	Cost Report Preparer Contact Information		-	2.	_	
41.00	Enter the first name, last name and the title/position	SMI TH		41.00		
	held by the cost report preparer in columns 1, 2, and 3,					
40	respectively.		_			
42. 00	. , , , , , , , , , , , , , , , , , , ,	BLUE & CO. LLO	j			42.00
43. 00	preparer. Enter the telephone number and email address of the cost	 317-713-7957		KCSMI TH@BLUEAN	DCO COM	43.00
	report preparer in columns 1 and 2, respectively.					.5. 55
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1		T.		"

Health Financial Systems WOODLAWN HOS	In Lieu	of Form CMS-2	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
			5/26/2023 7:1	/ pm
-	3.00			
Cost Report Preparer Contact Information	3.00			
	RECTOR			41.00
42.00 Enter the employer/company name of the cost report preparer.				42.00
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

Health Financial Systems WOOD HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: Provi der CCN: 15-1313

				To	12/31/2022	Date/Time Pre 5/26/2023 7:1	
						I/P Days /	/ pill
						0/P Visits /	
						Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00	2. 00	3. 00	4.00	5. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	21	7, 665	49, 608. 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		0.4	7 //5	40, 400, 00	0	6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7, 665	49, 608. 00	0	7. 00
8. 00	INTENSIVE CARE UNIT	31.00	4	1, 460	3, 336. 00	0	8.00
9. 00	CORONARY CARE UNIT	01.00	,	1, 100	0,000.00	· ·	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)					_	12.00
13. 00 14. 00	NURSERY	43. 00	25	0.125	E2 044 00	0	13. 00 14. 00
15. 00	Total (see instructions) CAH visits		25	9, 125	52, 944. 00	0	15.00
16. 00	SUBPROVI DER - I PF					O	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 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						22. 00 23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	88. 00				0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01				0	26. 01
26. 02 26. 03	RURAL HEALTH CLINIC III	88. 02				0	26. 02 26. 03
26. 03	RURAL HEALTH CLINIC IV RURAL HEALTH CLINIC V	88. 03 88. 04				0	26. 03
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 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges	00.00	_			2	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0	l	0	34.00

Provider CCN: 15-1313

						5/26/2023 7:1	7 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
	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	
	PART I - STATISTICAL DATA		1				
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	766	60	2, 067			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)	346	239				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	205	0	205			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	113			6.00
7.00	Total Adults and Peds. (exclude observation	971	60	2, 385			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	58	0	139			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	371			13.00
14.00	Total (see instructions)	1, 029	60	2, 895	0.00	237. 65	14.00
15.00	CAH vi si ts	o	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
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			O			25.00
26. 00	RURAL HEALTH CLINIC	1, 581	910	6, 044	0.00	4. 26	26.00
26. 01	RURAL HEALTH CLINIC II	514	8, 087	18, 819		21. 76	26.01
26. 02	RURAL HEALTH CLINIC III	2, 174	3, 911	12, 890		14. 17	26.02
26. 02	RURAL HEALTH CLINIC IV	651	1, 125	3, 528		0. 84	26. 03
26. 03	RURAL HEALTH CLINIC V	771	1, 081	5, 004		5. 85	26.03
26. 05	RURAL HEALTH CLINIC VI	2, 318	4, 777			12. 09	26.04
				17, 680		0.00	26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)		1.10	4 004	0. 00	296. 62	27.00
28. 00	Observation Bed Days		142	1, 201			28.00
29. 00	Ambul ance Tri ps	0		_			29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	0	30	123			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Health Financial Systems WOOD HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1313 Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm

						5/26/2023 7: 1	7 pm
		Full Time		Di sch	arges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	II tie v	II the Aviii	II LI E XIX	Patients	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	201	16	606	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)			70	80		2. 00
3. 00	HMO IPF Subprovider			70	0		3.00
4. 00	HMO IRF Subprovider				Ö		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	201	16	606	14. 00
15.00	CAH vi si ts						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 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0. 00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02 26. 03	RURAL HEALTH CLINIC III RURAL HEALTH CLINIC IV	0. 00 0. 00					26. 02 26. 03
26. 03	RURAL HEALTH CLINIC V	0.00					26. 03
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 Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			o			33. 00
33. 01	LTCH site neutral days and discharges			Ö			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

	Financial Systems FAL-BASED RHC/FQHC STATISTICAL DATA		HOSPITAL Provider C	CN: 15-1313	Peri od:	Worksheet S-	-2552 8
	AL BIOLD WILLIAM SWITTONE BANK			CCN: 15-8551	From 01/01/2022 To 12/31/2022	2 Date/Time Pr	epare
					RHC I	5/26/2023 7: Cost	1/ pm
					KIIC I	COST	
					1.	. 00	
	Clinic Address and Identification						
00	Street		1 01		1430 E 9TH STF		1.
				ty	State 2.00	ZIP Code 3.00	
00	City, State, ZIP Code, County		ROCHESTER 1.	00		3.00 146975	2.
00	orty, State, 211 code, county		INOCILETEN		1.0	140773	
						1.00	
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for				0 3.
					nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	
00	Community Health Center (Section 330(d), PHS	Act)					4.
00	Migrant Health Center (Section 329(d), PHS A						5
00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6
00	Appal achi an Regi onal Commission						7
00	Look-Alikes						8
00	OTHER (SPECIFY)						9
					1. 00	2.00	
00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N N		0 10
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o	f other operat	ion(s) and the	operati ng			
	hours.)	6	T.			T	
		from	day to	from	onday to	Tuesday from	
		1. 00	2.00	3.00	4. 00	5. 00	+
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
. 00	Facility hours of operations (1)	1.00	2.00	08: 00	17: 00	08: 00	11
. 00		1.00	2.00		17: 00	08: 00	11
	CLINIC			08: 00	17: 00		
. 00	CLINIC Have you received an approval for an excepti	on to the prod	uctivity stand	08: 00 ard?	17: 00 1. 00 Y	08: 00	12
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define	on to the prod	uctivity stand	08:00 ard? r 9, section	17: 00	08: 00	12
. 00	CLINIC Have you received an approval for an excepti	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	08:00 ard? r 9, section mn 2 the	17: 00 1. 00 Y	08: 00	12
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	o8:00 ard? r 9, section mn 2 the ders and	17: 00 1. 00 Y N	08: 00	12
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N	08: 00 2. 00	12
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N	08: 00	120 13
00 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00	120 13
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N	08: 00 2. 00 CCN 2. 00 Total Visits	120 13
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00	12 13
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visits	12 13
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visits	12 13
00 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visits	12 13
00 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visits	12 13
00 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visits	12 13
00 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	o8:00 ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visits	12 13
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi V 2.00	o8:00 ard? r 9, section mn 2 the ders and Provi XVIII 3.00	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visits	12 13
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in col umns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou	ard? r 9, section mn 2 the ders and Provi XVIII 3.00	17: 00 1. 00 Y N der name 1. 00	08: 00 2. 00 CCN 2. 00 Total Visits	114
. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou 4. FULTON	omator of the section	17: 00 1. 00 Y N der name 1. 00 XIX 4. 00	08: 00 2. 00 CCN 2. 00 Total Visits 5. 00	12 13 13 14 15
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in col umns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou 4. FULTON Wedne	ard? r 9, section mn 2 the ders and Provi XVIII 3.00	17: 00 1. 00 Y N der name 1. 00 XI X 4. 00	08: 00 2. 00 CCN 2. 00 Total Visits 5. 00	12 12 13 13 14 14 15 15 15 15 15 15 15 15 15 15 15 15 15
00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in col umns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	on to the prod d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi V 2.00 Cou 4. FULTON	omator of the section	17: 00 1. 00 Y N der name 1. 00 XIX 4. 00	08: 00 2. 00 CCN 2. 00 Total Visits 5. 00	14.

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8551	From 01/01/2022 To 12/31/2022		
				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 CLI NI C	08: 00	17: 00				11. 00

Heal th	n Financial Systems	WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od: From 01/01/2022	Worksheet S-8	3
			Component	CCN: 15-8552	To 12/31/2022		
					RHC I I	Cost	
					1	00	-
	Clinic Address and Identification	-					
1. 00	Street		1		1400 E 9TH STR		1.00
				00	2. 00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		ROCHESTER	00		46975	2.00
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urhan		1. 00	3.00
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - ENT	ei k ioi iui	ai 0i 0 10i		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds					T	
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00
6. 00	Health Services for the Homeless (Section 34						6.00
7. 00	Appal achi an Regi onal Commi ssi on						7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10.00	j '					C	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type o hours.)	or other operat	ion(s) and the	operating			
	Thou 3.)	Sur	nday	l N	Monday	Tuesday	
		from	to	from	to	from	
	Facility bours of energtions (1)	1. 00	2. 00	3.00	4. 00	5. 00	
11. 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11.00
10.00					1. 00	2. 00	10.00
12. 00 13. 00					Y		12.00
13.00	30. 8? Enter "Y" for yes or "N" for no in col				18		13.00
	number of providers included in this report.	List the name	s of all provi	ders and			
	numbers below.		,	Prov	ider name	CCN	
				1100	1. 00	2. 00	
14. 00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
15. 00	Have you provided all or substantially all	1. 00	2.00	3.00	4. 00	5. 00	15.00
13.00	GME cost? Enter "Y" for yes or "N" for no in	1					13.00
	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)			L			
				unty 00			
2. 00	City, State, ZIP Code, County		FULTON 4.	00			2.00
00	12. 21. State, 2.1. South Southly	Tuesday		esday	Thur	sday	
		to	from	to	from	to	
	Facility have of annual (1)	6. 00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1)	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
11.00	lori in o	117.00	po. 00	1.7.00	100.00	117.00	1 11.00

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 15-1313	Peri od:	Worksheet S-8	1
		Component	CCN: 15-8552	From 01/01/2022 To 12/31/2022		
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

Heal th	n Financial Systems	WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8550	From 01/01/2022 To 12/31/2022		
					RHC III	Cost	
					1	00	-
	Clinic Address and Identification					00	
1.00	Street		-		700 MAIN STREE	T	1.00
				ty	State	ZIP Code	
0.00	011 0111 710 0111 0111			00	2. 00	3.00	0.00
2. 00	City, State, ZIP Code, County		ROCHESTER		IN	46975	2.00
						1. 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for run	al or "U" for			C	3.00
					nt Award	Date	
	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	ict)					5.00
6.00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes						7.00
9. 00	OTHER (SPECIFY)						9.00
7. 00	TOTALLY (G. 2011)						71.00
					1. 00	2. 00	
10. 00	j '					C	10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o						
	hours.)	or other operat	Torr(s) and the	operating			
		Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
	Facility bours of energtions (1)	1. 00	2. 00	3. 00	4. 00	5. 00	
11. 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11.00
			1	155.55			
	To the second se				1. 00	2. 00	
12.00					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				N	C	13.00
	number of providers included in this report.						
	numbers below.						
				Prov	ider name	CCN	
14 00	RHC/FQHC name, CCN				1. 00	2. 00	14.00
11.00	Turo Fario Hamo, Gov	Y/N	V	XVIII	XIX	Total Visits	111.00
		1. 00	2. 00	3.00	4.00	5. 00	
15. 00							15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Cou	l inty			
				00			
2.00	City, State, ZIP Code, County		FULTON				2.00
		Tuesday		esday T		sday L +-	
		6. 00	7.00	8. 00	9.00	to 10.00	
	Facility hours of operations (1)	0.00	7.00	0.00	9.00	10.00	
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 (CCN: 15-1313	Peri od:	Worksheet S-8	}
		Component	CCN: 15-8550	From 01/01/2022 To 12/31/2022		pared:
				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

Health Financial Systems	WOODLAWN H	IOSPI TAL		In Lie	u of Form CMS	5-2552-1C
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 15-1313	Peri od:	Worksheet S-	-8
		Component	CCN: 15-8549	From 01/01/2022 To 12/31/2022	Date/Time Pr 5/26/2023 7:	
				RHC IV	Cost	
					00	
Clinic Address and Identification				1.	00	
1.00 Street				100 EAST DUNN	STREET	1.00
			ty	State	ZIP Code	
2 00 City Ctata 71D Cada Causty			00	2.00	3. 00	2.00
2.00 City, State, ZIP Code, County		FULTON		IN	46931	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	Date 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 Health Services for the Homeless (Section 34 7.00 Appalachian Regional Commission	W(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	nosni tal -hased (RHC or FOHC2 F	nter "Y" for	1. 00 N	2. 00	0 10.00
yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type of	ate number of o	other operatio	ns in column			10.00
hours.)	C	-1		4	T	
	Sun from	to	from	londay to	Tuesday 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 produ	uctivity stand	lard?	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				N		0 13.00
number of providers included in this report. numbers below.	List the names	s of all provi				
			Prov	ider name	CCN	
14.00 RHC/FQHC name, CCN				1. 00	2. 00	14.00
THE SECTION FROM THE MENT OF THE SECTION SECTI	Y/N	V	XVIII	XIX	Total Visits	
	1. 00	2. 00	3.00	4. 00	5. 00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15. 00
column 1. If yes, enter in columns 2, 3 and	1					
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			
2 00 City State 71D Code County			00			2.00
2.00 City, State, ZIP Code, County	Tuesday	FULTON Wedn	esday	Thur	sday	2.00
	to	from	to	from	to	
	6. 00	7. 00	8.00	9. 00	10. 00	
Facility hours of operations (1)	17.00	00.00	17.00	00.00	17.00	14.60
11. 00 CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CCN: 15-1313	Peri od:	Worksheet S-8	1
		Component	CCN: 15-8549	From 01/01/2022 To 12/31/2022		
				RHC IV	Cost	, p
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLI NI C	08: 00	17: 00				11. 00

Heal th	Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form C	MS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1313	Peri od:	Worksheet		
			Component	CCN: 15-8547	From 01/01/2022 To 12/31/2022			
					RHC V	Co:		, рііі
					1.	00		
1. 00	Clinic Address and Identification				105 SR 14 N			1. 00
1.00	Street		Ci	ty	State	ZIP Code	,	1.00
				00	2.00	3. 00		
2.00	City, State, ZIP Code, County		AKRON			46910		2.00
2 00	LIGORITAL BACER FOLIO. ONLY But and the Folio	II DII C	.1			1.00		2 00
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" Tor rur	al or "U" for		nt Award	Date	0	3. 00
					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	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	OTTIER (SPECITI)							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, indica 2. (Enter in subscripts of line 11 the type of hours.)							
	flour S.)	Sun	day	T M	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 exception	on to the produ	uctivity 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.			Provi	der name	CCN		
					1. 00	2. 00		
14. 00	RHC/FQHC name, CCN		,					14.00
		Y/N	V	XVIII	XI X	Total Visi	ts	
		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)		0=-	lntv.				
				unty 00				
2. 00	City, State, ZIP Code, County		FULTON 4.	00				2. 00
		Tuesday		esday	Thur	sday		
		to	from	to	from	to		
		6. 00	7. 00	8. 00	9. 00	10.00		
	Facility hours of operations (1)	17.00	laa aa	4-7-00		1.7.00		
11. 00	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	I	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	CCN: 15-1313	Peri od:	Worksheet S-8	}
		Component	CCN: 15-8547	From 01/01/2022 To 12/31/2022		
				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 CLI NI C	08: 00	17: 00				11.00

Heal th	n Financial Systems	WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od: From 01/01/2022	Worksheet S-8	3
			Component	CCN: 15-8548	To 12/31/2022		
					RHC VI	Cost	
					1	00	+
	Clinic Address and Identification						
1. 00	Street		0:		530 N MI CHI GAN		1.00
				00	State 2.00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		ARGOS	00		46501	2.00
			'				
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urbon		1. 00	3.00
3.00	HOSPITAL-BASED FUNCS UNLT. DESIGNATION - ENT	ei k ioi iui	ai 0i 0 10i		nt Award	Date	3.00
					1. 00	2. 00	
	Source of Federal Funds					I	
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00
6. 00	Health Services for the Homeless (Section 34						6.00
7. 00	Appal achi an Regi onal Commi ssi on						7.00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10.00						C	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type of hours.)	or other operat	ion(s) and the	operating			
	Thou 3.)	Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
	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
			<u>'</u>	•			
12.00	Have very received as a received for an average	4- 4		10	1.00	2. 00	10.00
12. 00 13. 00					Y		12.00
10.00	30. 8? Enter "Y" for yes or "N" for no in col						10.00
	number of providers included in this report.	List the name	s of all provi	ders and			
	numbers below.			Prov	ider name	CCN	
				1100	1. 00	2. 00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N 1. 00	V 2.00	3. 00	XIX	Total Visits	
15. 00	Have you provided all or substantially all	1.00	2. 00	3.00	4. 00	5. 00	15.00
.0.00	GME cost? Enter "Y" for yes or "N" for no in	ı					
	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 00			
2. 00	City, State, ZIP Code, County		MARSHALL 4.				2.00
		Tuesday	Wedn	esday		sday	
		to	from	to	from	to	
	Facility hours of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00	
11. 00	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	1	•	•	•	1	•	

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der (CCN: 15-1313	Peri od:	Worksheet S-8	1
		Component	CCN: 15-8548	From 01/01/2022 To 12/31/2022		
				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 CLI NI C	08: 00	17: 00				11. 00

	Financial Systems WOODLAWN HOSPI TAL UNCOMPENSATED AND INDIGENT CARE DATA P	rovider CCN: 15-131	3 Pe	ri od:	u of Form CMS-2 Worksheet S-1				
USFII	AL UNCOMPENSATED AND INDIGENT CARE DATA	TOVIDEL CON. 15-131		om 01/01/2022					
			To	12/31/2022	Date/Time Pre 5/26/2023 7:1				
					1. 00				
	Uncompensated and indigent care cost computation								
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 202 co	ol umn	8)	0. 338570	1. (
00	Medicaid (see instructions for each line)				F2/ 007	1 , ,			
00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				526, 807 Y	2. 3.			
00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments from Me	edi cai	d?	Ϋ́	4.			
00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid								
00	Medi cai d charges		26, 141, 245	6.					
00	Medicaid cost (line 1 times line 6)		8, 850, 641	7.					
00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	line 7 minus sum of	fline	s 2 and 5; if	8, 323, 834	8.			
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)							
00	Net revenue from stand-alone CHIP				0	9.			
0. 00	Stand-alone CHIP charges				0	10.			
1. 00					0	11.			
2. 00	,	line 11 minus line	9; if	< zero then	0	12.			
	enter zero) Other state or local government indigent care program (see inst	ructions for each I	i ne)			ł			
3. 00					0	13.			
1. 00				n lines 6 or	0				
	10)	, ,							
5. 00		,			0	15.			
5. 00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	igent care program	(Li ne	15 minus line	. 0	16.			
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/Local i	ndi ae	nt care progra	ms (see	l			
	instructions for each line)		. 3						
	Private grants, donations, or endowment income restricted to fu	9			0				
	Government grants, appropriations or transfers for support of h			(6 I !	0				
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care prog	grams	(sum of fines	8, 323, 834	19.			
	107 12 and 107	Uni nsur	red	Insured	Total (col. 1				
		pati en		pati ents	+ col. 2)				
	U	1.00		2. 00	3. 00				
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	ility 86	1, 361	0	861, 361	20.			
). OO	(see instructions)	11119	1, 501	O	001, 001	20.			
1.00	Cost of patients approved for charity care and uninsured discou	nts (see 29	1, 631	0	291, 631	21.			
	instructions)								
2. 00		off as	0	0	0	22.			
3 00	charity care Cost of charity care (line 21 minus line 22)	29	1, 631	0	291, 631	23			
3. 00	cost of chartey care (fine 21 minus fine 22)		1,001		271,001	20.			
					1. 00				
1. 00	Does the amount on line 20 column 2, include charges for patien		ngth o	f stay limit	N	24.			
- 00	imposed on patients covered by Medicaid or other indigent care		. ~ ~ ~ ~ '	a langth of	0	25			
5. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	e murgent care pro	ogi am	s rengin or	0	25.			
5. 00	Total bad debt expense for the entire hospital complex (see ins	tructions)			4, 475, 302	26.			
7. 00	Medicare reimbursable bad debts for the entire hospital complex	,)		224, 131	1			
7. 01	Medicare allowable bad debts for the entire hospital complex (s	ee instructions)			344, 816	27.			
3.00	Non-Medicare bad debt expense (see instructions)	,			4, 130, 486	1			
9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp Cost of uncompensated care (line 23 column 3 plus line 29)	ense (see instructi	ons)		1, 519, 144				
\sim	TEAST OF TOCOMPERSATED CARE LLINE 14 COLUMN 4 NIUS LINE 70)				1, 810, 775	30.			
0.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			10, 134, 609	21			

Health Financial Systems	WOODLAWN HO		ON 15 1010 5		U OT FORM CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (DF EXPENSES	Provider C		Period: From 01/01/2022	Worksheet A	
				To 12/31/2022	Date/Time Pre	
					5/26/2023 7:1	7 pm
Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Reclassified	
			+ col . 2)	i ons (See	Tri al Bal ance	
				A-6)	(col. 3 +-	
	1.00	2.00	2.00	4.00	<u>col. 4)</u> 5. 00	
CENEDAL CEDVICE COCT CENTERS	1.00	2. 00	3. 00	4. 00	5.00	
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT		2, 494, 044	2, 494, 044	-133, 980	2, 360, 064	1.00
1. 02 00102 AKRON BUI LDI NG		36, 324			36, 324	1.00
1. 03 00103 ARGOS BUILDING		81, 690			81, 690	1.02
1. 04 00101 CLAYS BUILDING	1	31, 098			165, 078	1.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	o	2, 883, 737			2, 883, 737	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	3, 829, 398	7, 040, 571			11, 104, 483	5.00
7. 00 00700 OPERATION OF PLANT	395, 747	1, 173, 623			2, 760, 531	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	36, 448	117, 449			153, 897	8.00
9. 00 00900 HOUSEKEEPI NG	304, 873	191, 445			495, 791	9.00
10. 00 01000 DI ETARY	455, 752	364, 761			261, 900	10.00
11. 00 01100 CAFETERI A	100,702	001,701	020,010		545, 438	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	195, 165	103, 428	1		667, 480	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	.00, .20) 270,070	0	0	14.00
15. 00 01500 PHARMACY	408, 975	3, 522, 556	3, 931, 531	-38, 516	3, 893, 015	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	327, 543	1, 123, 963			1, 390, 196	
INPATIENT ROUTINE SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,		,	, , , , , , , , , , , , , , , , , , , ,	
30. 00 03000 ADULTS & PEDIATRICS	2, 308, 312	1, 155, 422	3, 463, 734	-1, 175, 701	2, 288, 033	30.00
31.00 03100 INTENSIVE CARE UNIT	413, 823	132, 529	546, 352	-4, 386	541, 966	31.00
43. 00 04300 NURSERY	0	0		613, 877	613, 877	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	782, 327	2, 021, 910	2, 804, 237	-276, 065	2, 528, 172	50.00
51.00 05100 RECOVERY ROOM	415, 906	203, 430	619, 336	0	619, 336	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	/	172, 321	
53. 00 05300 ANESTHESI OLOGY	0	818, 594			818, 594	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 659, 736	1, 435, 296			2, 964, 090	54.00
60. 00 06000 LABORATORY	999, 022	2, 170, 793			3, 067, 806	
65. 00 06500 RESPIRATORY THERAPY	1, 045, 710	449, 855			1, 486, 255	65.00
66. 00 06600 PHYSI CAL THERAPY	581, 683	196, 192			776, 763	
67. 00 06700 OCCUPATI ONAL THERAPY	200, 910	58, 948			259, 858	67.00
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	44, 083	11, 532	55, 615		55, 615 0	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		621, 026	1	-	621, 026	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		021, 020	021,020		021,020	73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		'	<u> </u>	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	734, 823	770, 821	1, 505, 644	15, 108	1, 520, 752	88.00
88. 01 08801 RURAL HEALTH CLINIC II	3, 268, 480	1, 525, 686			4, 186, 056	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	1, 468, 700	896, 923			2, 363, 861	
88. 03 08803 RURAL HEALTH CLINIC IV	325, 760	118, 117			493, 426	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	590, 736	222, 041			800, 909	
88. 05 08805 RURAL HEALTH CLINIC VI	1, 125, 877	1, 207, 328			2, 314, 194	1
91. 00 09100 EMERGENCY	1, 751, 257	2, 554, 777	4, 306, 034	-11, 067	4, 294, 967	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	632, 708	519, 854	1, 152, 562	-3, 557	1, 149, 005	93.00
93. 01 04951 SHAFER MEDICAL CENTER	1, 689, 881	557, 666	2, 247, 547	-68, 701	2, 178, 846	93. 01
93. 02 O4O40 INTERNAL MEDICINE	746, 581	65, 356	811, 937	0	811, 937	93.02
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		0)			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	26, 740, 216	36, 878, 785	63, 619, 001	108, 288	63, 727, 289	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		-		190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0		-		192. 00
192. 01 19201 FCMC	0	0				192. 01
192. 02 19202 ARGOS MEDICAL CENTER	0	0				192.02
192. 03 19203 AKRON MEDICAL CENTER	0	0		<u> </u>		192.03
193. 00 19300 NONPAI D WORKERS	0	0)	0		193.00
194. 00 07950 ADVERTI SI NG	58, 116	226, 627			176, 455	
194. 01 07951 LTC/WELLNESS	28, 779	8, 526			37, 305	
200.00 TOTAL (SUM OF LINES 118 through 199)	26, 827, 111	37, 113, 938	63, 941, 049	이	63, 941, 049	J∠UU. UU

 Health Financial
 Systems
 WOODLAND

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1313

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm

				5/26/2023 7:1	
	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 & FLXT	-28, 588	2, 331, 476		1.00
1. 02	00102 AKRON BUILDING	0	36, 324		1. 02
1.03	00103 ARGOS BUILDING	0	81, 690		1.03
1.04	00101 CLAYS BUILDING	0	165, 078	3	1. 04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 883, 737		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 038, 626	8, 065, 857	'	5.00
7.00	00700 OPERATION OF PLANT	0	2, 760, 531		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	153, 897	,	8. 00
9.00	00900 HOUSEKEEPI NG	0	495, 791		9. 00
10.00	01000 DI ETARY	-12, 827	249, 073		10.00
11.00	01100 CAFETERI A	-114, 259	431, 179		11.00
13.00	01300 NURSING ADMINISTRATION	0	667, 480		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500 PHARMACY	-3, 439	3, 889, 576		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-10, 683	1, 379, 513		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	2, 288, 033	3	30.00
31.00	03100 INTENSIVE CARE UNIT	0			31.00
43.00		0			43.00
	ANCILLARY SERVICE COST CENTERS		<u> </u>		
50.00	05000 OPERATING ROOM	0	2, 528, 172		50.00
51.00	05100 RECOVERY ROOM	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			52.00
53.00	05300 ANESTHESI OLOGY	-770, 000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-194, 265			54.00
60.00	06000 LABORATORY	0	3, 067, 806		60.00
65.00	06500 RESPIRATORY THERAPY	-187, 325			65.00
66. 00	06600 PHYSI CAL THERAPY	-1, 934			66.00
67.00	06700 OCCUPATI ONAL THERAPY	-41, 833	1	•	67.00
68. 00	06800 SPEECH PATHOLOGY	0			68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	1	1	73.00
	OUTPATIENT SERVICE COST CENTERS			1	1
88. 00	08800 RURAL HEALTH CLINIC	-236, 353	1, 284, 399)	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	-222, 217			88. 01
88. 02	08802 RURAL HEALTH CLINIC III	-84, 771	2, 279, 090		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0			88. 03
88. 04	08804 RURAL HEALTH CLINIC V	-21, 185		l control of the cont	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	-31, 408			88. 05
91. 00	09100 EMERGENCY	-1, 468, 875			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 100, 0.0	2,020,072		92.00
93. 00	04950 WOODLAWN MEDICAL PROFESSIONALS	-950, 500	198, 505		93.00
93. 01	04951 SHAFER MEDICAL CENTER	-1, 600, 193			93. 01
93. 02		-711, 736	1	·	93. 02
70.02	SPECIAL PURPOSE COST CENTERS	711,700	100, 201		70.02
113 00	11300 INTEREST EXPENSE	0	0		113.00
118. 00		-9, 731, 017			118.00
110.00	NONREI MBURSABLE COST CENTERS	7,701,017	00,770,272		1110.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSICIANS PRIVATE OFFICES	Ö	ł .	·	192.00
	1 19201 FCMC	0			192.00
	19201 ARGOS MEDICAL CENTER			l e e e e e e e e e e e e e e e e e e e	192.01
	19203 AKRON MEDICAL CENTER	0	•	1	192.02
	19300 NONPALD WORKERS	0			193.00
	07950 ADVERTI SI NG	0	176, 455		194.00
	107951 LTC/WELLNESS	0	1	l control of the cont	194.00
200.00		-9, 731, 017		l control of the cont	200.00
_55.50	1.0 (35 3. 2. NES 110 till odgir 177)	1,751,517	0.,210,002	-1	

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

Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm

						5/26/2023 7:17 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00	 	
	- CAFETERIA RECLASS					
1.00 CAF	ETERI A	11. 00	307, 906	<u>237, 5</u> 32		1.00
0			307, 906	237, 532		
	- ADVERTISING RECLASS					
1.00 ADM	NI NI STRATI VE & GENERAL	5. 00	2 <u>2, 1</u> 02	8 <u>6, 1</u> 86		1.00
0			22, 102	86, 186		
	DEPRECIATION RECLASS					
1.00 CLA	AYS_BUI_LDI_NG	1. 04	0	13 <u>3, 9</u> 80		1.00
0			0	133, 980		
	NURSERY RECLASS					
	RSERY	43. 00	407, 595	206, 282		1.00
2. 00 <u>DEL</u>	IVERY ROOM & LABOR ROOM	<u>52.</u> 00	11 <u>4, 4</u> 16	5 <u>7, 9</u> 05		2.00
0			522, 011	264, 187		
	NURSING SUPERVISOR RECLAS					
	RSING ADMINISTRATION	13. 00	371, 782	0		1.00
2. 00		0. 00	0	0		2.00
3. 00		0. 00	0	0		3.00
0			371, 782			
	- MAINTENANCE RECLASS					
	ERATION OF PLANT	7. 00	0	1, 191, 161		1.00
2. 00		0. 00	0	0		2.00
3. 00		0.00	0	0		3.00
4. 00		0.00	0	0		4.00
5. 00		0. 00	o	0		5. 00
6. 00		0.00	o	0		6.00
7. 00		0. 00	O	0		7. 00
8. 00		0.00	o	O		8.00
9. 00		0. 00	o	O		9. 00
10. 00		0. 00	0	O		10.00
11. 00		0.00	ol	Ö		11.00
12. 00		0.00	ol	Ö		12.00
13. 00		0.00	ol	Ö		13. 00
14. 00		0.00	ol	Ö		14.00
15. 00		0. 00	0	0		15.00
16. 00		0. 00	0	0		16.00
17. 00		0. 00	0	Ö		17. 00
18. 00		0. 00	o	Ö		18.00
10.00				1, 191, 161		10.00
G -	RENT RECLASS		<u> </u>	1, 171, 101		
	RAL HEALTH CLINIC IV	88. 03	0	40, 086		1.00
0	CALL TIERLETTI GETATO TV		— — 	40, 086		1.00
H -	RHC OVERHEAD RECLASS		<u> </u>	10, 000		
	MINISTRATIVE & GENERAL	5. 00	n	564, 198		1.00
	RAL HEALTH CLINIC	88. 00	5, 863	0		2.00
	RAL HEALTH CLINIC III	88. 02	12, 470	o		3.00
	RAL HEALTH CLINIC IV	88. 03	3, 425	0		4.00
	RAL HEALTH CLINIC IV	88. 04	3, 425 4, 907	0		5. 00
	1					l l
6. 00 RUR	RAL HEALTH CLINIC VI		17, 247	0		6.00
U	CLINIC CUDEDVICOD		43, 912	564, 198	 	
	- CLINIC SUPERVISOR	00.00	0.045			1 00
	RAL HEALTH CLINIC	88. 00	9, 245	0		1.00
	RAL HEALTH CLINIC III	88. 02	25, 854	0		2.00
3. 00 RUR	RAL HEALTH CLINIC IV		6,038	0		3.00
E00 00 0	and Total . Incres-		41, 137			500.00
ouu. uu jura	and Total: Increases		1, 308, 850	2, 517, 330		500.00

Provider CCN: 15-1313

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/26/2023 7:17 pm

Decreases	1.00
1.00	
A - CAFETERIA RECLASS	
1.00	
O B - ADVERTISING RECLASS 194,00 22,102 86,186 0 0 0 22,102 86,186 0 0 0 22,102 86,186 0 0 0 22,102 86,186 0 0 0 22,102 86,186 0 0 0 22,102 86,186 0 0 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 0 0 0 0 0 0	
B - ADVERTISING RECLASS 194.00 22,102 86,186 0 0 22,102 86,186 0 0 22,102 86,186 0 0 22,102 86,186 0 0 22,102 86,186 0 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 133,980 9 0 0 0 0 0 0 0 0	1 00
1.00	1 00
1.00	1 1 00
C - DEPRECIATION RECLASS	1.00
1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 133, 980 9 0 0 133, 980 9 0 0 133, 980 9 0 0 133, 980 9 0 133, 980 9 0 133, 980 9 0 133, 980 9 0 133, 980 9 0 133, 980 9 0 133, 980 9 0 133, 980 9 0 0 0 0 0 0 0 0	
D - NURSERY RECLASS 30.00 522,011 264,187 0 0.00 0 0 0 0 0 0 0	
D - NURSERY RECLASS 1. 00 ADULTS & PEDI ATRI CS	1.00
1.00 ADULTS & PEDIATRICS 30.00 522,011 264,187 0 0 0 0 0 0 0 0 0	
2.00	
Color	1.00
E - NURSI NG SUPERVI SOR RECLASS 1.00 ADMI NI STRATI VE & GENERAL 5.00 3,303 0 0 0 0 0 0 0 0 0	2.00
1.00 ADMI NI STRATI VE & GENERAL 5.00 3,303 0 0 0 0 0 0 0 0 0	
2. 00 ADULTS & PEDIATRICS 30. 00 364, 023 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
3. 00 RADI OLOGY-DI AGNOSTI C	1.00
O 371, 782 O F - MAI NTENANCE RECLASS	2.00
F - MAI NTENANCE RECLASS	3.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 434, 669 0 2. 00 HOUSEKEEPI NG 9. 00 527 0 3. 00 DI ETARY 10. 00 13, 175 0 4. 00 NURSI NG ADMI NI STRATI ON 13. 00 2, 895 0 5. 00 PHARMACY 15. 00 38, 516 0 6. 00 MEDI CAL RECORDS & LI BRARY 16. 00 61, 310 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 25, 480 0 8. 00 I NTENSI VE CARE UNI T 31. 00 4, 386 0 9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY - DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINI C VI 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINI C VI 88. 05 36, 258 0	
2. 00 HOUSEKEEPI NG 9. 00 527 0 3. 00 DI ETARY 10. 00 13, 175 0 4. 00 NURSI NG ADMI NI STRATI ON 13. 00 2, 895 0 5. 00 PHARMACY 15. 00 38, 516 0 6. 00 MEDI CAL RECORDS & LI BRARY 16. 00 61, 310 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 25, 480 0 8. 00 I NTENSI VE CARE UNI T 31. 00 4, 386 0 9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINI C VI 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINI C VI 88. 05 36, 258 0	
3. 00 DI ETARY 10. 00 13, 175 0 4. 00 NURSI NG ADMI NI STRATI ON 13. 00 2, 895 0 5. 00 PHARMACY 15. 00 38, 516 0 6. 00 MEDI CAL RECORDS & LI BRARY 16. 00 61, 310 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 25, 480 0 8. 00 I NTENSI VE CARE UNI T 31. 00 4, 386 0 9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLI NI C V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLI NI C VI 88. 05	1.00
4. 00 NURSI NG ADMI NI STRATI ON 13. 00 2, 895 0 5. 00 PHARMACY 15. 00 38, 516 0 6. 00 MEDI CAL RECORDS & LI BRARY 16. 00 61, 310 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 25, 480 0 8. 00 I NTENSI VE CARE UNI T 31. 00 4, 386 0 9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINI C V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINI C VI 88. 05 36, 258 0	2.00
4. 00 NURSI NG ADMI NI STRATI ON 13. 00 2, 895 0 5. 00 PHARMACY 15. 00 38, 516 0 6. 00 MEDI CAL RECORDS & LI BRARY 16. 00 61, 310 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 25, 480 0 8. 00 I NTENSI VE CARE UNI T 31. 00 4, 386 0 9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINI C V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINI C VI 88. 05 36, 258 0	3.00
5. 00 PHARMACY 15. 00 38, 516 0 6. 00 MEDI CAL RECORDS & LI BRARY 16. 00 61, 310 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 25, 480 0 8. 00 I NTENSI VE CARE UNI T 31. 00 4, 386 0 9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINIC V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINIC VI 88. 05 36, 258 0	4.00
6. 00 MEDI CAL RECORDS & LI BRARY 16. 00 61, 310 0 7. 00 ADULTS & PEDI ATRI CS 30. 00 25, 480 0 8. 00 INTENSI VE CARE UNI T 31. 00 4, 386 0 9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLI NI C V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLI NI C VI 88. 05 36, 258	5. 00
7. 00 ADULTS & PEDI ATRI CS 30.00 25,480 0 8. 00 I NTENSI VE CARE UNI T 31.00 4,386 0 9. 00 OPERATI NG ROOM 50.00 276,065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54.00 126,486 0 11. 00 LABORATORY 60.00 102,009 0 12. 00 RESPI RATORY THERAPY 65.00 9,310 0 13. 00 PHYSI CAL THERAPY 66.00 1,112 0 14. 00 RURAL HEALTH CLINIC V 88.04 16,775 0 15. 00 RURAL HEALTH CLINIC VI 88.05 36,258 0	6.00
8. 00 INTENSI VE CARE UNI T 31. 00 4, 386 0 9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINIC V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINIC VI 88. 05 36, 258 0	7.00
9. 00 OPERATI NG ROOM 50. 00 276, 065 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINIC V 88.04 16, 775 0 15. 00 RURAL HEALTH CLINIC VI 88.05 36, 258 0	8.00
10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 126, 486 0 11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINIC V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINIC VI 88. 05 36, 258 0	9.00
11. 00 LABORATORY 60. 00 102, 009 0 12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINIC V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINIC VI 88. 05 36, 258 0	10.00
12. 00 RESPI RATORY THERAPY 65. 00 9, 310 0 13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINIC V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINIC VI 88. 05 36, 258 0	11.00
13. 00 PHYSI CAL THERAPY 66. 00 1, 112 0 14. 00 RURAL HEALTH CLINIC V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINIC VI 88. 05 36, 258 0	12.00
14. 00 RURAL HEALTH CLINIC V 88. 04 16, 775 0 15. 00 RURAL HEALTH CLINIC VI 88. 05 36, 258 0	13.00
15.00 RURAL HEALTH CLINIC VI 88.05 36,258 0	14.00
	15.00
16. 00 EMERGENCY 91. 00 11, 067 0	16.00
17. 00 WOODLAWN MEDICAL 93. 00 3, 557	17.00
PROFESSI ONALS	17.00
18. 00 SHAFER MEDI CAL CENTER 93. 01 27, 564 0	18.00
0 1, 191, 161	10.00
G - RENT RECLASS	
1. 00 RURAL HEALTH CLINIC III 88. 02 0 40, 086 0	1.00
0 40,086	1.00
H - RHC OVERHEAD RECLASS	
1. 00 RURAL HEALTH CLINIC II 88. 01 43, 912 564, 198 0	1.00
2.00 RURAL HEALTH CLINIC II 88.01 43,912 504,198 0 0	2.00
3.00	3.00
4.00 0 0 0	4.00
5. 00 0 0 0 0	5.00
6.00 0 0 0 0 0 0 0 0 0	6.00
0 43, 912 564, 198	
J - CLINIC SUPERVISOR	
1. 00 SHAFER MEDICAL CENTER 93. 01 41, 137 0	1.00
2.00 0.00 0 0	2.00
3.00000	3.00
0 41, 137 0	
500.00 Grand Total: Decreases 1,308,850 2,517,330	500.00

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

| Period: | Worksheet A-7 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				To	12/31/2022	Date/Time Pre 5/26/2023 7:1	
				Acqui si ti ons		3/20/2023 /. 1	/ pili
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances	. u. c.iacco	5011421 011		Retirements	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES	•				
1.00	Land	596, 216	0	0	0	0	1.00
2.00	Land Improvements	513, 782	0	0	0	0	2.00
3.00	Buildings and Fixtures	27, 528, 763	2, 106, 377	0	2, 106, 377	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	11, 394, 525	4, 915, 445	0	4, 915, 445	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	40, 033, 286	7, 021, 822	0	7, 021, 822	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	40, 033, 286	7, 021, 822	0	7, 021, 822	0	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	596, 216	0				1.00
2.00	Land Improvements	513, 782	0				2.00
3.00	Buildings and Fixtures	29, 635, 140	0				3.00
4.00	Building Improvements	0	0				4.00
5. 00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	16, 309, 970	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	47, 055, 108	0				8.00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	47, 055, 108	0				10. 00

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2022	Worksheet A-7 Part II	
				Γο 12/31/2022		
		SL	JMMARY OF CAPI	TAL	072072020 7.1	, join
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see	instructions)	
	9. 00	10. 00	11.00	instructions) 12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2	12.00	13.00	
1. 00 CAP REL COSTS-BLDG & FLXT	1, 454, 501		419, 74	572, 422	0	1.00
1. 02 AKRON BUILDING	14, 473	0		0	0	1. 02
1. 03 ARGOS BUILDING	26, 691	0		22, 495	0	1.03
1. 04 CLAYS BUILDING	0	0		0	0	1.04
3.00 Total (sum of lines 1-2)	1, 495, 665		419, 74	594, 917	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Relat					
	ed Costs (see	9 through 14)				
	instructions)					
	14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			

	PART II - RECONCILIATION OF AMOUNTS FROM WORL	NOMEET A, CULUN	IN Z, LINES I AND Z	
1.00	CAP REL COSTS-BLDG & FIXT	47, 377	2, 494, 044	1.00
1. 02	AKRON BUILDING	21, 851	36, 324	1.02
1.03	ARGOS BUILDING	32, 504	81, 690	1.03
1.04	CLAYS BUILDING	31, 098	31, 098	1.04
3.00	Total (sum of lines 1-2)	132, 830	2, 643, 156	3.00

Heal th	n 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 01/01/2022 To 12/31/2022	Worksheet A-7 Part III	pared:
		COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	•
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 -	instructions)		
				col . 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		_			_	
1.00	CAP REL COSTS-BLDG & FIXT	36, 516, 371	0	, ,		0	1.00
1. 02	AKRON BUILDING	1, 174, 214	l .	.,, = .		0	1. 02
1. 03	ARGOS BUILDING	2, 516, 172		2, 516, 17			1. 03
1. 04	CLAYS BUILDING	6, 848, 350		6, 848, 35		0	1.04
3. 00	Total (sum of lines 1-2)	47, 055, 107		47, 055, 10			3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
	, , , , , , , , , , , , , , , , , , ,		Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 1, 319, 880	0	1.00
1. 02	AKRON BUILDING	0	0		0 14, 473	0	1.02
1.03	ARGOS BUILDING	0	0		0 26, 691	0	1.03
1.04	CLAYS BUILDING	0	0		0 133, 980		1.04
3.00	Total (sum of lines 1-2)	0	0		0 1, 495, 024	0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions			
			instructions)		ed Costs (see		
			,		instructions)		
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			-		
1.00	CAP REL COSTS-BLDG & FLXT	391, 797	572, 422		0 47, 377	2, 331, 476	1.00
1.02	AKRON BUILDING	0	0		0 21, 851	36, 324	1.02
1.03	ARGOS BUILDING	0	22, 495		0 32, 504		1.03
1.04	CLAYS BUILDING	0	0		0 31, 098	165, 078	1.04
3.00	Total (sum of lines 1-2)	391, 797	594, 917		0 132, 830	2, 614, 568	3.00

| Peri od: | Worksheet A-8 | To 12/31/2022 | T Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-1313

				Fr Tc	om 01/01/2022 12/31/2022		
				Expense Classification on	Worksheet A	5/26/2023 7: 1	/ pm
				To/From Which the Amount is t	o be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
1. 00	Investment income - CAP REL	1. 00 B	2. 00 -27, 947	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1.00
1 00	COSTS-BLDG & FIXT (chapter 2)				4 00		4 00
1. 02	Investment income - AKRON BUILDING (chapter 2)		U	AKRON BUILDING	1. 02	0	1. 02
1. 03	Investment income - ARGOS		0	ARGOS BUILDING	1. 03	0	1. 03
1. 04	BUILDING (chapter 2) Investment income - CLAYS		0	CLAYS BUILDING	1. 04	0	1.04
2. 00	BUILDING (chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		O	cost center bereted	2.00	J	2.00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physi ci an	A-8-2	-5, 713, 609			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
12.00	transactions (chapter 10)	A-0-1	0			U	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-114 250	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		-114, 230	CALLIENTA	0.00	0	15.00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
10.00	supplies to other than		Ö		0.00	J	10.00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
	pati ents	5	-				
18. 00	Sale of medical records and abstracts	В	-10, 683	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines	В	-9	CAFETERI A	11. 00	0	
21. 00	Income from imposition of interest, finance or penalty		U		0. 00	0	21. 00
22.00	charges (chapter 21)		0		0.00	0	22.00
22. 00	Interest expense on Medicare overpayments and borrowings to		U		0. 00	U	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	O	RESTRATORT THERALT	03.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
۷٦. ۵۵	therapy costs in excess of	7 0-0	O	THE TONE THEMS	55.00		27.00
25 00	limitation (chapter 14) Utilization review -		Ω	*** Cost Center Deleted ***	114. 00		25. 00
23.00	physicians' compensation		O	SSST SSITTED BEFOLEG	. 14. 00		
26. 00	(chapter 21) Depreciation - CAP REL		Ω	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
	COSTS-BLDG & FLXT						
26. 02 26. 03	Depreciation - AKRON BUILDING Depreciation - ARGOS BUILDING			AKRON BUILDING ARGOS BUILDING	1. 02 1. 03	0	26. 02 26. 03
26. 04	Depreciation - CLAYS BUILDING		0	CLAYS BUILDING	1. 04	0	26. 04
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2. 00	0	27. 00
		<u>'</u>		. '	<u>'</u>		

			Expense Classification on To/From Which the Amount is		0, 20, 2020 ,	, p
Cook Cooker December of	Basis/Code	A	Cost Center	Li ne #	Wkst. A-7	
Cost Center Description	(2)	Amount	Cost Center	Line #	Ref.	
	1.00	2. 00	3.00	4. 00	5. 00	
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29.00 Physicians' assistant		0		0. 00	0	
30.00 Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
therapy costs in excess of						
limitation (chapter 14)		_				
30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
instructions)	A 0 0		CDEECH DATHOLOGY	(0.00		21 00
31.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
limitation (chapter 14)						
32.00 CAH HIT Adjustment for	В	-641	CAP REL COSTS-BLDG & FLXT	1. 00	9	32.00
Depreciation and Interest		041	OAN REE COSTS BEBO & TTAT	1.00	,	32.00
33. 00 PHYSI CI AN RECRUI TMENT	A	3. 050	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
34. 00 PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	34.00
34. 01 HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	34. 01
35. 00 ADMIN OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	35.00
36.00 HOME MEAL PROGRAM	В		DI ETARY	10.00	0	36.00
37. 00 DRUG SALES	В	-3, 439	PHARMACY	15. 00	0	37.00
38.00 PT - OTHER REVENUE	В	-1, 934	PHYSI CAL THERAPY	66. 00	0	38. 00
39.00 OCC THER OTH REV	В	-41, 833	OCCUPATI ONAL THERAPY	67. 00	0	39.00
40.00 MISC REV -OTH REV	В	-55, 593	ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41.00 STAFF RENTAL AGREEMENTS	В		RESPI RATORY THERAPY	65. 00	0	41.00
42.00 I HA & AHA LOBBYING	A		ADMINISTRATIVE & GENERAL	5. 00	0	42.00
43.00 PART B BILLING OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	0	43.00
44.00 LTC EXPENSES	Α		ADMINISTRATIVE & GENERAL	5. 00	0	44.00
45. 00 RHC OFFSETS	A		RURAL HEALTH CLINIC	88. 00	0	45.00
45. 01 RHC OFFSETS	Α		RURAL HEALTH CLINIC II	88. 01	0	45. 01
45. 02 RHC OFFSETS	A		RURAL HEALTH CLINIC III	88. 02	0	45. 02
45. 03 RHC OFFSETS	A		RURAL HEALTH CLINIC V	88. 04	0	45. 03
45. 04 RHC OFFSETS	A		RURAL HEALTH CLINIC VI	88. 05	0	45. 04
50.00 TOTAL (sum of lines 1 thru 49)	'	-9, 731, 017				50.00
(Transfer to Worksheet A, column 6, line 200.)						
(1) Description - all chapter refere	nces in this co	lumn nertain t	L CMS Pub 15_1			

- (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.

					'	10 12/31/2022	5/26/2023 7: 1	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					•		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00		ANESTHESI OLOGY	782, 000	770, 000	12, 000	0	0	1.00
2.00	54. 00	RADI OLOGY-DI AGNOSTI C	194, 265	194, 265	0	0	0	2.00
3. 00		RESPIRATORY THERAPY	26, 690		8, 650		1	
4. 00		EMERGENCY	2, 426, 318		957, 443	l e	0	4.00
5. 00	93. 00	WOODLAWN MEDICAL	950, 500	950, 500	0	0	0	5. 00
		PROFESSI ONALS			_	_	_	
6. 00		SHAFER MEDICAL CENTER	1, 600, 193		0	0	0	6. 00
7. 00		INTERNAL MEDICINE	711, 736	711, 736	0	0	0	7.00
8. 00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	7.00
10.00	0. 00		((01 702	F 712 400	070 003	0	0	10.00
200.00	Wkst. A Line #	Cost Costos / Dhysi si as	6, 691, 702 Unadj usted RCE		978, 093 Cost of	Provi der	0 Physician Cost	200.00
	WKSt. A LINE #	Cost Center/Physician Identifier	Limit	Unadjusted RCE		Component	of Malpractice	
		rdentifier	LIIIII	Limit	Continuing	Share of col.	Insurance	
				Limit	Education	12	Trisul ance	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		ANESTHESI OLOGY	0.00	0	0			1. 00
2. 00		RADI OLOGY-DI AGNOSTI C	0	0			o o	
3. 00		RESPIRATORY THERAPY	0	0	0		o o	3. 00
4. 00		EMERGENCY	0	0	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	0	0	0	0	6.00
7. 00	93. 02	INTERNAL MEDICINE	0	0	0	0	0	7. 00
8. 00	0. 00		0	0	0	0	0	8.00
9. 00	0. 00		0	0	0	0	0	9.00
10. 00	0. 00		0	0	0	1	0	
200.00			0	0	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ANESTHESI OLOGY	15.00	16.00	17.00			1. 00
2. 00		RADI OLOGY-DI AGNOSTI C						2.00
3. 00		RESPIRATORY THERAPY		0	0	1 .,., 200		3. 00
4. 00		EMERGENCY		0	0			4. 00
5. 00		WOODLAWN MEDICAL		0	_	.,,		5. 00
5.00	73.00	PROFESSI ONALS		0	0	730, 300		3.00
6. 00	93 01	SHAFER MEDICAL CENTER	0	0	0	1, 600, 193		6. 00
7. 00		INTERNAL MEDICINE	1 0	0	0	711, 736		7. 00
8. 00	0.00		l 0	0	l n	1, 700		8. 00
9. 00	0.00		1 0	0	0	l		9. 00
10.00	0. 00		l 0	l o	0			10. 00
200.00			0	0	0	5, 713, 609		200.00
	'	•	•	•	•	•	. '	•

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

			IC	12/31/2022	Date/IIme Pre 5/26/2023 7:1	
		·	CAPITAL REL	ATED COSTS		
Cost Center Description	Net Expenses	BLDG & FIXT	AKRON	ARGOS	CLAYS	
	for Cost		BUI LDI NG	BUI LDI NG	BUI LDI NG	
	Allocation (from Wkst A					
	col. 7)					
	0	1. 00	1. 02	1. 03	1. 04	
1. 00 OO100 CAP REL COSTS-BLDG & FLXT	2, 331, 476	2, 331, 476				1.00
1. 02 00102 AKRON BUILDING	36, 324	2, 331, 470	36, 324			1.00
1. 03 00103 ARGOS BUILDING	81, 690	o	0	81, 690		1.03
1. 04 00101 CLAYS BUILDING	165, 078	0	0	0	165, 078	1.04
4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL	2, 883, 737	0 250, 294	0	0	0 129	4. 00 5. 00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	8, 065, 857 2, 760, 531	250, 294 226, 882	4, 151 2, 491	6, 535 7, 450	37, 659	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	153, 897	6, 876	0	0	0,,007	8.00
9. 00 00900 HOUSEKEEPI NG	495, 791	25, 983	0	0	348	9. 00
10. 00 01000 DI ETARY	249, 073	82, 468	0	0	0	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	431, 179 667, 480	31, 787 54, 686	0	0	0	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	007, 480	34, 080	0	0	0	14.00
15. 00 01500 PHARMACY	3, 889, 576	29, 688	Ö	Ö	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 379, 513	28, 275	0	0	34, 360	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2, 288, 033	323, 357	0	ol	0	30.00
31. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	2, 288, 033 541, 966	44, 083	0	0	0	30.00
43. 00 04300 NURSERY	613, 877	4, 006	Ö	Ö	0	43.00
ANCILLARY SERVICE COST CENTERS			-			
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	2, 528, 172	176, 545	0	0	0	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	619, 336 172, 321	105, 751 17, 008	0	0	0	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	48, 594	2, 935	0	o	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 769, 825	255, 799	0	0	0	54.00
60. 00 06000 LABORATORY	3, 067, 806	56, 185	0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 298, 930 774, 829	89, 086 67, 495	0	O	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	218, 025	07, 475	0	ol	0	67.00
68.00 06800 SPEECH PATHOLOGY	55, 615	О	0	0	0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	621, 026 0	0	0	0	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>	0	75.00
88.00 08800 RURAL HEALTH CLINIC	1, 284, 399	0	0	0	45, 559	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	3, 963, 839	164, 442	0	0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III 88. 03 08803 RURAL HEALTH CLINIC IV	2, 279, 090 493, 426	0	0	0	0	88. 02 88. 03
88. 04 08804 RURAL HEALTH CLINIC V	779, 724	o	29, 682	o	0	88. 04
88.05 08805 RURAL HEALTH CLINIC VI	2, 282, 786	o	0	67, 705	0	88. 05
91. 00 09100 EMERGENCY	2, 826, 092	134, 047	0	0	0	91.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	198, 505	122, 588	0		0	92. 00 93. 00
93. 01 04950 WOODLAWN MEDICAL PROFESSIONALS 93. 01 04951 SHAFER MEDICAL CENTER	578, 653	122, 366	0	0	47, 023	93.00
93. 02 04040 I NTERNAL MEDICINE	100, 201	11, 610	0	Ö	0	93. 02
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	53, 996, 272	2 211 074	24 224	01 (00	1/5 070	113.00
NONREI MBURSABLE COST CENTERS	53, 990, 272	2, 311, 876	36, 324	81, 690	165, 078	118.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	12, 531	0	0		192. 00
192. 01 19201 FCMC	0	0	0	0		192. 01
192. 02 19202 ARGOS MEDI CAL CENTER 192. 03 19203 AKRON MEDI CAL CENTER		0	0	0		192. 02 192. 03
193. 00 19300 NONPALD WORKERS		ol	0	ol		193. 00
194. 00 07950 ADVERTI SI NG	176, 455	7, 069	0	0	0	194. 00
194. 01 07951 LTC/WELLNESS	37, 305	0	0	0	0	194. 01
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	0		0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	54, 210, 032	2, 331, 476	36, 324	81, 690	165, 078	202.00
	. '		'			

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				1	0 12/31/2022	5/26/2023 7:1	
	Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	
		BENEFITS		E & GENERAL	PLANT	LINEN SERVICE	
		DEPARTMENT	4.0	F 00	7.00	0.00	
	GENERAL SERVICE COST CENTERS	4. 00	4A	5. 00	7. 00	8. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	Ι		I			1.00
1. 02	00102 AKRON BUILDING						1.00
1. 03	00103 ARGOS BUILDING						1. 03
1. 04	00101 CLAYS BUILDING						1.04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 883, 737					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	413, 663	8, 740, 629	8, 740, 629			5.00
7.00	00700 OPERATION OF PLANT	42, 540	3, 077, 553	591, 601	3, 669, 154		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 918	164, 691	31, 659	10, 662	207, 012	8. 00
9. 00	00900 HOUSEKEEPI NG	32, 772	554, 894			37, 488	9. 00
10.00	01000 DI ETARY	15, 892	347, 433		127, 874	4, 067	10.00
11.00	01100 CAFETERI A	33, 098	496, 064			0	11.00
13.00	01300 NURSING ADMINISTRATION	60, 943	783, 109			0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0		0	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	43, 962 35, 209	3, 963, 226 1, 477, 357		46, 035 184, 969	0	15. 00 16. 00
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	35, 209	1,477,307	203, 994	104, 909	0	10.00
30. 00	03000 ADULTS & PEDIATRICS	152, 885	2, 764, 275	531, 379	501, 400	35, 074	30.00
31. 00	03100 I NTENSI VE CARE UNI T	44, 483	630, 532			0	31.00
43. 00	04300 NURSERY	43, 814	661, 697			Ö	43.00
	ANCILLARY SERVICE COST CENTERS			· · · ·			
50.00	05000 OPERATING ROOM	84, 095	2, 788, 812	536, 096	273, 750	9, 023	50.00
51.00	05100 RECOVERY ROOM	44, 707	769, 794	147, 978	163, 978	8, 641	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	12, 299	201, 628			0	52.00
53.00	05300 ANESTHESI OLOGY	0	51, 529			0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	177, 931	3, 203, 555		396, 642	43, 969	54.00
60.00	06000 LABORATORY	107, 388	3, 231, 379		87, 120		60.00
65. 00	06500 RESPI RATORY THERAPY	112, 407	1, 500, 423			4, 829	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	62, 527	904, 851	173, 940		5, 846 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	21, 596 4, 739	239, 621 60, 354	46, 063 11, 602	0	0	68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 737	00, 334	11,002	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		621, 026	_	0	ő	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	l ol	02.7,020		0	Ö	73.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
88.00	08800 RURAL HEALTH CLINIC	80, 612	1, 410, 570	271, 155	187, 128	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	346, 618	4, 474, 899	860, 215	254, 984	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	161, 995	2, 441, 085	469, 252	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	36, 034	529, 460			0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	64, 027	873, 433		94, 992	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	122, 878	2, 473, 369				88. 05
91.00	09100 EMERGENCY	188, 248	3, 148, 387	605, 218	207, 853	58, 075	91.00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 WOODLAWN MEDICAL PROFESSIONALS	68, 012	389, 105	74, 798	190, 084	0	92. 00 93. 00
93. 00	04951 SHAFER MEDICAL CENTER	177, 228	802, 904				93.00
93. 02	04040 I NTERNAL MEDICINE	80, 252	192, 063			0	93. 02
75. 02	SPECIAL PURPOSE COST CENTERS	00, 232	172,003	30, 720	10,002		73.02
113.00	11300 INTEREST EXPENSE						113.00
118.00	1	2, 876, 772	53, 969, 707	8, 694, 431	3, 669, 154	207, 012	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	12, 531	2, 409	0		192. 00
	19201 FCMC	0	0	0	0		192. 01
	19202 ARGOS MEDICAL CENTER	0	0	0	0		192. 02
	3 19203 AKRON MEDICAL CENTER	0	0	0	0		192.03
	19300 NONPAL D WORKERS	2 071	107 205	0	0		193. 00 194. 00
	007950 ADVERTI SI NG 1 07951 LTC/WELLNESS	3, 871 3, 094	187, 395 40, 399				194.00
200.00		3, 094	40, 399 ^	7, 766	U	0	200.00
200.00	, ,		0	0	n	n	200.00
202.00		2, 883, 737	54, 210, 032	8, 740, 629	3, 669, 154		
0	(, ,		.,,		

| Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

					0 12/31/2022	5/26/2023 7:1	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	, p
	,				ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		9. 00	10. 00	11. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS	,			,		
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 02	00102 AKRON BUILDING						1. 02
1. 03	00103 ARGOS BUILDING						1.03
1.04	00101 CLAYS BUILDING						1.04
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	740 747					8.00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	740, 767 700	546, 861				9. 00 10. 00
11. 00	01100 CAFETERI A	14, 177	0	654, 890			11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	550	0	22, 164			13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	22, 104		0	14.00
15. 00	01500 PHARMACY	4, 551	0	17, 130	i i	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 075	0	22, 632	l l	0	16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	3,073	<u>U</u>	22, 032	01,007		10.00
30. 00	03000 ADULTS & PEDI ATRI CS	173, 397	527, 107	77. 028	696, 688	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	17, 752	19, 754	14, 048		0	31.00
43. 00	04300 NURSERY	0	0	20, 135		0	43.00
	ANCILLARY SERVICE COST CENTERS		- '	.,	,		
50.00	05000 OPERATING ROOM	100, 212	0	39, 997	0	0	50.00
51.00	05100 RECOVERY ROOM	55, 732	o	19, 120	o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	5, 658	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	75, 734	0	83, 193	0	0	54.00
60.00	06000 LABORATORY	27, 878	0	66, 492	I I	0	60.00
65. 00	06500 RESPI RATORY THERAPY	30, 829	0	56, 541	I I	0	65.00
66. 00	06600 PHYSI CAL THERAPY	19, 752	0	27, 354	I I	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	8, 311	l l	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	1, 795	. 1	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0		0	72. 00 73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	U U	<u> </u>		ıl U	0	73.00
88. 00	08800 RURAL HEALTH CLINIC	29, 179	ol	0	O	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	54, 082	ő	84, 909	- 1	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0 1, 002	0	01, 707	. 1	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	o	0	o o	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	o	0	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	o	ol	0	ol	0	88. 05
91.00	09100 EMERGENCY	85, 686	o	60, 092	161, 702	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	17, 777	o	14, 750	o	0	93.00
93. 01	04951 SHAFER MEDICAL CENTER	28, 904	0	0	0	0	93. 01
93. 02	04040 I NTERNAL MEDICINE	0	0	10, 575	0	0	93. 02
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
118.00		739, 967	546, 861	651, 924	1, 041, 156	0	118. 00
400.00	NONREI MBURSABLE COST CENTERS		- I				
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	800	0	0	- 1		190.00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	0	-		192.00
	19201 FCMC	0	0	0			192.01
	2 19202 ARGOS MEDICAL CENTER	0	0	0			192. 02 192. 03
	B 19203 AKRON MEDICAL CENTER D 19300 NONPAID WORKERS	0	O O	0			192.03
	07950 ADVERTI SI NG		O A	1, 834			193.00
	07951 LTC/WELLNESS		٥	1, 132			194.00
200. 00		١	4	1, 132	"	U	200.00
201.00	, ,		n	n		n	201.00
202.00		740, 767	546, 861	654, 890	1, 041, 156		202.00
	1 1 1 2 (2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		- 10, 001	55.,570	., 5 ,	Ü	,

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/26/2023 7:17 pm | Total Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS WOODLAWN HOSPITAL Provider CCN: 15-1313

		Cost Center Description	PHARMACY	MEDI CAL	Subtotal	Intorn &	Total	/ pili
		cost center bescription	PHARWACT		Subtotal	Intern &	TOTAL	
				RECORDS & LI BRARY		Residents		
				LIBRARY		Cost & Post		
						Stepdown		
		•	1F 00	14.00	24.00	Adjustments	27, 00	
	CENED	AL SERVICE COST CENTERS	15. 00	16. 00	24. 00	25. 00	26. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1.00
1. 00		AKRON BUILDING						1.00
								•
1.03		ARGOS BUILDING						1.03
1.04		CLAYS BUILDING						1.04
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00		ADMINISTRATIVE & GENERAL						5.00
7. 00	1	OPERATION OF PLANT						7.00
8. 00	1	LAUNDRY & LINEN SERVICE						8. 00
9. 00	1	HOUSEKEEPI NG						9. 00
10. 00		DI ETARY						10.00
11. 00		CAFETERI A						11. 00
13.00		NURSING ADMINISTRATION						13.00
14.00		CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	4, 792, 797					15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2, 053, 034				16.00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	97, 340	5, 403, 688	0	5, 403, 688	30.00
31.00	03100	INTENSIVE CARE UNIT	o	5, 280	978, 687	o	978, 687	31.00
43.00	04300	NURSERY	o	4, 146	819, 388	o	819, 388	43.00
		LARY SERVICE COST CENTERS	'			'	·	
50.00		OPERATING ROOM	0	225, 169	3, 973, 059	0	3, 973, 059	50.00
51.00	05100	RECOVERY ROOM	o	20, 994	1, 186, 237	ol	1, 186, 237	1
52.00		DELIVERY ROOM & LABOR ROOM	o	4, 321	276, 738	o	276, 738	
53.00		ANESTHESI OLOGY	0	26, 592	92, 576	0	92, 576	1
54. 00		RADI OLOGY-DI AGNOSTI C	0	452, 700	4, 871, 616	0	4, 871, 616	
60.00	1	LABORATORY	o o	409, 842	4, 443, 882	0	4, 443, 882	•
65. 00	1	RESPI RATORY THERAPY	o o	124, 875	2, 144, 062	0	2, 144, 062	
66. 00		PHYSI CAL THERAPY	o o	31, 360	1, 267, 760	0	1, 267, 760	
67. 00		OCCUPATI ONAL THERAPY	0	10, 787	304, 782	0	304, 782	
68. 00		SPEECH PATHOLOGY	0	1, 031	74, 782	0	74, 782	1
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 031	74, 732	0	74, 732	71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	18, 631	759, 037	0	759, 037	72.00
73.00		DRUGS CHARGED TO PATTENTS	4, 792, 797	271, 294	5, 064, 091	0	5, 064, 091	ł
73.00		TIENT SERVICE COST CENTERS	4, 172, 171	271, 274	3,004,071	<u> </u>	3, 004, 071	73.00
88. 00		RURAL HEALTH CLINIC	0	18, 609	1, 916, 641	o	1 016 6/1	88. 00
88. 01		RURAL HEALTH CLINIC	0			0	1, 916, 641	1
		· · · · · · · · · · · · · · · · · · ·	0	67, 236	5, 796, 325	-1	5, 796, 325	1
88. 02		RURAL HEALTH CLINIC III	0	32, 799	2, 943, 136	0	2, 943, 136	1
88. 03		RURAL HEALTH CLINIC IV	0	7, 661	638, 900	0	638, 900	•
88. 04	1	RURAL HEALTH CLINIC V	0	12, 343	1, 148, 669	0	1, 148, 669	•
88. 05		RURAL HEALTH CLINIC VI	0	43, 961	3, 199, 246	0	3, 199, 246	1
91.00		EMERGENCY	U	99, 648	4, 426, 661	0	4, 426, 661	91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART		40.070	700 004	0	700 004	92.00
93.00	1	WOODLAWN MEDICAL PROFESSIONALS	0	13, 870	700, 384	0	700, 384	1
		SHAFER MEDI CAL CENTER	0	34, 594	1, 213, 885	0	1, 213, 885	
93. 02		INTERNAL MEDICINE	0	17, 951	275, 511	0	275, 511	93.02
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4, 792, 797	2, 053, 034	53, 919, 743	0	53, 919, 743	118. 00
		MBURSABLE COST CENTERS						
		GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	800	0		190. 00
		PHYSICIANS PRIVATE OFFICES	0	0	14, 940	0	14, 940	
	19201		0	0	0	0	0	192. 01
192. 02	19202	ARGOS MEDICAL CENTER	0	0	0	0	0	192. 02
192.03	19203	AKRON MEDICAL CENTER	0	0	0	0	0	192. 03
193.00	19300	NONPALD WORKERS	0	0	0	0		193.00
194.00	07950	ADVERTI SI NG	o	ol	225, 252	o	225, 252	
194. 01	07951	LTC/WELLNESS	o	ol	49, 297	o	49, 297	
200.00		Cross Foot Adjustments			0	o		200. 00
201.00	1	Negative Cost Centers	o	ol	0	o		201.00
202.00		TOTAL (sum lines 118 through 201)	4, 792, 797	2, 053, 034	54, 210, 032	o	54, 210, 032	
			'	'	. '	'		

				127 0 17 2022	5/26/2023 7:1	7 pm
			CAPITAL RELA	ATED COSTS		
Cost Center Description	Di rectly	BLDG & FIXT	AKRON	ARGOS	CLAYS	
	Assigned New		BUI LDI NG	BUI LDI NG	BUI LDI NG	
	Capi tal					
	Related Costs	1.00	1.00	4 00	1.01	
CENEDAL CEDVICE COST CENTEDS	0	1.00	1. 02	1. 03	1. 04	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.02 00102 AKRON BUILDING						1.00
1. 03 00103 ARGOS BUILDING						1.02
1. 04 00101 CLAYS BUILDING						1.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			0	0	0	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	0	250, 294	4, 151	6, 535	129	5.00
7. 00 00700 OPERATION OF PLANT	0	226, 882	2, 491	7, 450	37, 659	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE		6, 876	2, 491	7, 430	37,039	8.00
9. 00 00900 HOUSEKEEPI NG		25, 983	0	0	348	9.00
10. 00 01000 DI ETARY	0	82, 468	0	0	0	10.00
11. 00 01100 CAFETERI A	0	31, 787	0	0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	54, 686	0	0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	04,000	0	0	0	14.00
15. 00 01500 PHARMACY	0	29, 688	0	0	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0		0	Ö	34, 360	16.00
INPATIENT ROUTINE SERVICE COST CENTERS		20,210	<u> </u>	9	01,000	10.00
30. 00 03000 ADULTS & PEDIATRICS	0	323, 357	0	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		0	o	0	31.00
43. 00 04300 NURSERY	0	4, 006	0	o	0	43.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>	.,		-,		
50. 00 05000 OPERATI NG ROOM	0	176, 545	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	105, 751	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	17, 008	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	2, 935	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	255, 799	0	0	0	54.00
60. 00 06000 LABORATORY	0	56, 185	0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	89, 086	0	0	0	65.00
66. 00 O6600 PHYSI CAL THERAPY	0	67, 495	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	45, 559	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0	164, 442	0	0	43, 337	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0	104, 442	0	0	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	0	o o	0	o	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	0	0	29, 682	ol	0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI	0	o	0	67, 705	0	88. 05
91. 00 09100 EMERGENCY	0	134, 047	0	o	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	0	122, 588	0	0	0	93.00
93. 01 04951 SHAFER MEDICAL CENTER	0	0	0	0	47, 023	93. 01
93. 02 04040 I NTERNAL MEDICINE	0	11, 610	0	0	0	93. 02
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 311, 876	36, 324	81, 690	165, 078	118. 00
NONREI MBURSABLE COST CENTERS	_			_1		
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0		0	0		190.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	,	0	0		192.00
192. 01 19201 FCMC	0	1	0	0		192. 01
192. 02 19202 ARGOS MEDICAL CENTER	0		0	0		192.02
192. 03 19203 AKRON MEDICAL CENTER			0	o		192. 03 193. 00
193. 00 19300 NONPAI D WORKERS 194. 00 07950 ADVERTI SI NG		7, 069	0			193.00
194. 01 07950 ADVERTISING 194. 01 07951 LTC/WELLNESS		7,009	0			194.00
200.00 Cross Foot Adjustments			o o	4	U	200.00
201.00 Negative Cost Centers		ا	O	n	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	2, 331, 476	36, 324	81, 690	165, 078	202. 00
, , , , , , , , , , , , , , , , , , , ,	,			- , - : -	,	

					5/26/2023 7:1	7 pm
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					9. 9.	
1. 00	0	C				1.00 1.02 1.03 1.04 4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	261, 109 274, 482 6, 876 26, 331	0 0 0	261, 109 17, 674 946	292, 156	8, 671 1, 570	5. 00 7. 00 8. 00 9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	82, 468 31, 787 54, 686	0	1, 995 2, 849 4, 497	10, 182	170 0 0	10. 00 11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 29, 688 62, 635	C C	22, 761	3, 666 14, 728	0 0 0	14. 00 15. 00 16. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 43. 00 04300 NURSERY ANCILLARY SERVICE COST CENTERS	323, 357 44, 083 4, 006	C C	3, 621		1, 469 0 0	30. 00 31. 00 43. 00
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	176, 545 105, 751	C	4, 421	13, 057	378 362	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 60. 00 06000 LABORATORY	17, 008 2, 935 255, 799 56, 185	0 0 0 0	296 18, 398	362 31, 583	0 0 1, 842 0	52. 00 53. 00 54. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	89, 086 67, 495	0	8, 617	10, 999 8, 333	202 245 0	65. 00 66. 00 67. 00
68.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0 0	C C C	347	0 0 0	0	68. 00 71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	45, 559	C		0 14, 900	0	73. 00 88. 00
88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III 88. 03 08803 RURAL HEALTH CLINIC IV	164, 442 0	0	25, 677 14, 019	20, 303	0	88. 01 88. 02
88. 04 08804 RURAL HEALTH CLINIC V 88. 05 08805 RURAL HEALTH CLINIC VI	29, 682 67, 705	C	5, 016 14, 205	16, 439	0	88. 03 88. 04 88. 05
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	134, 047 0 122, 588	C		16, 550 15, 135	2, 433	91.00 92.00 93.00
93. 01 04951 SHAFER MEDICAL CENTER 93. 02 04040 INTERNAL MEDICINE SPECIAL PURPOSE COST CENTERS	47, 023 11, 610	C	1		0	93. 01 93. 02
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 594, 968	C	259, 729	292, 156		113. 00 118. 00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS PRIVATE OFFICES 192.01 19201 FCMC	0 12, 531 0	0000	72	0 0 0	0 0	190. 00 192. 00 192. 01
192. 02 19202 ARGOS MEDICAL CENTER 192. 03 19203 AKRON MEDICAL CENTER 193. 00 19300 NONPAID WORKERS 194. 00 07950 ADVERTISING	0 0 0 7,069	0 0 0 0	0 0 0 0 1,076	0 0 0 0	0 0 0	192. 02 192. 03 193. 00 194. 00
194.01 07951 LTC/WELLNESS 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 0 0 2, 614, 568	C C	1	0 0 292, 156	0	194. 01 200. 00 201. 00 202. 00
	2, 311, 300		201, 107	2,2,130	3, 371	,_02.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1313

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 5/26/2023 7:17 pm |

				'	0 12/31/2022	5/26/2023 7: 1	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	<i>,</i> biii
		9. 00	10. 00	11.00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS				191.99		
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						4.00
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, 410					9. 00
10.00	01000 DI ETARY	33	94, 848				10.00
11.00	01100 CAFETERI A	659	0	39, 220)		11.00
13.00	01300 NURSING ADMINISTRATION	26	0	1, 327	67, 288		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	C	0	0	14.00
15.00	01500 PHARMACY	211	0	1, 026	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	143	0	1, 355	5, 235	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 053	91, 422	4, 613	45, 025	0	30.00
31.00	03100 INTENSIVE CARE UNIT	825	3, 426	841	6, 577	0	31.00
43.00	04300 NURSERY	0	0	1, 206	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 655	0	2, 395	0	0	50.00
51.00	05100 RECOVERY ROOM	2, 589	0	1, 145	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	339	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 518	0	4, 982	. 0	0	54.00
60.00	06000 LABORATORY	1, 295	0	3, 982	. 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	1, 432	0	3, 386		0	65.00
66. 00	06600 PHYSI CAL THERAPY	918	0	1, 638		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	498		0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	107	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	_	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	1, 355	0	C		0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 512	0	5, 087	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	C	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	C	0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0	C	0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	0	2 500	0	0	88. 05
91.00	09100 EMERGENCY	3, 980	0	3, 599	10, 451	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	00/	0	000		0	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	826	0	883	1	0	93.00
93. 01 93. 02	04951 SHAFER MEDI CAL CENTER	1, 343	0	(22		0	93. 01 93. 02
93. 02		U U	U	633	ıl U	0	93.02
112 0	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118.00		34, 373	94, 848	39, 042	67, 288	0	118.00
110.00	NONREI MBURSABLE COST CENTERS	34, 373	94, 040	39, 042	07, 200	0	110.00
100 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	37	0	C	O	0	190. 00
	19200 PHYSI CLANS PRI VATE OFFICES	0	0		1		192.00
	1 19201 FCMC		0	C	-		192.01
192.0	2 19202 ARGOS MEDICAL CENTER		0		1		192. 02
	3 19203 AKRON MEDICAL CENTER	0	0	C	-		192. 03
	19300 NONPALD WORKERS	0	n		-		193. 00
	07950 ADVERTI SI NG		n	110			194.00
	07735 ADVERTI SING		n	68	1		194. 01
200.00			Ĭ			ū	200.00
201.00			o	C	ol	0	201. 00
202.00		34, 410	94, 848	39, 220	67, 288	0	202.00

Health Financial Systems In Lieu of Form CMS-2552-10 WOODLAWN HOSPITAL ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1313 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/26/2023 7:17 pm Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Total RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00102 AKRON BULLDING 1.02 1 02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 57, 352 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 92, 580 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 4, 387 534, 124 534, 124 30.00 03100 INTENSIVE CARE UNIT 0 0 65, 054 31.00 238 65,054 31.00 04300 NURSERY 0 9,694 0 9,694 43.00 43.00 187 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 10, 148 231, 934 0 231, 934 50.00 05100 RECOVERY ROOM 0 51.00 946 128, 271 0 128, 271 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 20, 800 52.00 0 0 195 20,800 52 00 05300 ANESTHESI OLOGY 53.00 1, 199 4, 792 4, 792 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 20, 455 336, 577 0 336, 577 54.00 06000 LABORATORY 60.00 0 0 18, 472 105, 429 0 0 105, 429 60.00 06500 RESPIRATORY THERAPY 119, 350 65 00 5, 628 119 350 65 00 06600 PHYSI CAL THERAPY 66.00 1, 413 85, 239 85, 239 66.00 0 06700 OCCUPATI ONAL THERAPY 486 2, 360 0 2, 360 67.00 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 46 500 500 68.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 71 00 0 0 o 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 840 4, 407 4, 407 72.00 07300 DRUGS CHARGED TO PATIENTS 57, 352 0 73.00 12, 227 69, 579 69, 579 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 70.754 0 70, 754 88 00 0 839 88.01 08801 RURAL HEALTH CLINIC II 0 3,030 221, 051 0 221, 051 88.01 88 02 08802 RURAL HEALTH CLINIC III 0 1, 478 15, 497 0 15, 497 88 02 0 0 08803 RURAL HEALTH CLINIC IV 3, 386 3, 386 88.03 88.03 345 08804 RURAL HEALTH CLINIC V 556 88 04 42,818 42,818 88 04 1, 981 88.05 08805 RURAL HEALTH CLINIC VI 0 100, 330 0 100, 330 88.05 0 09100 EMERGENCY 0 91.00 4, 491 193, 632 91.00 193, 632 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 625 142, 292 0 142, 292 93.00 93. 01 04951 SHAFER MEDICAL CENTER 0 1, 559 69, 915 0 69, 915 93.01 04040 INTERNAL MEDICINE 15, 588 809 15, 588 93.02 93.02 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 352 92, 580 2, 593, 373 2, 593, 373 118. 00 118.00 0 NONREI MBURSABLE COST CENTERS 37 190. 00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 37 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 12,603 0 12, 603 192. 00

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8, 255 194, 00

2, 614, 568 202. 00

300 194. 01

192. 01 19201 FCMC

200.00

201.00

202 00

192. 02 19202 ARGOS MEDICAL CENTER

192. 03 19203 AKRON MEDICAL CENTER

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

193. 00 19300 NONPALD WORKERS

194. 00 07950 ADVERTI SI NG

MCRI F32 - 19. 1. 175. 2

194. 01 07951 LTC/WELLNESS

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm Provider CCN: 15-1313

Cost Center Description						'	0 12/31/2022	5/26/2023 7: 1	
SOURMENT FETTY COULARY FET					CAPI TAL RE	LATED COSTS			
SOURMENT FETTY COULARY FET			Cost Contor Description	DIDC 0 FIVE	AKDON	ADCOS	CLAVE	EMDL OVEE	
COMMERT CONTINUE			cost center bescription						
DEBBAL SERVICE COST CENTERS 1.00				(SQUARE TEET)					
1.02 1.02 1.02 1.03 1.04 4.00					,	,	,		
BEBERAL SERVICE COST CENTERS									
1.00		CENED	AL CEDILLOS COCT CENTEDO	1. 00	1.02	1. 03	1. 04	4. 00	
1.02 00102 ARRON BILLIDING	1 00			100 045					1 00
1.03 OCH				100, 043	l .				1
1.04 00100 CLAYS BRILLION 0 0 0 20.414 0 1.04				Ö					1
5 00 00000 ADMINISTRATIVE & SEMERAL 11,685 400 600 16 3,848,197 5,00 600 684 4,657 395,747 7,00 60000 60000 ADMINISTRATIVE & 11,000 13,	1.04	00101	CLAYS BUILDING	0	0				1.04
7. 0.0 0.0000 DOREDATION OF PLANT 10.592 240 684 4.657 395, 747 7.00 30.488 8.00 3000 4.0000 4.0000 30.488 8.00 3000 30.8873 9.00 9.0				0	0	0	0	26, 827, 111	
8.00 00000 LANDREY & LINEN SERVICE 331 0 0 3 30.4,873 9.00 10.00 01000 DIETARY 3.8,850 0 0 0 3 30.4,873 9.00 10.00 01000 DIETARY 3.8,850 0 0 0 3 30.4,873 9.00 11.00 01000 CAFTERA BOAIN STRATION 2.6,850 0 0 0 0 30.7,960 11.00 01000 CARTERA SERVICES & SUPPLY 2.6,50 0 0 0 0 0 0 0 11.00 01000 CENTRAL SERVICES & SUPPLY 1.300 0 0 0 0 0 0 0 11.00 01000 CENTRAL SERVICES & SUPPLY 1.300 0 0 0 0 0 0 0 0 11.00 01000 CENTRAL SERVICES & SUPPLY 1.300 0 0 0 0 0 0 0 0 0		1	l .			•			1
9.00 0.0090 NUISEKEFE NK					l	i e			1
10.00 01000 DETARY 3.850 0 0 0 147,846 10.00 13.00		1	l e e e e e e e e e e e e e e e e e e e		_		_	·	1
11.00 01100 CAFETERIA 1,484 0 0 0 0 307,906 11.00 11.00 1307,906 11.00 13.00 1309 01851 MADINISTRATION 2,553 0 0 0 0 0 0 0 0 0 1.00 14					l .		0		1
13.00 01300 MURSING ADMINISTRATION 2.555 0 0 0 0 566, 947 13.00					l .	· -	o o		1
15.00 01500 PHARMACY 1, 386 0 0 4.08, 975 15.00					l .	0	O		1
1-0.00 1	14.00			0	0	0	0		1
Impart Emil Routh New Service Cost centers 15,096									1
30.00 30.00 ADULT'S A PEDIATRICS 15,096 0 0 1,422,278 30.00 31.00 31.00 10.01 INTENSIVE CASE UNIT 2,058 0 0 0 471,823 31.00 31.0	16.00			1, 320	0	0	4, 249	327, 543	16.00
31.00	30 00			15 096		0	٥	1 422 278	30 00
43.00 0.4300 MURSERY 187									1
50.00		1							1
51.00 05100 RECOVERY ROOM & LABOR ROOM 4,937 0 0 0 1415,906 51.00 520 05200 DELIVERY ROOM & LABOR ROOM 794 0 0 0 0 1415,906 53.00 05300 ANESTHESIOLOGY 137 0 0 0 0 1,65.20 53.00 05300 ANESTHESIOLOGY 137 0 0 0 0 0 53.00 0 0 0 0 53.00 0 0 0 0 0 0 0 0 0									
52.00 05200 BELIVERY ROOM & LABOR ROOM 794 0 0 0 0 0 114, 41 52.00 54.00 05400 MESTHESI DLOGY 137 0 0 0 0 0 0 0 55.00 55.00 05400 MESTHESI DLOGY 137 0 0 0 0 0 0 0 99.022 60.00 65.00 05400 LABORATORY 2, 263 0 0 0 0 0 0 99.022 60.00 65.00 06500 LABORATORY THERAPY 4, 159 0 0 0 0 5.61, 633 66.00 66.00 06600 PISSI CAL THERAPY 3, 151 0 0 0 0 0 5.61, 633 66.00 66.00 06600 SEEPI RATION THERAPY 0 0 0 0 0 0 0 0 200, 910 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 200, 910 67.00 67.10 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	l e e e e e e e e e e e e e e e e e e e						
53.00 05300 ANESTHESIOLOGY 137 0 0 0 53.00								·	1
54.00 05400 RADIOLOGY-DI AGNOSTIC 11, 942 0 0 0 1, 555, 280 54.00 0.00 06000 LABORATORY 2, 2633 0 0 0 0 1, 045, 710 65.00 65.00 06500 PHSI CAL THERAPY 4, 159 0 0 0 0 0 200, 910 67.00 67.00 06700 OCCUPATI ONAL THERAPY 3, 151 0 0 0 0 0 200, 910 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 71.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0		1	l e e e e e e e e e e e e e e e e e e e				0		1
60.00 06000 LABORATORY 2, 623 0 0 999,022 60.00 65.00 6500 6500 RESPIRATORY THERAPY 3, 151 0 0 0 581,683 66.00 66.00 06600 PHYSICAL THERAPY 3, 151 0 0 0 0 581,683 66.00 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 0 0		1	l e e e e e e e e e e e e e e e e e e e		_		0		1
66.00 06600 PHYSICAL THERAPY 3,151 0 0 0 581,683 66.00 67.00 670.00					l .	Ö	o		1
67. 00 06/700 OCCUPATI ONAL THERRAPY 0 0 0 0 0 200,910 67.00 80. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 44,083 68,00 71. 00 07/100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 77.00 72. 00 07/200 IMPL. DEV CHARGED TO PATIENTS 0 0 0 0 0 0 0 77.00 73. 00 07/300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 77.30 80. 00 07/300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73.00 80. 00 07/300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 80. 00 08/00 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0	65.00	06500	RESPI RATORY THERAPY	4, 159	0	0	O	1, 045, 710	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	l .	3, 151	_	1			
17.00		1	l .	0	_	· -	-	·	1
12.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00				0					1
13.00 O7300 DRUGS CHARGED TO PATIENTS O O O O O O O O O O O O O O O O O O						1	-		
88 00 08800 RURAL HEALTH CLINIC 11 7,677 0 0 0 5,634 749,931 88.00 88.02 08801 RURAL HEALTH CLINIC 11 7,677 0 0 0 0 3,224,568 88.01 88.02 08802 RURAL HEALTH CLINIC 11 0 0 0 0 0 0 3,224,568 88.01 88.02 08803 RURAL HEALTH CLINIC 1 0 0 0 0 0 3,35,223 88.03 88.04 08804 RURAL HEALTH CLINIC V 0 0 0 0 0 0 335,223 88.03 88.05 08805 RURAL HEALTH CLINIC V 0 0 0 0 0 0 595,643 88.00 88.05 08805 RURAL HEALTH CLINIC V 0 0 0 0 0 1,143,124 88.05 88.05 08805 RURAL HEALTH CLINIC V 0 0 0 0 0 1,751,257 91.00 92.00 09200 085RVATI ON BEDI CAL PROFESSIONALS 5,723 0 0 0 0 0 3,751,257 91.00 93.00 04951 SHAFER MEDI CAL PROFESSIONALS 5,723 0 0 0 0 5,815 1,648,744 93.01 93.01 04951 SHAFER MEDI CAL CENTER 0 0 0 0 746,581 93.02 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 10900 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 192.00 192.01 19200 PHYSI CLAWS PRI VATE OFFI CES 585 0 0 0 0 0 192.00 192.02 19202 ARGOS MEDI CAL CENTER 0 0 0 0 0 0 192.00 192.02 19202 ARGOS MEDI CAL CENTER 0 0 0 0 0 0 192.00 192.03 19202 ARGOS MEDI CAL CENTER 0 0 0 0 0 0 0 0 0 194.01 07951 ADVERTISI NG 330 0 0 0 0 0 0 0 0				0		•			1
88 01 08801 RURAL HEALTH CLINIC III 7,677 0 0 0 0 3,224,568 88 01 88 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 0 0 1,507,024 88.02 88 03 08803 RURAL HEALTH CLINIC IV 0 0 2,00 0 0 0 3335,223 88.03 88 04 08804 RURAL HEALTH CLINIC V 0 0 2,860 0 0 0 595,643 88.04 89 05 08805 RURAL HEALTH CLINIC V 0 0 0,0 6,216 0 1,143,124 88.05 91.00 09100 EMERGENCY 6,6258 0 0 0 1,751,257 91,00 92,00 92,00 085ERVATION BEDS (NON-DISTINCT PART 92.00 0920 085ERVATION BEDS (NON-DISTINCT PART 93.01 04951 SHAFER MEDICAL CENTER 0 0 0 0 5,815 1,648,744 93.01 04951 SHAFER MEDICAL CENTER 0 0 0 0 5,815 1,648,744 93.01 04951 SHAFER MEDICAL CENTER 542 0 0 0 0 746,581 93.00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 107,930 3,500 7,500 20,414 26,762,318 118.00 NONEEL IMBURSABLE COST CENTERS 585 0 0 0 0 0 0 192.01						,			
88 02 08802 RURAL HEALTH CLINIC III				_					
88. 03 08803 RURAL HEALTH CLINIC IV 0 0 0 0 335, 223 88. 03 88. 04 08804 RURAL HEALTH CLINIC V 0 0 2,860 0 0 595,643 88. 04 88. 05 08805 RURAL HEALTH CLINIC V 0 0 0 6,216 0 1,143,124 88. 05 08805 RURAL HEALTH CLINIC V 0 0 0 6,216 0 1,751,257 91. 00 09000 08ERGENCY 0 0 0 0 1,751,257 92. 00 99200 08SEGNATION BEDS (NON-DISTINCT PART 0 0 0 0 0 632,708 93. 01 04950 WOODLAWN MEDI CAL PROFESSIONALS 5,723 0 0 0 0 632,708 93. 01 04951 SHAFER MEDI CAL CENTER 0 0 0 0 5,815 1,648,744 93. 01 04951 SHAFER MEDI CAL CENTER 0 0 0 0 746,581 8FECI AL PURPOSE COST CENTERS 113. 00 1300 113		1	l .	7,677			_		
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91.00 09100 BMERGENCY 6,258 0 0 0 1,751,257 91.00 92.00 09200 085ERVATION BEDS (NON-DISTINCT PART 92.00 0.00 0.00 0.00 0.00 0.00 93.00 0.00				0	2, 860	0	Ö		
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 93.00 04950 WOODLAWN MEDI CAL PROFESSI ONALS 5,723 0 0 0 5 632,708 93.01 094951 SHAFER MEDI CAL CENTER 0 0 0 0 5,815 1,648,744 93.01 094951 SHAFER MEDI CAL CENTER 542 0 0 0 5 746,581 93.02 04040 INTERNAL MEDI CINE 542 0 0 0 746,581 93.02 04040 INTERNAL MEDI CINE 542 0 0 0 746,581 93.02 04040 INTERNAL MEDI CINE 542 0 0 0 746,581 93.02 04040 INTERNAL MEDI CINE 542 0 0 0 746,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 044,581 93.02 0	88. 05	08805	RURAL HEALTH CLINIC VI	0	0	6, 216	0	1, 143, 124	88. 05
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 5,723 0 0 0 5,815 1,648,708 93. 01 93. 01 04951 SHAFER MEDICAL CENTER 542 0 0 0 5,815 1,648,744 93. 01 93. 02 04040 INTERNAL MEDICINE 542 0 0 0 746,581 SPECIAL PURPOSE COST CENTERS				6, 258	0	0	0	1, 751, 257	1
93. 01 04951 SHAFER MEDI CAL CENTER 0 0 0 5,815 1,648,744 93. 01 93. 02 SPECI AL PURPOSE COST CENTERS 113. 00 1300 INTERNAL MEDI CINE SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 107,930 3,500 7,500 20,414 26,762,318 113. 00 118. 00 NONNEI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 192. 01 192. 00 19200 PYSI CIANS PRI VATE OFFICES 585 0 0 0 0 0 192. 01 192. 01 19202 ARGOS MEDI CAL CENTER 0 0 0 0 0 192. 01 192. 02 19202 ARGOS MEDI CAL CENTER 0 0 0 0 0 192. 01 193. 00 19300 NONNEI DI CAL CENTER 0 0 0 0 0 0 194. 00 19300 NONNEI DI CAL CENTER 0 0 0 0 0 194. 00 19500 ADVERTI ISI NG 330 0 0 0 0 194. 01 07951 ADVERTI ISI NG 330 0 0 0 0 200. 00 Cross Foot Adjustments 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 202. 00 Cost to be allocated (per Wkst. B, Part I) 21. 420148 10. 378286 10. 892000 8. 086509 0. 107493 203. 00 204. 00 Unit cost multiplier (Wkst. B, Part II) 21. 420148 10. 378286 10. 892000 8. 086509 0. 107493 203. 00 205. 00 Unit cost multiplier (Wkst. B, Part II) 21. 420148 10. 378286 10. 892000 8. 086509 0. 107493 203. 00 206. 00 NAHE adjustment amount to be allocated 206. 00				F 700				/00 700	1
93. 02 04040 INTERNAL MEDICINE 542 0 0 0 746, 581 93. 02 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11400 11500				5, /23					1
113. 00 11300 INTEREST EXPENSE 113. 00 11300				542					
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 107,930 3,500 7,500 20,414 26,762,318 118.00	70.02			0.12				, 10, 001	70.02
NONRE MBURSABLE COST CENTERS 190.00 GFF FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190.00 192.00 19200 19200 PHYSI CLANS PRI VATE OFFI CES 585 0 0 0 0 0 192.00 192.01 19201 FCMC 0 0 0 0 0 0 192.01 192.02 19202 ARGOS MEDI CAL CENTER 0 0 0 0 0 0 192.03 19203 AKRON MEDI CAL CENTER 0 0 0 0 0 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 194.01 07951 TC/WELLNESS 0 0 0 0 200.00 28, 779 194.01 200.00 Cost to be allocated (per Wkst. B, Part I) 21.420148 10.378286 10.892000 8.086509 0.107493 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) 205.00 NAHE adjustment amount to be allocated 206.00		11300	INTEREST EXPENSE						
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 0 192. 00 192.00 19200 PHYSICI ANS PRI VATE OFFICES 585 0 0 0 0 0 192. 00 192. 00 192.01 19201 FCMC 0 0 0 0 0 0 0 192. 01 192. 01 192.02 19202 ARGOS MEDI CAL CENTER 0 0 0 0 0 0 0 192. 02 192.03 19203 AKRON MEDI CAL CENTER 0 0 0 0 0 0 0 192. 03 193. 00 193.00 193.00 NONPAI D WORKERS 0 0 0 0 0 0 0 192. 03 193. 00 194. 00 07951 LTC/WELLNESS 0 0 0 0 0 0 0 36, 014 194. 01 07951 LTC/WELLNESS 0 0 0 0 0 0 0 28, 779 194. 01 200. 00 Cross Foot Adjustments 200. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 NAHE adjustment amount to be allocated	118.00			107, 930	3, 500	7, 500	20, 414	26, 762, 318]118.00
192.00 19200 PHYSICIANS PRIVATE OFFICES 585 0 0 0 192.00 192.01 FCMC 0 0 0 0 0 192.01 192.01 192.02 192.02 ARGOS MEDICAL CENTER 0 0 0 0 0 0 192.01 192.02 192.03 19203 AKRON MEDICAL CENTER 0 0 0 0 0 0 192.02 193.00 193.00 NONPAID WORKERS 0 0 0 0 0 0 0 192.03 194.00 193.00 NONPAID WORKERS 0 0 0 0 0 0 0 193.00 194.01 07950 ADVERTISING 330 0 0 0 0 0 36,014 194.00 194.01 07951 LTC/WELLNESS 0 0 0 0 0 0 36,014 194.01 200.00 Cost to be allocated (per Wkst. B, Part I) 200.00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 21.420148 10.378286 10.892000 8.086509 0.107493 203.00 205.00 NAHE adjustment amount to be allocated 206.00 206.00	100.00							^	100 00
192.01 19201 FCMC 0 0 0 0 0 192.01 192.01 192.02 19202 ARGOS MEDICAL CENTER 0 0 0 0 0 0 192.02 192.02 19203 AKRON MEDICAL CENTER 0 0 0 0 0 0 192.03 193.00 1									
192.02 19202 ARGOS MEDICAL CENTER 0 0 0 0 0 0 192.02 19203 AKRON MEDICAL CENTER 0 0 0 0 0 0 192.03 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193.00 194.00 07950 ADVERTISING 330 0 0 0 0 36,014 194.00 194.01 07951 LTC/WELLNESS 0 0 0 0 0 0 28,779 194.01 200.00 Cross Foot Adjustments 0 0 0 0 0 28,779 194.01 200.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 21.420148 10.378286 10.892000 8.086509 0.107493 203.00 Unit cost multiplier (Wkst. B, Part I) 21.420148 10.378286 10.892000 8.086509 0.107493 203.00 Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part III) Unit cost multiplier (Wkst. B, Part III) NAHE adjustment amount to be allocated 206.00 NAHE adjustment amount to be allocated 206.00		1	l e e e e e e e e e e e e e e e e e e e		l .				
193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193.00 194.00 07950 ADVERTISING 194.01 07951 LTC/WELLNESS 0 0 0 0 0 0 36,014 194.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated				0	0	0	o		
194. 00 07950 ADVERTISING 330 0 0 0 36, 014 194. 00 194. 01 07951 LTC/WELLNESS 0 0 0 0 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 201. 00 202. 00 Cost to be allocated (per Wkst. B, Part I) 203. 00 Unit cost multiplier (Wkst. B, Part I) 204. 00 Cost to be allocated (per Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 206. 00 NAHE adjustment amount to be allocated 208. 00 NAHE adjustment amount to be allocated 209. 00 NAHE adjustment amount to be allocated 200. 00 0 0 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 200. 00 0 0 200. 00 0 0 200. 00 0 0 200. 00 0 0 200. 00 0 200. 00 0 200. 00 0 200. 00 0 200. 00 0 200. 00		1	l .	0	0	0	0		
194. 01 07951 LTC/WELLNESS 0 0 0 0 0 0 28,779 194. 01 200. 00 201. 00				0	_	0	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 21.420148 10.378286 10.892000 8.086509 0.107493 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 206.00 2				330		0	0		
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 21.420148 10.378286 10.892000 8.086509 0.107493 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 206.00 206			l e e e e e e e e e e e e e e e e e e e				ı -	20, 779	1
203.00 Part I) Unit cost multiplier (Wkst. B, Part I) 21.420148 10.378286 10.892000 8.086509 0.107493 203.00 204.00 Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit dost multiplier (Wkst. B, Part II) 0.000000 205.00 NAHE adjustment amount to be allocated 206.00									
203.00 Unit cost multiplier (Wkst. B, Part I) 21.420148 10.378286 10.892000 8.086509 0.107493 203.00 (Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated 206.00		1	, ,	2, 331, 476	36, 324	81, 690	165, 078	2, 883, 737	202.00
204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 0.000000 205.00 II) NAHE adjustment amount to be allocated 206.00									
Part II) Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 206.00		1		21. 420148	10. 378286	10. 892000	8. 086509		
205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated 206.00	∠U4. UU	΄						0	204.00
206.00 NAHE adjustment amount to be allocated 206.00	205.00							0. 000000	205.00
			[11]						
(per wkst. B-2)	206.00)							206.00
		1	(PCI WKSt. D-2)	l	I	I	ı l		<u> </u>

Health Financial Syste	WOODLAWN I	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STA	TISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/26/2023 7:1	
			CAPITAL REI	_ATED COSTS			
Cost Cent	er Description	BLDG & FIXT	AKRON	ARGOS	CLAYS	EMPLOYEE	
		(SQUARE FEET)	BUI LDI NG	BUI LDI NG	BUI LDI NG	BENEFI TS	
			(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT	
						(GROSS	
						SALARI ES)	
		1. 00	1. 02	1. 03	1. 04	4. 00	
207.00 NAHE unit Parts III	cost multiplier (Wkst. D, and IV)						207. 00

Period: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm

					12/31/2022	5/26/2023 7:1	
	Cost Center Description		ADMINISTRATIV	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		n	E & GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	(POUNDS OF	(HOURS OF S ERVIC)	
			, ,		LAUNDR)		
	CENTERAL SERVICE COST CENTERS	5A	5. 00	7.00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 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 ADMI NI STRATI VE & GENERAL	-8, 740, 629					5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	0			1, 629		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG		554, 894		295	148, 135	
10.00	01000 DI ETARY	0	347, 433		32	140	
11. 00	01100 CAFETERI A	0	496, 064		0	2, 835	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	783, 109		0	110	
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0	3, 963, 226	0 1, 386	0	0 910	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY				0	615	1
.0.00	INPATIENT ROUTINE SERVICE COST CENTERS		1, 1, 1, 1, 1, 001	0,007		0.0	10.00
30.00	03000 ADULTS & PEDIATRICS	0	2, 764, 275	15, 096	276	34, 675	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0	3, 550	
43. 00	04300 NURSERY	0	661, 697	187	0	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	Ιο	2, 788, 812	8, 242	71	20, 040	50.00
51. 00	05100 RECOVERY ROOM		,		68	11, 145	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	
53.00	05300 ANESTHESI OLOGY	0	51, 529		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			346		1
60.00	06000 LABORATORY	0			0	5, 575	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	1, 500, 423 904, 851		38 46	6, 165 3, 950	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	239, 621		0	0,730	67.00
68. 00	06800 SPEECH PATHOLOGY	0	60, 354		0	0	68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	-	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0		0	0	0	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	1, 410, 570	5, 634	0	5, 835	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	4, 474, 899		0	10, 815	
88. 02	08802 RURAL HEALTH CLINIC III	0	2, 441, 085		0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	529, 460	1	0	0	88. 03
88. 04 88. 05	08804 RURAL HEALTH CLINIC V 08805 RURAL HEALTH CLINIC VI	0	873, 433 2, 473, 369		0	0	88. 04 88. 05
91. 00	09100 EMERGENCY					17, 135	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0, 110, 007	0,200		177.00	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	0	389, 105		0	3, 555	
93. 01	04951 SHAFER MEDI CAL CENTER	0	,			5, 780	
93. 02	O4040 INTERNAL MEDICINE SPECIAL PURPOSE COST CENTERS	0	192, 063	542	0	0	93. 02
113 00	11300 INTEREST EXPENSE						113.00
118.00		-8, 740, 629	45, 229, 078	110, 470	1, 629	147, 975	
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0					190.00
	19200 PHYSICIANS PRIVATE OFFICES	0	1				192.00
	19201 FCMC 19202 ARGOS MEDICAL CENTER	0		0	0		192. 01 192. 02
	19203 AKRON MEDICAL CENTER				0		192. 02
	19300 NONPAI D WORKERS	0	O	0	0		193.00
194.00	07950 ADVERTI SI NG	0	187, 395	0	0		194. 00
	07951 LTC/WELLNESS	0	40, 399	0	0	0	194. 01
200.00	, ,						200.00
201. 00 202. 00			8, 740, 629	3, 669, 154	207, 012	740, 767	201.00
202. UC	Part I)		0, 740, 029	3,009,134	201,012	/40, /0/	202.00
203.00			0. 192231	33. 214031	127. 079190	5. 000621	203.00
204.00	Cost to be allocated (per Wkst. B,		261, 109				204.00
00= ::	Part II)						
205.00			0. 005743	2. 644664	5. 322897	0. 232288	205.00
206.00							206. 00
200.00	(per Wkst. B-2)						200.00
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)		l	1			l

	Financial Systems	WOODLAWN H		ON 45 4040 D		u or form CMS	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C	F	eriod: rom 01/01/2022	Worksheet B-1	
				T	o 12/31/2022	Date/Time Pre 5/26/2023 7:1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(PATI ENT DAYS)	(FTES)	ADMI NI STRATI O N	SERVICES & SUPPLY	(COSTED REQUIS.)	
		DATS)		(DIRECT NRS	(COSTED	KLQUI 3.)	
				ING HR)	REQUIS.)		
	CENEDAL SERVICE COST CENTERS	10. 00	11. 00	13. 00	14. 00	15. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
1. 02	00102 AKRON BUILDING						1. 02
1.03	00103 ARGOS BUILDING						1.03
1. 04 4. 00	00101 CLAYS BUILDING 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 04 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 848					9.00
11. 00	01100 CAFETERI A	0	16, 783				11.00
13.00	01300 NURSING ADMINISTRATION	0	568		_		13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 0	0 439		0	100	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		580				1
	INPATIENT ROUTINE SERVICE COST CENTERS	-			•		
30.00	03000 ADULTS & PEDI ATRI CS	3, 709	1, 974		0		
	03100 INTENSIVE CARE UNIT 04300 NURSERY	139	360 516				
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	010		<u> </u>		10.00
50.00	05000 OPERATING ROOM	0	1, 025				
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	490 145			0	
53.00	05300 ANESTHESI OLOGY		0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	2, 132		0	0	54.00
60.00	06000 LABORATORY	0	1, 704		0	0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		1, 449 701	0 0	0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	213		0	0	1
68. 00	06800 SPEECH PATHOLOGY	0	46		0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0	0			1
	OUTPATIENT SERVICE COST CENTERS						
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	0 2, 176		0	0	
88. 02	08802 RURAL HEALTH CLINIC III	o	2, 170	0	0	0	1
88. 03	08803 RURAL HEALTH CLINIC IV	O	0	0	0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0	0	0	0	
88. 05 91. 00	08805 RURAL HEALTH CLINIC VI 09100 EMERGENCY	0	0 1, 540	12, 935	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,010	12, 700	0		92.00
	04950 WOODLAWN MEDICAL PROFESSIONALS	0	378		0	0	
93. 01	04951 SHAFER MEDICAL CENTER 04040 INTERNAL MEDICINE	0	0 271	0 0			
73. 02	SPECIAL PURPOSE COST CENTERS	<u> </u>	271	0	0	0	73.02
	11300 I NTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 848	16, 707	83, 285	0	100	118.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	O	0	0	0	0	190. 00
192.00	19200 PHYSICIANS PRIVATE OFFICES	o	0	0		0	192. 00
	19201 FCMC	0	0	0	0		192. 01
	19202 ARGOS MEDICAL CENTER 19203 AKRON MEDICAL CENTER	0	0	0	0		192. 02 192. 03
	19300 NONPAI D WORKERS	o	0	Ö	0		193. 00
	07950 ADVERTI SI NG	O	47	0	0		194. 00
194. 01 200. 00	07951 LTC/WELLNESS Cross Foot Adjustments	0	29	0	0	0	194. 01 200. 00
200.00	,						201.00
202.00	Cost to be allocated (per Wkst. B,	546, 861	654, 890	1, 041, 156	0	4, 792, 797	202. 00
202.00	Part I)	140 115444	20 021022	10 501100	0.000000	47 027 070000	202 00
203. 00 204. 00		142. 115644 94, 848	39. 021033 39, 220			47, 927. 970000 57 352	204.00
204.00	Part II)	74,040	37, 220	07,200	0	37,332	204.00
205.00		24. 648649	2. 336889	0. 807925	0. 000000	573. 520000	205. 00
206. 00							206. 00
200.00	(per Wkst. B-2)						
207. 00							207. 00
	Parts III and IV)	1		<u> </u>	<u> </u>	<u> </u>	<u> </u>

Health FinancialSystemsWOODLAWN HOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 15-1313Period:Worksheet B-1

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00102 AKRON BULLDING 1.02 1 02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 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 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 159, 257, 392 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 550, 996 30.00 03100 INTENSIVE CARE UNIT 31.00 409, 597 31.00 04300 NURSERY 43.00 43.00 321, 612 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 467, 110 50.00 05100 RECOVERY ROOM 51.00 1, 628, 559 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 335, 188 52 00 05300 ANESTHESI OLOGY 53.00 2, 062, 864 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 35, 113, 871 54.00 06000 LABORATORY 60.00 31, 792, 871 60.00 06500 RESPIRATORY THERAPY 65 00 9 687 010 65 00 66.00 06600 PHYSI CAL THERAPY 2, 432, 696 66.00 06700 OCCUPATI ONAL THERAPY 836, 764 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 80, 013 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 445, 304 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 21, 045, 252 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1, 443, 555 88 00 88. 01 08801 RURAL HEALTH CLINIC II 5, 215, 701 88.01 88.02 08802 RURAL HEALTH CLINIC III 2, 544, 344 88 02 08803 RURAL HEALTH CLINIC IV 594, 270 88.03 88.03 08804 RURAL HEALTH CLINIC V 88.04 957, 524 88 04 88.05 08805 RURAL HEALTH CLINIC VI 3, 410, 185 88.05 09100 EMERGENCY 91.00 7, 730, 043 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92 00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 1,075,974 93.00 93. 01 04951 SHAFER MEDICAL CENTER 2, 683, 592 93.01 04040 INTERNAL MEDICINE 93.02 1, 392, 497 93.02 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 159, 257, 392 118.00 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 192. 02 0 192. 03 19203 AKRON MEDICAL CENTER 192.03 193. 00 19300 NONPALD WORKERS 0 193.00 0 194. 00 07950 ADVERTI SI NG 194. 00 194. 01 07951 LTC/WELLNESS 194. 01 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 053, 034 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.012891 203.00 204.00 Cost to be allocated (per Wkst. B, 92, 580 204.00 Part II) Unit cost multiplier (Wkst. B, Part 205.00 0.000581 205.00 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1313	Period: Worksheet C From 01/01/2022 Part I

					From 01/01/2022 To 12/31/2022	Part I Date/Time Pre 5/26/2023 7:1	pared: 7 pm
			Title	XVIII	Hospi tal	Cost	
					Costs		
Cost C	enter Description		Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)	2.00	2.00	4.00	5. 00	
I NDATI ENT. DO	OUTINE SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5.00	
	& PEDIATRICS	5, 403, 688		5, 403, 68	88 0	0	30.00
31. 00 03100 I NTENS		978, 687		978, 68		0	31.00
43. 00 04300 NURSER		819, 388		819, 38		0	43.00
	ERVI CE COST CENTERS	017, 300		017, 30	50 ₁ 0 ₁	0	43.00
50. 00 05000 OPERAT		3, 973, 059		3, 973, 05	59 0	0	50.00
51. 00 05100 RECOVE		1, 186, 237		1, 186, 23		0	51.00
	RY ROOM & LABOR ROOM	276, 738		276, 73		0	52.00
53. 00 05300 ANESTH		92, 576		92, 57		0	53.00
	OGY-DI AGNOSTI C	4, 871, 616		4, 871, 6		0	54.00
60. 00 06000 LABORA		4, 443, 882		4, 443, 88		0	60.00
	ATORY THERAPY	2, 144, 062	0	1		0	65.00
66. 00 06600 PHYSI C		1, 267, 760	0	1, 267, 76		0	66.00
	TI ONAL THERAPY	304, 782	0	304, 78		0	67.00
68. 00 06800 SPEECH		74, 782	0	74, 78		0	68.00
	L SUPPLIES CHARGED TO PATIENT	0			o o	0	71.00
72. 00 07200 I MPL.	DEV. CHARGED TO PATIENTS	759, 037		759, 03	37 o	0	72. 00
	CHARGED TO PATIENTS	5, 064, 091		5, 064, 09	0	0	73.00
OUTPATIENT S	SERVICE COST CENTERS						
88. 00 08800 RURAL	HEALTH CLINIC	1, 916, 641		1, 916, 64	11 0	0	88. 00
	HEALTH CLINIC II	5, 796, 325		5, 796, 32	25 0	0	88. 01
	HEALTH CLINIC III	2, 943, 136		2, 943, 13	86 0	0	88. 02
	HEALTH CLINIC IV	638, 900		638, 90		0	88. 03
	HEALTH CLINIC V	1, 148, 669		1, 148, 66		0	88. 04
	HEALTH CLINIC VI	3, 199, 246		3, 199, 24		0	88. 05
91. 00 09100 EMERGE		4, 426, 661		4, 426, 66		0	91.00
	ATION BEDS (NON-DISTINCT PART	1, 858, 860		1, 858, 86		0	92.00
	WN MEDICAL PROFESSIONALS	700, 384		700, 38		0	93.00
	MEDICAL CENTER	1, 213, 885		1, 213, 88		0	93. 01
93. 02 04040 I NTERN		275, 511		275, 5	1 0	0	93. 02
	POSE COST CENTERS	1		1			
113. 00 11300 I NTERE			_				113.00
	al (see instructions)	55, 778, 603	0				200.00
	bservation Beds	1, 858, 860	•	1, 858, 86			201.00
202. 00 Total	(see instructions)	53, 919, 743	0	53, 919, 74	13 0	0	202. 00

| Peri od: | Worksheet C | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared:

Title XVIII
Inpatient Outpatient Total (col. 6 + col. 7) Ratio Inpatient Inp
INPATIENT ROUTINE SERVICE COST CENTERS
INPATIENT ROUTINE SERVICE COST CENTERS 3,105,981 3,105,981 3,105,981 321,612 321,612 43.00 30.
INPATIENT ROUTINE SERVICE COST CENTERS 3, 105, 981 3, 105, 981 30, 00 3000 ADULTS & PEDI ATRI CS 3, 105, 981 409, 597 409, 59
INPATI ENT ROUTI NE SERVI CE COST CENTERS 3, 105, 981 3, 105, 981 3, 100 3000 ADULTS & PEDI ATRI CS 409, 597 409, 597 31, 00 3100 INTENSI VE CARE UNI T 409, 597 321, 612 321, 612 43, 00 43. 00 43.00 AURISERY 321, 612 321, 612 43. 00 43. 00 AURISERY ANCI LLARY SERVI CE COST CENTERS 321, 612 43. 00 43. 00 AURISERY ANCI LLARY SERVI CE COST CENTERS 50. 00 05100 RECOVERY ROOM 236, 565 1, 391, 994 1, 628, 559 0, 728397 0, 000000 51. 00 51. 00 05100 RECOVERY ROOM 221, 840 113, 348 335, 188 0, 825620 0, 000000 52. 00 53. 00 05300 ANESTHESI OLOGY 169, 234 1, 893, 630 2, 062, 864 0, 044877 0, 000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 862, 222 34, 250, 949 35, 113, 871 0, 138738 0, 000000 54. 00 0600 LABORATORY 2, 139, 112 29, 653, 759 31, 792, 871 0, 139776 0, 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 2, 385, 340 7, 301, 670 9, 687, 010 0, 221334 0, 000000 66. 00 66. 00 06600 PHYSI CAL THERAPY 105, 931 730, 833 836, 764 0, 364239 0, 000000 67. 00 68. 00 06600 PHYSI CAL THERAPY 105, 931 730, 833 836, 764 0, 364239 0, 000000 67. 00 68. 00 06600 PHYSI CAL THERAPY 105, 931 730, 833 836, 764 0, 364239 0, 000000 67. 00 68. 00 06600 PHYSI CAL THERAPY 105, 931 730, 833 836, 764 0, 364239 0, 000000 67. 00 68. 00 000000 0000000 0000000 000000
30. 00 3000 ADULTS & PEDIATRICS 3, 105, 981 409, 597 409, 597 409, 597 31. 00 31. 00 31. 00 31. 00 1NTENSI VE CARE UNIT 409, 597 409, 597 409, 597 43. 00 321, 612 43. 00
31. 00 03100 INTENSI VE CARE UNI T 409, 597 321, 612 3
43. 00 04300 NURSERY 321, 612, 612, 612, 612, 612, 612, 612, 6
ANCILLARY SERVICE COST CENTERS
50. 00 05000 OPERATI NG ROOM 2, 570, 282 14, 896, 828 17, 467, 110 0. 227459 0. 000000 50. 00 51. 00 05100 RECOVERY ROOM 236, 565 1, 391, 994 1, 628, 559 0. 728397 0. 000000 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 221, 840 113, 348 335, 188 0. 825620 0. 000000 52. 00 53. 00 05300 ANESTHESI OLOGY 169, 234 1, 893, 630 2, 062, 864 0. 04477 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 862, 922 34, 250, 949 35, 113, 871 0. 138738 0. 000000 54. 00 60. 00 06000 LABORATORY 2, 139, 112 29, 653, 759 31, 792, 871 0. 139776 0. 000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 2, 385, 340 7, 301, 670 9, 687, 010 0. 221334 0. 000000 65. 00 67. 00 06600 PHYSI CAL THERAPY 257, 768 2, 174, 928 2, 432, 696 0. 521134 0. 000000 66. 00 68. 00 06
51. 00 05100 RECOVERY ROOM 236, 565 1, 391, 994 1, 628, 559 0. 728397 0. 000000 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 221, 840 113, 348 335, 188 0. 825620 0. 000000 52. 00 53. 00 05300 ANESTHESI OLOGY 169, 234 1, 893, 630 2, 062, 864 0. 044877 0. 000000 53. 00 54. 00 O5400 RADI OLOGY-DI AGNOSTI C 862, 922 34, 250, 949 35, 113, 871 0. 138738 0. 000000 54. 00 60. 00 06000 LABORATORY 2, 139, 112 29, 653, 759 31, 792, 871 0. 1387738 0. 000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 2, 385, 340 7, 301, 670 9, 687, 010 0. 221334 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 257, 768 2, 174, 928 2, 432, 696 0. 521134 0. 000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 105, 931 730, 833 836, 764 0. 3642
52. 00 05200 DELI VERY ROOM & LABOR ROOM 221, 840 113, 348 335, 188 0. 825620 0. 000000 52. 00 53. 00 05300 ANESTHESI OLOGY 169, 234 1, 893, 630 2, 062, 864 0. 044877 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 862, 922 34, 250, 949 35, 113, 871 0. 138738 0. 000000 54. 00 60. 00 06000 LABORATORY 2, 139, 112 29, 653, 759 31, 792, 871 0. 138776 0. 00000 60. 00 65. 00 06500 RESPI RATORY THERAPY 2, 385, 340 7, 301, 670 9, 687, 010 0. 221334 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 257, 768 2, 174, 928 2, 432, 696 0. 521134 0. 000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 105, 931 730, 833 836, 764 0. 364239 0. 000000 67. 00 68. 00 OBSOO SPEECH PATHOLOGY 11, 470 68, 543 80, 013 0. 934623
53. 00 05300 ANESTHESI OLOGY 169, 234 1, 893, 630 2, 062, 864 0. 044877 0. 000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 862, 922 34, 250, 949 35, 113, 871 0. 138738 0. 000000 54. 00 60. 00 06000 LABORATORY 2, 139, 112 29, 653, 759 31, 792, 871 0. 139776 0. 000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 2, 385, 340 7, 301, 670 9, 687, 010 0. 221334 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 257, 768 2, 174, 928 2, 432, 696 0. 521134 0. 000000 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 105, 931 730, 833 836, 764 0. 364239 0. 000000 67. 00 68. 00 O8600 SPEECH PATHOLOGY 11, 470 68, 543 80, 013 0. 934623 0. 000000 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0. 000000 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS
54. 00 05400 RADI OLOGY-DI AGNOSTI C 862, 922 34, 250, 949 35, 113, 871 0. 138738 0. 000000 54. 00 60. 00 06000 LABORATORY 2, 139, 112 29, 653, 759 31, 792, 871 0. 139776 0. 000000 60. 00 65. 00 06500 RESPI RATORY THERAPY 2, 385, 340 7, 301, 670 9, 687, 010 0. 221334 0. 000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 257, 768 2, 174, 928 2, 432, 696 0. 521134 0. 000000 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 105, 931 730, 833 836, 764 0. 364239 0. 000000 66. 00 68. 00 08800 SPECH PATHOLOGY 11, 470 68, 543 80, 013 0. 934623 0. 000000 67. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 526, 386 918, 918 1, 445, 304 0. 525175 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 261, 1
60. 00
65. 00
66. 00
67. 00
68. 00
71. 00
72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 261, 138 17, 784, 114 21, 045, 252 0. 240629 0. 000000 73. 00 000000 73. 00 000000 0000000 000000 000000 000000
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 1, 443, 555 1, 443, 555 88. 00 88. 01 08801 RURAL HEALTH CLINIC III 0 5, 215, 701 5, 215, 701 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 0 2, 544, 344 2, 544, 344 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 594, 270 594, 270 88. 03
88. 00
88. 01 08801 RURAL HEALTH CLINIC I
88. 02 08802 RURAL HEALTH CLINIC III 0 2, 544, 344 2, 544, 344 2, 544, 344 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 0 594, 270 594, 270 88. 03
88. 03 08803 RURAL HEALTH CLINIC IV 0 594, 270 594, 270 88. 03
88. 04 08804 RURAL HEALTH CLINI C V 0 957, 524 957, 524 88. 04
88. 05 08805 RURAL HEALTH CLINIC VI 0 3, 410, 185 3, 410, 185 88. 05
91. 00 09100 EMERGENCY 165, 143 7, 564, 900 7, 730, 043 0. 572657 0. 000000 91. 00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 472, 051 3, 972, 964 4, 445, 015 0. 418190 0. 000000 92. 00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 1, 075, 974 1, 075, 974 0. 650930 0. 000000 93. 00
93. 01 04951 SHAFER MEDI CAL CENTER 0 2, 683, 592 2, 683, 592 0. 452336 0. 000000 93. 01
93. 02 04040 NTERNAL MEDICINE 0 1, 392, 497 1, 392, 497 0. 197854 0. 000000 93. 02
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
200.00 Subtotal (see instructions) 17, 222, 372 142, 035, 020 159, 257, 392 200.00
201.00 Less Observation Beds 201.00
202. 00 Total (see instructions) 17, 222, 372 142, 035, 020 159, 257, 392 202. 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 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 7:17 pm

				10 12/31/2022	Date/IIMe Pre 5/26/2023 7:1	
			Title XVIII	Hospi tal	Cost	, p
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS					30.00
1	O INTENSIVE CARE UNIT					31.00
	O NURSERY					43.00
	LLARY SERVICE COST CENTERS					
	O OPERATING ROOM	0. 000000				50.00
	O RECOVERY ROOM	0. 000000				51.00
	O DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	O ANESTHESI OLOGY	0. 000000				53.00
	O RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	O LABORATORY	0. 000000				60.00
	O RESPIRATORY THERAPY	0. 000000				65.00
	O PHYSI CAL THERAPY	0. 000000				66.00
	O OCCUPATI ONAL THERAPY	0. 000000				67.00
	O SPEECH PATHOLOGY	0. 000000				68. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
	O IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
	O DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	ATIENT SERVICE COST CENTERS					
	O RURAL HEALTH CLINIC					88. 00
	1 RURAL HEALTH CLINIC II					88. 01
	2 RURAL HEALTH CLINIC III					88. 02
	3 RURAL HEALTH CLINIC IV					88. 03
	4 RURAL HEALTH CLINIC V					88. 04
	5 RURAL HEALTH CLINIC VI					88. 05
	O EMERGENCY	0. 000000				91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
	O WOODLAWN MEDICAL PROFESSIONALS	0. 000000				93.00
	1 SHAFER MEDICAL CENTER	0. 000000				93. 01
	O INTERNAL MEDICINE	0. 000000				93. 02
	I AL PURPOSE COST CENTERS					
	O INTEREST EXPENSE					113. 00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202. 00	Total (see instructions)					202. 00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: From 01/01/2022	

Title XIX Hospital Cost Cost Center Description Total Cost (From Wkst. B, Part I), coci. 26) 1.00 2.00 3.00 4.00 5.00
Total Cost Center Description
CFrom Wkst. B, Part I Col. 26) 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00
INPATIENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00
INPATIENT ROUTINE SERVICE COST CENTERS 5, 403, 688 5, 403, 688 0 5, 403, 688 30, 00 3300 ADULTS & PEDIATRICS 5, 403, 688 5, 403, 688 0 5, 403, 688 31, 00 03300 INTENSI VE CARE UNIT 978, 687 978, 687 0 978, 687 31, 00 04300 NURSERY 819, 388 819, 388 0 819, 388 0 819, 388 43, 00 819, 388 819, 388 0 819, 388
INPATI ENT ROUTINE SERVI CE COST CENTERS
30. 00 03000 ADULTS & PEDIATRICS 5, 403, 688 798, 687 0 978, 687 31. 00 03100 INTENSIVE CARE UNIT 978, 687 978, 687 0 978, 687 31. 00 03100 INTENSIVE CARE UNIT 978, 687 978, 687 0 978, 687 31. 00 0300 NURSERY 819, 388 819, 388 0 819, 388 0 819, 388 43. 00 0500 PERATING ROOM 1, 186, 237 1, 186, 237 0 1, 186, 237 1, 186, 237 0 1, 186, 237 1, 186, 237 0 05100 RECOVERY ROOM 1, 186, 237 1, 186, 237 0 1, 186, 237 1, 186, 237 0 05200 DELI VERY ROOM 4, LABOR ROOM 276, 738 27
31. 00 03100 INTENSIVE CARE UNIT 978, 687 819, 388 819, 388 0 819, 388 43. 00 849, 388 78, 388
43. 00 04300 NURSERY 819, 388 819, 388 0 819, 388 43. 00 819, 388 50 819, 388 43. 00 819, 388 50 819, 388 43. 00 819, 388 50
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 3, 973, 059 3, 973, 059 0 1, 186, 237 1, 186, 237 1, 186, 237 0, 1, 186, 237 1, 186, 23
50. 00 05000 OPERATI NG ROOM 3, 973, 059 3, 973, 059 0 3, 973, 059 50. 00 51. 00 05100 RECOVERY ROOM 1, 186, 237 1, 186, 237 0 1, 186, 237 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 276, 738 276, 738 0 276, 738 52. 00 53. 00 05300 ANESTHESI OLOGY 92, 576 92, 576 0 92, 576 0 92, 576 0 92, 576 0 92, 576 0 92, 576 0 92, 576 0 92, 576 0 92, 576 0 92, 576 0 92, 576 0 92, 576 0 0 92, 576 53. 00 0 0 0 0 06000 LABORATORY 4, 443, 882 4, 443, 882 0 4, 443, 882 0 0 4, 443, 882 0 4, 443, 882 0 0 2, 144, 062 0 2, 144, 062 0 2, 144, 062 0 2, 144, 062 0 0 1, 267, 760 0 1, 267, 760 0 1, 267, 760
51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 276, 738 276, 738 0 276, 738 52. 00 53. 00 05300 ANESTHESI OLOGY 92, 576 92, 576 0 92, 576 53. 00 54. 00 O5400 RADI OLOGY-DI AGNOSTI C 4, 871, 616 4, 871, 616 0 4, 871, 616 0 4, 871, 616 0 4, 871, 616 0 4, 871, 616 0 4, 871, 616 0 4, 871, 616 0 4, 871, 616 0 4, 443, 882 0 4, 443, 882 0 4, 443, 882 0 4, 443, 882 0 4, 443, 882 0 2, 144, 062 0 2, 144, 062 0 2, 144, 062 0 2, 144, 062 0 2, 144, 062 0 2, 144, 062 0 2, 144, 062 0 1, 267, 760 0 1, 267, 760 0 1, 267, 760 0 1, 267, 760 0 0 74, 782 0 304, 782 0 304, 782 0 74, 782 0 74, 782 0 74, 782 0 74, 782
53. 00 05300 ANESTHESI OLOGY 92, 576 92, 576 0 92, 576 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 4, 871, 616 4, 871, 616 0 4, 871, 616 54. 00 60. 00 06000 LABORATORY 4, 443, 882 4, 443, 882 0 4, 443, 882 60. 00 65. 00 06500 RESPI RATORY THERAPY 2, 144, 062 0 0 0 1, 267, 760 0 0 1, 267, 760 0 0 7, 760 6 0 0 0 7, 760 0
54. 00
60. 00
65. 00
65. 00
66. 00 06600
67. 00 06700 0CCUPATI ONAL THERAPY 304, 782 0 304, 782 0 304, 782 0 304, 782 67. 00 68. 00 06800 SPEECH PATHOLOGY 74, 782 0 74, 782 0 74, 782 0 74, 782 0 74, 782 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 759, 037 759, 037 0 759, 037 72. 00 07300 DRUGS CHARGED TO PATI ENTS 5, 064, 091 5, 064, 091 0
68. 00 06800 SPEECH PATHOLOGY 74, 782 0 74, 782 0 74, 782 0 74, 782 68. 00 71. 00 0 0 0 0 0 0 0 0 0
71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 064, 091 5, 064, 091 0 5, 064, 091 73. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 5, 064, 091 5, 064, 091 0 5, 064, 091 73. 00
SECTION SURVICE COST CENTERS SECTION COST CENTERS COST
88. 01 08801 RURAL HEALTH CLINIC II 5, 796, 325 5, 796, 325 0 5, 796, 325 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 2, 943, 136 2, 943, 136 0 2, 943, 136 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 638, 900 638, 900 0 638, 900 0 638, 900 88. 04 08804 RURAL HEALTH CLINIC V 1, 148, 669 1, 148, 669 0 1, 148, 669 88. 04 88. 05 08805 RURAL HEALTH CLINIC VI 3, 199, 246 3, 199, 246 0 3, 199, 246 88. 05
88. 01 08801 RURAL HEALTH CLINIC II 5, 796, 325 5, 796, 325 0 5, 796, 325 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 2, 943, 136 2, 943, 136 0 2, 943, 136 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 638, 900 638, 900 0 638, 900 0 638, 900 90 1, 148, 669 0 1, 148, 669 88. 04 88. 05 08805 RURAL HEALTH CLINIC VI 3, 199, 246 3, 199, 246 0 3, 199, 246 88. 05
88.02 08802 RURAL HEALTH CLINIC III 2,943,136 2,943,136 0 2,943,136 88.02 88.03 08803 RURAL HEALTH CLINIC IV 638,900 638,900 0 638,900 0 638,900 88.03 88.04 08804 RURAL HEALTH CLINIC V 1,148,669 1,148,669 0 1,148,669 88.04 88.05 08805 RURAL HEALTH CLINIC VI 3,199,246 3,199,246 0 3,199,246 88.05
88. 03 08803 RURAL HEALTH CLINIC IV 638, 900 638, 900 0 638, 900 88. 03 88. 04 08804 RURAL HEALTH CLINIC V 1, 148, 669 1, 148, 669 0 1, 148, 669 88. 04 88. 05 08805 RURAL HEALTH CLINIC VI 3, 199, 246 3, 199, 246 0 3, 199, 246 88. 05
88. 05 08805 RURAL HEALTH CLINIC VI 3, 199, 246 3, 199, 246 0 3, 199, 246 88. 05
71. 00 $ 07100 $ EMILINGLING $ 07100 $ $ 0710$
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 1,858,860 1,858,860 1,858,860 92. 00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 700, 384 700, 384 0 700, 384 93.00
93. 01 04951 SHAFER MEDI CAL CENTER 1, 213, 885 1, 213, 885 0 1, 213, 885 93. 01
93. 02 04040 I NTERNAL MEDI CI NE 275, 511 275, 511 0 275, 511 93. 02
SPECIAL PURPOSE COST CENTERS
113. 00 11300 INTEREST EXPENSE 113. 00
200.00 Subtotal (see instructions) 55,778,603 0 55,778,603 0 55,778,603 200.00
201.00 Less Observation Beds 1,858,860 1,858,860 1,858,860 201.00
202.00 Total (see instructions) 53,919,743 0 53,919,743 0 53,919,743 202.00

| Peri od: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				'	0 12/31/2022	5/26/2023 7: 1	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	·	+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7.00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	3, 105, 981		3, 105, 981			30.00
31.00	03100 INTENSIVE CARE UNIT	409, 597		409, 597	,		31.00
43.00	04300 NURSERY	321, 612		321, 612	2		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	2, 570, 282	14, 896, 828	17, 467, 110		0.000000	50.00
	05100 RECOVERY ROOM	236, 565	1, 391, 994	1, 628, 559	0. 728397	0.000000	51.00
	05200 DELIVERY ROOM & LABOR ROOM	221, 840	113, 348	335, 188	0. 825620	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	169, 234	1, 893, 630	2, 062, 864	0. 044877	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	862, 922	34, 250, 949	35, 113, 871	0. 138738	0.000000	54.00
60.00	06000 LABORATORY	2, 139, 112	29, 653, 759	31, 792, 871	0. 139776	0.000000	60.00
	06500 RESPI RATORY THERAPY	2, 385, 340	7, 301, 670	9, 687, 010	0. 221334	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	257, 768	2, 174, 928	2, 432, 696	0. 521134	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	105, 931	730, 833	836, 764	0. 364239	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	11, 470	68, 543	80, 013	0. 934623	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0. 000000	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	526, 386	918, 918	1, 445, 304	0. 525175	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 261, 138	17, 784, 114	21, 045, 252	0. 240629	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	1, 443, 555	1, 443, 555	1. 327723	0.000000	88. 00
	08801 RURAL HEALTH CLINIC II	0	5, 215, 701	5, 215, 701	1. 111322	0.000000	88. 01
	08802 RURAL HEALTH CLINIC III	0	2, 544, 344	2, 544, 344	1. 156737	0.000000	
88. 03	08803 RURAL HEALTH CLINIC IV	0	594, 270	594, 270	1. 075101	0.000000	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	957, 524	957, 524	1. 199624	0.000000	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	3, 410, 185	3, 410, 185	0. 938144	0.000000	88. 05
	09100 EMERGENCY	165, 143	7, 564, 900	7, 730, 043	0. 572657	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	472, 051	3, 972, 964	4, 445, 015	0. 418190	0.000000	92.00
	04950 WOODLAWN MEDICAL PROFESSIONALS	0	1, 075, 974	1, 075, 974	0. 650930	0.000000	93.00
93. 01	04951 SHAFER MEDICAL CENTER	0	2, 683, 592	2, 683, 592	0. 452336	0.000000	93. 01
93.02	04040 INTERNAL MEDICINE	0	1, 392, 497	1, 392, 497	0. 197854	0.000000	93. 02
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113.00
200.00		17, 222, 372	142, 035, 020	159, 257, 392	2		200. 00
201.00							201. 00
202.00	Total (see instructions)	17, 222, 372	142, 035, 020	159, 257, 392	2		202. 00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/26/2023 7:17 pm
	Ti +l o YI Y	Hosni tal	Cost

Cost Center Description					5/26/2023 7:17 pm
INPATI ENT ROUTINE SERVICE COST CENTERS 11.00			Title XIX	Hospi tal	Cost
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 33.00 3	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 31.		Ratio			
30.00		11. 00			
31.00 03100 INTENSIVE CARE UNIT	INPATIENT ROUTINE SERVICE COST CENTERS				
43.00					
ANCI LLARY SERVICE COST CENTERS	31.00 03100 INTENSIVE CARE UNIT				31.00
50.00					43.00
51.00 05100 RECOVERY ROOM 0.000000 52.00 52.00 05200 05200 05200 05200 05200 0.000000 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05300 ANESTHESI OLOGY 0.000000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000 0.00000 0.00000 0.000000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000					
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 000000 53. 00 05300 ANESTHESI OLOGY 0. 000000 55. 00 05400 RADIOLOGY-DI AGNOSTI C 0. 000000 54. 00 05400 RADIOLOGY-DI AGNOSTI C 0. 000000 65. 00 05000 RESPIRATORY THERAPY 0. 000000 65. 00 05000 RESPIRATORY THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 06800 SPEECH PATHOLOGY 0. 000000 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 000000 000000 000000 000000					
53. 00 05300 ANESTHESI OLOGY 0.000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.6000 0.6000 RASPI RATORY THERAPY 0.000000 0.6500 RESPI RATORY THERAPY 0.000000 0.6700 0.000000 0.6700 0.000000 0.6700 0.000000 0.6700 0.000000 0.6700 0.000000 0.6800 SPECCH PATHOLOGY 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1			
54, 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54, 00 60, 00 06000 LABORATORY 0.000000 65, 00 65, 00 06500 RESPIRATORY THERAPY 0.000000 65, 00 66, 00 06600 PHYSI CAL THERAPY 0.000000 66, 00 67, 00 06700 OCCUPATI ONAL THERAPY 0.000000 67, 00 68, 00 08600 SPEECH PATHOLOGY 0.000000 68, 00 71, 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71, 00 72, 00 07200 I IMPL. DEV. CHARGED TO PATIENTS 0.000000 72, 00 73, 00 07300 D RUGS CHARGED TO PATIENTS 0.000000 73, 00 00 079300 D RUGS CHARGED TO PATIENTS 0.000000 73, 00 88, 01 08800 RURAL HEALTH CLINIC III 0.000000 88, 01 88, 02 08801 RURAL HEALTH CLINIC III 0.000000 88, 02 88, 03 08803 RURAL HEALTH CLINIC IV 0.000000 88, 03 88, 05 08805 RURAL HEALTH CLINIC V 0.000000 88, 04 88, 05 08805 RURAL HEALTH CLINIC V 0.0000					
60. 00 06000 LABORATORY 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 66. 00 06600 PATSI CAL THERAPY 0. 000000 66. 00 06600 PATSI CAL THERAPY 0. 000000 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67. 00 068. 00 06800 SPECH PATHOLOGY 0. 000000 77. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 000000 77. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 000000 000000 000000 0000000		1			
65. 00					
66. 00 06600 PHYSICAL THERAPY 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72. 00 0017PATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	1			
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 71. 00 67. 00 07000 MeDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 71. 00 67. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 72. 00 67. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 0000000000000000000000000000000000					
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
71. 00		0. 000000			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 073.00 DRUGS CHARGED TO PATIENTS 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		0. 000000			68.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0.000000 88. 01 08801 RURAL HEALTH CLINIC III 0.000000 88. 02 08802 RURAL HEALTH CLINIC III 0.000000 88. 03 08803 RURAL HEALTH CLINIC IV 0.000000 88. 04 08804 RURAL HEALTH CLINIC IV 0.000000 88. 05 08805 RURAL HEALTH CLINIC V 0.000000 88. 05 91. 00 92. 00 92. 00 92. 00 92. 00 93. 00 93. 01 94. 05 95 SHAFER MEDICAL CENTER 0.000000 93. 00 93. 01 93. 02 04040 INTERNAL MEDICINE 0.000000 0201. 00 0201. 00 0201. 00 085 SUBSTINATION BEDS 0.000000 0201. 00 085 SUBSTINATION BEDS 0.0000000 093. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.000000 093. 00 04950 WOODLAWN MEDICAL CENTER 0.000000 05 05 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTERENAL MEDICINE 0.00000 00 00 00 00 00 00 00 00 00 00 0					
S8. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
88. 00 08800 RURAL HEALTH CLINIC 0.000000 88. 01 88. 01 88. 02 88. 02 88. 02 88. 02 88. 02 88. 03 88. 04 88. 04 88. 04 88. 05 88. 05 88. 05 88. 05 88. 05 88. 05 88. 05 88. 05 88. 05 88. 06 88. 06 88. 07 88. 07 88. 07 88. 08 88. 09 98. 09 99. 09		0. 000000			73. 00
88. 01					
88. 02					
88. 03 08803 RURAL HEALTH CLINIC IV 0.000000 88. 03 88. 04 RURAL HEALTH CLINIC V 0.000000 88. 04 88. 05 08805 RURAL HEALTH CLINIC VI 0.000000 91. 00 92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART 0.000000 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.000000 93. 01 04951 SHAFER MEDICAL CENTER 0.000000 93. 01 04951 SHAFER MEDICAL CENTER 0.000000 93. 01 04040 INTERNAL MEDICINE 0.000000 93. 02 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE Subtotal (see instructions) Less Observation Beds 201. 00					
88. 04 08804 RURAL HEALTH CLINIC V 0.000000 88. 04 88. 05 08805 RURAL HEALTH CLINIC VI 0.000000 91. 00 92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART 0.000000 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.000000 93. 00 04951 SHAFER MEDICAL CENTER 0.000000 93. 01 04951 SHAFER MEDICAL CENTER 0.000000 93. 01 04951 SHAFER MEDICAL CENTER 0.000000 93. 01 04040 INTERNAL MEDICINE 0.000000 93. 02 050000 04040 INTERSE EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Less Observation Beds 201. 00					
88. 05 08805 RURAL HEALTH CLINIC VI 0.000000 91.00 91.00 92.00 92.00 09200 08SERVATION BEDS (NON-DISTINCT PART 0.000000 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.000000 93.01 04951 SHAFER MEDICAL CENTER 0.000000 93.01 04951 SHAFER MEDICAL CENTER 0.000000 93.01 04950 INTERNAL MEDICINE 0.000000 93.01 04950 INTERNAL MEDICINE 0.000000 93.01 04950 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 200.00 Less Observation Beds 201.00					
91. 00 09100 EMERGENCY 0. 000000 91. 00 92. 00 92. 00 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0. 000000 93. 01 04951 SHAFER MEDICAL CENTER 0. 000000 93. 01 04040 INTERNAL MEDICINE 0. 000000 93. 02 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 201. 00 Less Observation Beds 201. 00 201					
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.000000 93. 00 04950 WOODLAWN MEDICAL PROFESSI ONALS 0.000000 93. 01 04951 SHAFER MEDICAL CENTER 0.000000 93. 01 04000 INTERNAL MEDICINE 0.000000 93. 02 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201. 00 Cost of the co					
93. 00					
93. 01 04951 SHAFER MEDI CAL CENTER 0.000000 93. 01 04040 I NTERNAL MEDI CI NE 0.000000 93. 02 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00					
93. 02 04040 INTERNAL MEDICINE 0.000000 93. 02					
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
113.00		0. 000000			93. 02
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
201.00 Less Observation Beds 201.00					
202.00 Total (see instructions)					
	202.00 Total (see instructions)				202. 00

Health Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022		pared:
		Title	XVIII	Hospi tal	Cost	/ pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription	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)	onal goo	301 a 1)	
	col . 26)	, ,				
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	231, 934	17, 467, 110	0. 01327	8 534, 968	7, 103	50.00
51.00 05100 RECOVERY ROOM	128, 271	1, 628, 559	0. 07876	37, 338	2, 941	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	20, 800	335, 188	0. 06205	5 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	4, 792	2, 062, 864	0. 00232	33, 708	78	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	336, 577	35, 113, 871	0. 00958	5 300, 176	2, 877	54.00
60. 00 06000 LABORATORY	105, 429	31, 792, 871	0. 00331	6 726, 803	2, 410	60.00
65. 00 06500 RESPIRATORY THERAPY	119, 350	9, 687, 010	0. 01232	1 901, 256	11, 104	65.00
66. 00 06600 PHYSI CAL THERAPY	85, 239	2, 432, 696	0. 03503	94, 599	3, 315	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 360	836, 764	0. 00282	0 26, 196	74	
68. 00 06800 SPEECH PATHOLOGY	500	80, 013	0.00624	9 7, 275	45	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.0000		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 407	1, 445, 304			576	
73.00 07300 DRUGS CHARGED TO PATIENTS	69, 579	21, 045, 252	0. 00330	6 761, 590	2, 518	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	70, 754	1, 443, 555			0	
88.01 08801 RURAL HEALTH CLINIC II	221, 051	5, 215, 701			0	
88.02 08802 RURAL HEALTH CLINIC III	15, 497	2, 544, 344			0	
88. 03 08803 RURAL HEALTH CLINIC IV	3, 386	594, 270			0	
88. 04 08804 RURAL HEALTH CLINIC V	42, 818	957, 524			0	
88. 05 08805 RURAL HEALTH CLINIC VI	100, 330	3, 410, 185			0	
91. 00 09100 EMERGENCY	193, 632	7, 730, 043			53	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	183, 737	4, 445, 015			947	
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	142, 292	1, 075, 974			0	
93. 01 04951 SHAFER MEDICAL CENTER	69, 915	2, 683, 592			0	
93. 02 04040 I NTERNAL MEDI CI NE	15, 588				0	
200.00 Total (lines 50 through 199)	2, 168, 238	155, 420, 202		3, 637, 739	34, 041	200.00

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

Period: Worksheet D From 01/01/2022 Part IV Date/Time Prepared: D4/02022 7.17 THROUGH COSTS

					.0 12,01,2022	5/26/2023 7: 1	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60.00	06000 LABORATORY	0	0		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0		0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0		0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	0	0		0	0	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	0		0	0	88. 05
91.00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	0	0		0	0	93.00
93. 01	04951 SHAFER MEDICAL CENTER	0	0		0	0	93. 01
93. 02	04040 I NTERNAL MEDICINE	0	0		0	0	93. 02
200.00	Total (lines 50 through 199)	0	0		0	0	200. 00

Health Financial Systems		WOODLAWN HOS	SPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCLILARY SERVICE	OTHER PASS	Provider CCN: 15-1313	Peri od:	Worksheet D

THROUGH COSTS

						5/26/2023 7:1	7 pm
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	C	, ,		
- 1	D5100 RECOVERY ROOM	0	0	C	1, 628, 559	0.000000	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	C	335, 188		
53.00	D5300 ANESTHESI OLOGY	0	0	C	2, 062, 864	0.000000	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	0	C	35, 113, 871	0.000000	54.00
60.00	06000 LABORATORY	0	0	C	31, 792, 871	0.000000	60.00
	06500 RESPI RATORY THERAPY	0	0	C	9, 687, 010	0.000000	65.00
66.00	D6600 PHYSI CAL THERAPY	0	0	C	2, 432, 696	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	836, 764	0.000000	67.00
68.00	D6800 SPEECH PATHOLOGY	0	0	C	80, 013	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	l c	1, 445, 304	0.000000	72.00
73.00	D7300 DRUGS CHARGED TO PATIENTS	0	0	C	21, 045, 252	0.000000	73.00
C	DUTPATIENT SERVICE COST CENTERS						
88.00	D8800 RURAL HEALTH CLINIC	0	0	C	1, 443, 555	0.000000	88. 00
88. 01	D8801 RURAL HEALTH CLINIC II	0	0	C	5, 215, 701	0.000000	88. 01
88. 02	D8802 RURAL HEALTH CLINIC III	0	0	C	2, 544, 344	0.000000	88. 02
88. 03	D8803 RURAL HEALTH CLINIC IV	0	0	C	594, 270	0.000000	88. 03
88. 04	D8804 RURAL HEALTH CLINIC V	0	0	C	957, 524	0.000000	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	0	0	l c	3, 410, 185	0.000000	88. 05
91.00	09100 EMERGENCY	0	0	l c	7, 730, 043	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	l c	4, 445, 015	0.000000	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	0	0	l c	1, 075, 974	0.000000	93.00
93. 01	D4951 SHAFER MEDICAL CENTER	О	0	C	2, 683, 592	0.000000	93. 01
93. 02	04040 INTERNAL MEDICINE	0	0	l c	1, 392, 497		93. 02
200.00	Total (lines 50 through 199)	0	0	l c			200. 00
'	, ,	'		•	1	•	

Health Financial Systems	WOODLAWN HOS	PI TAL	In Lieu	ı of Form CMS-2552-10
ADDODTI ONMENT OF INDATIENT (OUTDATIENT	ANCLL LADY CEDVICE OTHER DACC	D CON 15 1212	D!!	Wasalsalaa - + D

Period: From 01/01/2022 To 12/31/2022 Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Date/Time Prepared: 5/26/2023 7:17 pm 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 Pass-Through to Charges Charges Pass-Through Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 534, 968 05000 OPERATING ROOM 0 51.00 05100 RECOVERY ROOM 0.000000 37, 338 0 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 0 05300 ANESTHESI OLOGY 0.000000 0 53.00 33, 708 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.000000 300, 176 0 60.00 06000 LABORATORY 0.000000 726, 803 0 0 65.00 06500 RESPIRATORY THERAPY 0.000000 901, 256 0 0 06600 PHYSI CAL THERAPY 94, 599 66.00 0.000000 0

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 01/01/2022 Part V 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. 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 1, 695, 889 50.00 0. 227459 05100 RECOVERY ROOM 161, 164 0 51.00 0.728397 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.825620 1, 812 0 52.00 53.00 05300 ANESTHESI OLOGY 0.044877 317, 920 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 138738 7, 371, 113 0 54.00 06000 LABORATORY 60.00 0.139776 5, 860, 975 0 60.00 06500 RESPIRATORY THERAPY 65.00 0. 221334 0 1, 576, 935 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 521134 542, 357 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.364239 0 205, 556 0 67.00 0. 934623 06800 SPEECH PATHOLOGY 0 68.00 68.00 1, 471 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 525175 150, 872 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73 00 0.240629 7, 447, 107 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 0.572657 1, 275, 151 0 91.00 0 0 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.418190 489, 833 0 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.650930 0 93.00 0 04951 SHAFER MEDICAL CENTER 0. 452336 93.01 93.01 0 0 0 93. 02 | 04040 | I NTERNAL MEDICINE 0.197854 0 0 93.02 Ω

0

0

27, 098, 155

27, 098, 155

0 200.00

0 202.00

201.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST Provider CCN	: 15-1313 Peri od: Worksheet D Part V

- THE CONTROLLED OF MEDICAL CONTROL OF THE CONTROL	D WIGGINE GOOT	Trovider of	on. 10 1010	From 01/01/2022 To 12/31/2022	Part V Date/Time Pro 5/26/2023 7:	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	385, 745	0				50.00
51.00 05100 RECOVERY ROOM	117, 391	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 496	0				52.00
53. 00 05300 ANESTHESI OLOGY	14, 267	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 022, 653	0				54.00
60. 00 06000 LABORATORY	819, 224	0				60.00
65. 00 06500 RESPIRATORY THERAPY	349, 029	0				65.00
66. 00 06600 PHYSI CAL THERAPY	282, 641	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	74, 872	0				67.00
68. 00 06800 SPEECH PATHOLOGY	1, 375	0				68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	79, 234	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 791, 990	0				73.00
OUTPATIENT SERVICE COST CENTERS						1
88. 00 08800 RURAL HEALTH CLINIC						88. 00
88.01 08801 RURAL HEALTH CLINIC II						88. 01
88.02 08802 RURAL HEALTH CLINIC III						88. 02
88.03 08803 RURAL HEALTH CLINIC IV						88. 03
88. 04 08804 RURAL HEALTH CLINIC V						88. 04
88. 05 08805 RURAL HEALTH CLINIC VI						88. 05
91. 00 09100 EMERGENCY	730, 224	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	204, 843	0				92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	0	0				93.00
93. 01 04951 SHAFER MEDICAL CENTER	0	0				93. 01
93. 02 04040 I NTERNAL MEDI CI NE	0	0				93. 02
200.00 Subtotal (see instructions)	5, 874, 984	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	5, 874, 984	0				202. 00
			'			•

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1313	Peri od: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room	patient days (including private room days and swing-bed days, excluding newborn)			
2.00 Inpatient days (including private room	days, excluding swing-bed and newborn days)		3, 268	2.00
3.00 Private room days (excluding swing-bed	and observation bed days). If you have only	private room days,	0	3.00

	Cost Center Description	COST	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 586	1.00
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, 268 0	2. 00 3. 00
0.00	do not complete this line.		0.00
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, 067 205	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	113	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)	766	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)	205	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT	0	10.00
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	250. 44	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	250. 44	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, 403, 688 0	21. 00 22. 00
23. 00	$5 ext{ x line 17}$) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	28, 300	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	345, 593	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	5, 058, 095	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 547. 77	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	1, 185, 592	
	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, 185, 592	40. 00 41. 00

13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	•	14.00
15. 00	Total nursery days (title V or XIX only)	0	
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT		17.00
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		18. 00
10.00	reporting period	250 44	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	250. 44	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	250. 44	20. 00
20.00	reporting period	200	20.00
21.00		5, 403, 688	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	28, 300	24 00
21.00	7 x line 19)	20,000	21.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	345, 593	
27. 00		5, 058, 095	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28. 00		0	
29. 00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	•	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	5, 058, 095	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 547. 77	
39. 00		1, 185, 592	
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)	1, 185, 592	41. 00

MCRI F32 - 19. 1. 175. 2

COMPLIT	Financial Systems ATION OF INPATIENT OPERATING COST	WOODLAWN F		CCN: 15-1313	Period:	u of Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INFATIENT OPERATING COST		Frovider	JON. 13-1313	From 01/01/2022 To 12/31/2022		epared:
		T. 1.1		e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col.		Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0. 0	00 0	0	42.00
43. 00	INTENSIVE CARE UNIT	978, 687	139	7, 040. 9	71 58	408, 373	43.00
44.00	CORONARY CARE UNIT			1,515			44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (W					851, 957	
48. 01	Program inpatient cellular therapy acquisit				, column 1)	0	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	01)(see instru	uctions)		2, 445, 922	49.00
50. 00	Pass through costs applicable to Program in	patient routine	services (fro	om Wkst. D. su	m of Parts I and	0	50.00
00.00	III)	patront routine	301 11 003 (110	om moe. D, sa	iii or rarts r and	ĺ	00.00
51.00	Pass through costs applicable to Program in	patient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost excl		elated, non-ph	nysician anest	hetist, and	0	
00.00	medical education costs (line 49 minus line		латоа, поп р	., 5. 5. 4 455 6	notrot, and] 00.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor	use onl v)				0.00	1
56.00	Target amount (line 54 x sum of lines 55, 5		ı			0	1
57.00	Difference between adjusted inpatient opera	ting cost and ta	arget amount ((line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)					0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket		i the cost rep	porting period	enaing 1996,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54		om prior year	cost report,	updated by the	0. 00	60.00
	market basket)			•			
61. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 enter zero. (see instructions)	sser of 50% of t	he amount by	which operati	ng costs (line	0	61.00
62. 00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive pay	ment (see instru	ıcti ons)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST	. I. Ilian II Dani	24 6 11		1	047.000	
64. 00	Medicare swing-bed SNF inpatient routine compositions instructions (title XVIII only)	sis inrough bece	ember 31 of tr	ie cost report	ing period (See	317, 293	64.00
65.00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions	ine costs (line	64 plus line	65)(title XVI	II only); for	317, 293	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31	of the cost r	eporting period	0	67.00
	(line 12 x line 19)	· ·					
68. 00	Title V or XIX swing-bed NF inpatient routing 12 v line 20)	ne costs after [December 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lir	ne 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N					, and the second]
70.00	Skilled nursing facility/other nursing faci	•)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71. 00 72. 00
72.00	Medically necessary private room cost applic	,	n (line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine ser		•				74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75.00
74 00	26, line 45)	ino 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ 1) Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 min						78.00
79. 00	Aggregate charges to beneficiaries for exce	ss costs (from p					79. 00
80.00	Total Program routine service costs for com		cost limitatio	on (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation (1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service cost		•				83.00
84. 00	Program inpatient ancillary services (see in		- /				84.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86.00	Total Program inpatient operating costs (su		rough 85)				86.00
00.00							II.
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instruction:					1, 201	87. 00

Health Financial Systems					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 858, 860	89.00
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	534, 124	5, 403, 688	0. 09884	4 1, 858, 860	183, 737	90.00
91.00 Nursing Program cost	0	5, 403, 688	0.00000	0 1, 858, 860	0	91.00
92.00 Allied health cost	o	5, 403, 688	0.00000	0 1, 858, 860	0	92.00
93.00 All other Medical Education	o	5, 403, 688	0. 00000	1, 858, 860	0	93. 00

		HOSPI TAL		u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1313	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre	
			10 12/31/2022	5/26/2023 7:1	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS	In the second of the second		0. 50/	4 00
1.00	Inpatient days (including private room days and swing-bed			3, 586	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding sw Private room days (excluding swing-bed and observation be			3, 268 0	2. 00 3. 00
3.00	do not complete this line.	u days). II you have only p	iiivate room uays,	U	3.00
4. 00	Semi-private room days (excluding swing-bed and observati	on hed days)		2, 067	4.00
5. 00	Total swing-bed SNF type inpatient days (including privat		er 31 of the cost		5. 00
0.00	reporting period	o room dayo, tin ough booms		200	0.00
6.00	Total swing-bed SNF type inpatient days (including privat	e room days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	3 .			
7.00	Total swing-bed NF type inpatient days (including private	room days) through Decembe	er 31 of the cost	113	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private	room days) after December	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicab	le to the Program (excludin	ig swing-bed and	60	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVI	II only (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see ins		1 doill days)	U	10.00
11. 00			room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year		room dayo, artor	· ·	
12.00	Swing-bed NF type inpatient days applicable to titles V o		ite room days)	0	12.00
	through December 31 of the cost reporting period	3 (3)	<i>,</i>		
13.00	Swing-bed NF type inpatient days applicable to titles V o	r XIX only (including priva	ite room days)	0	13.00
	after December 31 of the cost reporting period (if calend				
	Medically necessary private room days applicable to the P	rogram (excluding swing-bed	l days)		14.00
	Total nursery days (title V or XIX only)				15.00
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT		6		47.0-
17.00	Medicare rate for swing-bed SNF services applicable to se	rvices through December 31	or the cost		17. 00

	Cost Center Description		
	DADT I ALL DDOVIDED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 586	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3, 268	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	0.0/7	4.00
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, 067 205	4. 00 5. 00
5.00	reporting period	203	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	113	7. 00
0.00	reporting period	0	0.00
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	60	9. 00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
44.00	through December 31 of the cost reporting period (see instructions)		44 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		0	12.00
	through December 31 of the cost reporting period		
13.00		0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
14. 00 15. 00		0 371	14. 00 15. 00
16. 00	j	0	
10.00	SWING BED ADJUSTMENT		10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	250. 44	19. 00
19.00	reporting period	250. 44	19.00
20. 00		250. 44	20.00
	reporting period		
21. 00		5, 403, 688	1
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
23. 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. 00
23.00	Swing bed east approache to swing period (The east reporting period (The ea		25.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	28, 300	24.00
	7 x line 19)		
25. 00		0	25. 00
26 00	x line 20) Total swing-bed cost (see instructions)	345, 593	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 058, 095	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	., ,	
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	
30. 00 31. 00		0 000000	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3)	0. 000000 0. 00	1
33. 00		0.00	1
34.00		0.00	1
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00		5, 058, 095	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 547. 77	38. 00
39. 00		92, 866	39. 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)	92, 866	41.00

	ncial Systems	WOODLAWN HO	SPI TAL		In Lie	u of Form CMS-2	2552-1
COMPUTATI ON	OF INPATIENT OPERATING COST		Provi der CC	CN: 15-1313	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/26/2023 7:1	pared:
	Cost Center Description	Total Inpatient Cost	Titl Total Inpatient Days	e XIX Average Per Diem (col. ÷ col. 2)		Cost Program Cost (col. 3 x col. 4)	
40.00 NUIDO		1. 00	2.00	3. 00	4.00	5. 00	40.0
	ERY (title V & XIX only) sive Care Type Inpatient Hospital Units	819, 388	371	2, 208. 5	59 0	0	42.0
43. 00 I NTEI 44. 00 COROI 45. 00 BURN 46. 00 SURG	ISIVE CARE UNIT IARY CARE UNIT INTENSIVE CARE UNIT CAL INTENSIVE CARE UNIT R SPECIAL CARE (SPECIFY)	978, 687	139	7, 040. 9	91 0	0	43. 0 44. 0 45. 0 46. 0 47. 0
	Cost Center Description					1. 00	
48. 01 Progr 49. 00 Total	am inpatient ancillary service cost (Wk- ram inpatient cellular therapy acquisiti Program inpatient costs (sum of lines THROUGH COST ADJUSTMENTS	on cost (Worksh	et D-6, Part), column 1)	65, 491 0 158, 357	48.0
50. 00 Pass	through costs applicable to Program input	atient routine s	services (from	n Wkst. D, su	ım of Parts I and	0	50.0
51. 00 Pass and	through costs applicable to Program inpo	atient ancillary	y services (fr	om Wkst. D,	sum of Parts II	0	51.0
52. 00 Total 53. 00 Total medic	Program excludable cost (sum of lines: Program inpatient operating cost exclusal education costs (line 49 minus line: T AMOUNT AND LIMIT COMPUTATION	ding capital rel	ated, non-phy	ysician anest	hetist, and	0	
54.00 Progr 55.00 Targe	ram discharges et amount per discharge					0.00	54. 0 55. 0
	anent adjustment amount per discharge stment amount per discharge (contractor :	use only)					55. 0 55. 0
56.00 Targe	et amount (line 54 x sum of lines 55, 55	. 01, and 55. 02)				0.00	56.0
	erence between adjusted inpatient operat s payment (see instructions)	ing cost and tai	rget amount (I	ine 56 minus	line 53)	0	57. C
59. 00 Trend upda	ded costs (lesser of line 53 ÷ line 54, ced and compounded by the market basket)		•	0 .	O	0. 00	59.0
	cted costs (lesser of line 53 ÷ line 54, et basket)	or line 55 from	n prior year o	cost report,	updated by the	0. 00	60.0
61. 00 Conti 55. 0 53) a	nuous improvement bonus payment (if lingle, or line 59, or line 60, enter the less are less than expected costs (lines 54 x zero. (see instructions)	ser of 50% of th	ne amount by w	vhich operati	ng costs (line	0	61.0
62.00 Relie 63.00 Allo	ef payment (see instructions) wable Inpatient cost plus incentive paym	ent (see instrud	ctions)			0	62. 0 63. 0
	AM INPATIENT ROUTINE SWING BED COST care swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	e cost report	ing period (See	0	64.0
55.00 Medi	ructions)(title XVIII only) care swing-bed SNF inpatient routine costructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reportin	g period (See	0	65.0
66. 00 Total	Medicare swing-bed SNF inpatient routi	ne costs (line d	64 plus line 6	65)(title XVI	<pre>II only); for</pre>	0	66.0
67. 00 Ti tl	see instructions e V or XIX swing-bed NF inpatient routin e 12 x line 19)	e costs through	December 31 d	of the cost r	reporting period	0	67. C
58.00 Ťitle (Line	e V or XIX swing-bed NF inpatient routing e 13 x line 20)				orting period	0	
	title V or XIX swing-bed NF inpatient					0	69.0
70. 00 Ski I	ed nursing facility/other nursing facil	ity/ICF/IID rou	tine service d	cost (line 37	')		70. C
-	sted general inpatient routine service or ram routine service cost (line 9 x line		ne 70 ÷ line	2)			71. 0 72. 0
, ,	cally necessary private room cost applications.		(line 14 x li	ne 35)			73.0
1	Program general inpatient routine servical-related cost allocated to inpatient	,			Part II, column		74. C
	ine 45) Hiem capital-related costs (line 75 ÷ li	ne 2)					76. (
7. 00 Progi	ram capital-related costs (line 9 x line						77.0
	tient routine service cost (line 74 minus		rovi don na	46)			78.0
	egate charges to beneficiaries for excest Program routine service costs for comp				nus line 79)		79.0
31. 00 I npa	ient routine service cost per diem limi	tati on		(o /o iiii			81.0
1 .	ient routine service cost limitation (82.0
	onable inpatient routine service costs (: ram inpatient ancillary services (see in:		<i>i)</i>				83.0
5	zation review - physician compensation		ns)				85.0
86. 00 Total	Program inpatient operating costs (sum	of lines 83 th					86.0
	IV - COMPUTATION OF OBSERVATION BED PASS					1, 201	97 /
	observation bed days (see instructions sted general inpatient routine cost per	,				1,∠∪1	١٥/.٤

Health Financial Systems					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 858, 860	89. 00
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	534, 124	5, 403, 688	0. 09884	4 1, 858, 860	183, 737	90.00
91.00 Nursing Program cost	0	5, 403, 688	0.00000	1, 858, 860	0	91.00
92.00 Allied health cost	0	5, 403, 688	0.00000	1, 858, 860	0	92.00
93.00 All other Medical Education	o	5, 403, 688	0. 00000	1, 858, 860	0	93. 00

ealth Financial Systems NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	WOODLAWN HOSPITAL Provider (CCN: 15-1313	Peri od:	u of Form CMS-: Worksheet D-3	
	1.00, 40.	79.11 10 1010	From 01/01/2022 To 12/31/2022		pared:
	Ti +1 (e XVIII	Hospi tal	Cost	7 PIII
Cost Center Description	11.01	Ratio of Cos		Inpati ent	
0001 001101 20001 1 211 011		To Charges	10.00	Program Costs	
			Charges	(col. 1 x	
			3.1	col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 097, 431		30.00
31.00 03100 INTENSIVE CARE UNIT			172, 842		31.0
3. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATING ROOM		0. 2274			
1.00 05100 RECOVERY ROOM		0. 7283			
2.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 82562		-	52.0
3. 00 05300 ANESTHESI OLOGY		0. 0448			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1387			
0. 00 06000 LABORATORY		0. 1397			
5. 00 06500 RESPI RATORY THERAPY		0. 2213			
6. 00 06600 PHYSI CAL THERAPY		0. 52113			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 36423			
8. 00 06800 SPEECH PATHOLOGY		0. 9346	· ·		
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000			
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS		0. 5251 0. 2406		•	72. 0 73. 0
OUTPATIENT SERVICE COST CENTERS		0. 2406.	29 761, 590	183, 261	/3.0
8. 00 08800 RURAL HEALTH CLINIC		0.0000	20	0	88.0
8. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	
B. 02 08802 RURAL HEALTH CLINIC III		0.00000		Ö	
B. 03 08803 RURAL HEALTH CLINIC IV		0. 00000		0	88.0
3. 04 08804 RURAL HEALTH CLINIC V		0. 00000		l ő	1
B. 05 08805 RURAL HEALTH CLINIC VI		0. 00000		Ö	
I. 00 09100 EMERGENCY		0. 5726!			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 41819	· ·		
3. 00 04950 WOODLAWN MEDICAL PROFESSIONALS		0. 6509:			
3. 01 04951 SHAFER MEDI CAL CENTER		0. 4523			
3. 02 04040 INTERNAL MEDICINE		0. 1978!		0	1
00.00 Total (sum of lines 50 through 94 and 96	through 98)		3, 637, 739		
01.00 Less PBP Clinic Laboratory Services-Progr			0		201.0
Net charges (line 200 minus line 201)	, , ,		3, 637, 739		202.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1313	Peri od: From 01/01/2022	Worksheet D-3	3
	Component		To 12/31/2022		
	Title		Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
13. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS		0.00745	4 705	1 205	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM		0. 22745 0. 72839		395 1	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 72839		0	
53. 00 05300 ANESTHESI OLOGY		0. 02302		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13873		_	
00. 00 06000 LABORATORY		0. 13977	·		
55. 00 06500 RESPIRATORY THERAPY		0. 22133	83, 755	18, 538	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 52113		24, 744	66.0
57. 00 06700 OCCUPATI ONAL THERAPY		0. 36423		14, 043	
58. 00 06800 SPEECH PATHOLOGY		0. 93462		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000		0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 52517		10.05(1
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0. 24062	29 45, 117	10, 856	73.0
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88.0
8. 01 08801 RURAL HEALTH CLINIC II		0. 00000		Ö	
8. 02 08802 RURAL HEALTH CLINIC III		0.00000		0	88.0
8. 03 08803 RURAL HEALTH CLINIC IV		0. 00000	00	0	88. 0
8.04 08804 RURAL HEALTH CLINIC V		0.00000		0	88. (
8. 05 08805 RURAL HEALTH CLINIC VI		0. 00000		0	1
1. 00 09100 EMERGENCY		0. 57265		6	91. (
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 41819		254	
3. 00 04950 WOODLAWN MEDICAL PROFESSIONALS		0. 65093		0	
3. 01 04951 SHAFER MEDICAL CENTER 3. 02 04040 INTERNAL MEDICINE		0. 45233 0. 19785		0	
00.00 Total (sum of lines 50 through 94 and 96	through 98)	0. 19785	249, 179		
201.00 Less PBP Clinic Laboratory Services-Progr			247, 1/9 0	13, 203	200. (
Net charges (line 200 minus line 201)	am only charges (Title 01)		249, 179		202. 0

	Financial Systems	WOODLAWN HOSPITAL			u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2022	Worksheet D-3	1
				To 12/31/2022	Date/Time Pre	
		T: +1	- VIV	Hanni kal	5/26/2023 7: 1	7 pm
	Cost Center Description		e XIX Ratio of Cos	Hospi tal t Inpati ent	Cost	
	cost center bescription		To Charges	Program	Inpatient Program Costs	
			10 Charges	Charges	(col. 1 x	
				onal ges	col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			151, 960		30.00
31.00	03100 INTENSIVE CARE UNIT			4, 260		31.00
43.00	04300 NURSERY			0		43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 22745		19, 841	
51.00	05100 RECOVERY ROOM		0. 72839	1	6, 634	1
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 82562		0	
53.00	05300 ANESTHESI OLOGY		0. 04487		275	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 13873		1, 075	
60.00	06000 LABORATORY		0. 13977		8, 534	1
65.00	06500 RESPIRATORY THERAPY		0. 22133			1
66.00	06600 PHYSI CAL THERAPY		0. 52113		504	
67.00	06700 OCCUPATI ONAL THERAPY		0. 36423		63	67.00
68.00	06800 SPEECH PATHOLOGY		0. 93462		156	1
	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS		0. 00000 0. 52517		0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 52517		13, 973	
73.00	OUTPATIENT SERVICE COST CENTERS		0. 24002	30,007	13, 7/3	73.00
88. 00	08800 RURAL HEALTH CLINIC		1. 32772	23 0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II		1. 11132		ő	1
88. 02	08802 RURAL HEALTH CLINIC III		1. 15673		0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV		1. 07510		0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V		1. 19962		0	88. 04
	08805 RURAL HEALTH CLINIC VI		0. 93814		0	1
91.00	09100 EMERGENCY		0. 57265		5, 567	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 41819	00	0	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS		0. 65093	0 0	0	93.00
93. 01	04951 SHAFER MEDICAL CENTER		0. 45233	86 0	0	93. 01
03 03	OAOAO INTERNAL MEDICINE		0 10705		۸ ا	02 02

0. 197854

280, 432

93.01 04931 SHAFER MEDICINE
93.02 04040 INTERNAL MEDICINE
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)
202.00 Net charges (line 200 minus line 201)

0 93.02

65, 491 200. 00 201. 00 202. 00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	Period: Worksheet E From 01/01/2022 Part B To 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm

	71.11			5/26/2023 7:1	7 pm
	Title XVI	11	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			5, 874, 984	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0	2.00
3. 00	OPPS payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions)			0. 000	4. 01 5. 00
6. 00	Line 2 times line 5			0.000	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, li	ne 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			5, 874, 984	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for ser	vi ces on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for s	ervi ces d	on a chargebasis	0	16.00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)				47.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000 0	17. 00 18. 00
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 e	vcaade li	no 11) (soo	0	19.00
17.00	instructions)	ACCEUS II	116 11) (366	0	17.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 e	xceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			5, 933, 734	21.00
22. 00	Interns and residents (see instructions)			0	22.00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	23. 00 24. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			U	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			76, 212	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH,	see instr	ructions)	4, 219, 355	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of			1, 638, 167	27.00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			1, 638, 167 578	30. 00 31. 00
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			1, 637, 589	31.00
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			1,007,007	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			313, 287	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			203, 637	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			154, 669	36.00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 841, 226 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (se	e instrud	ctions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			1, 841, 226	40.00
40. 01	Sequestration adjustment (see instructions)			23, 199	40. 01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	40. 02 40. 03
41. 00	Interim payments			2, 169, 552	41.00
41. 01	Interim payments-PARHM or CHART			_, .5,, 552	41. 01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-351, 525	43.00
43. 01	Balance due provider/program-PARHM (see instructions)			_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pu	b. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			Ö	91.00
92. 00	The rate used to calculate the Time Value of Money			0.00	
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313		Worksheet E	
		From 01/01/2022		
		To 12/31/2022	Date/Time Pre	epared:
			5/26/2023 7:1	7 pm
	Title XVIII	Hospi tal	Cost	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm Provider CCN: 15-1313

					5/26/2023 /: 1.	/ pm
		Title	XVIII	Hospi tal	Cost	
		Inpatien	t 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, 663, 041		2, 169, 552	1. 00
2. 00	Interim payments payable on individual bills, either		2,000,011		0	2. 00
2.00	submitted or to be submitted to the contractor for				Ĭ	2.00
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
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	12/05/2022	33, 500)	0	3.01
3.02			C		0	3.02
3.03			1		l ol	3.03
3. 04			ď		0	3. 04
3. 05					0	3. 05
3.03	Provider to Program			<u>'</u>	0	3.03
2 50	ADJUSTMENTS TO PROGRAM			\	0	2 50
3. 50	ADJUSTMENTS TO PROGRAM					3.50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			()	0	3. 53
3.54			C)	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		33, 500)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 696, 541		2, 169, 552	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		, ,		, ,	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
F 04						F 04
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5.02
5. 03			()	0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		(0	5.50
5. 51)	0	5. 51
5. 52					o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	l ol	5. 99
	5. 50-5. 98)		_		-	
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
4 01	SETTLEMENT TO PROVIDER		,		0	6. 01
6. 01	1		[-2		1 - 1	
6. 02	SETTLEMENT TO PROGRAM		507, 502		351, 525	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 189, 039		1, 818, 027	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()			8. 00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 WOODLAWN HOSPITAL Provi der CCN: 15-1313 Component CCN: 15-Z313 Swing Beds - SNF Title XVIII

		Title	XVIII Sw	<i>i</i> ing Beds - SNF	Cost	
		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		456, 338		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
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
2 01			0			2 01
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		o o		0	3. 99
5. 77	3. 50-3. 98)					3. //
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		456, 338		0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		430, 330			4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
5.00						3.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider					F 04
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	TENTATI VE 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		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		72, 588		0	6. 02
7. 00	Total Medicare program liability (see instructions)		383, 750			
7.00	Trotal medical or program frability (see first detrois)		303, 730	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8.00
5. 00	Thame of contractor	I	ļ		1	0.00

Heal th	Health Financial Systems WOODLAWN HOSPITAL In Lieu			u of Form CMS-	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-1313	Peri od:	Worksheet E-1	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		Title XVIII	Hospi tal	Cost	7 рііі
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	The same of the sa	ı (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	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-Z313	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		Title XVIII	Swing Beds - SNF		, p
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1. 00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		320, 466	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		525, 155		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par			0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swin	ng-bed pass-through, see			
3. 01	instructions) Nursing and allied health payment-PARHM or CHART (see instructions)	tions)			3. 01
4. 00	Per diem cost for interns and residents not in approved teachi			0. 00	1
	instructions)	3 3 3			
5.00	Program days		205	0	1
6. 00 7. 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional me		0	0	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thou only	394, 482	0	1
9. 00	Primary payer payments (see instructions)		0	Ö	1
10.00	Subtotal (line 8 minus line 9)		394, 482	0	10.00
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)		394, 482	0	12.00
13. 00	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	5, 835	0	
.0.00	for physician professional services)	, (5,6, 446 50, 1,54, 4,165	0,000	· ·	
14.00	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (see instructions)		388, 647	0	
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	2)	0	0	16. 00 16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	•	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	
19. 00	· ·	detrons)	388, 647	0	
	Sequestration adjustment (see instructions)		4, 897	0	1
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
	Sequestration adjustment-PARHM or CHART pass-throughs				19.03
19. 25	Sequestration for non-claims based amounts (see instructions)		456, 338	0	19. 25 20. 00
	Interim payments Interim payments-PARHM or CHART		430, 330	U	20.00
	Tentative settlement (for contractor use only)		0	0	1
	Tentative settlement-PARHM or CHART (for contractor use only)				21.01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	•	-72, 588	0	
22. 01	Balance due provider/program-PARHM or CHART (see instructions)		0	0	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordanchapter 1, §115.2	nce with CMS Pub. 15-2,	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			1
200.00	Is this the first year of the current 5-year demonstration pe				200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from N	Wkst. D-1, Pt. II, line			201. 00
201.00	66 (title XVIII hospital))	mkst. D-1, It. II, IIIle			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	m Wkst. D-3, col. 3, lir	ne		202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5_vear demons		204.00
	period)	Trist year or the earle	ore 5 year demons	iti ati on	
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
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				207 00
	Program reimbursement under the §410A Demonstration (see inst Medicare swing-bed SNF inpatient service costs (from Wkst. E-:	•	1		207. 00 208. 00
200.00	and 3)	L, 501. 1, 50m 01 111165			
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 2	200 plus line 210) (215 00
∠15.00	iotal adjustment to medicare swing-bed SNF PPS payment (line . instructions)	207 prus rrie 210) (See			215. 00
	1.1101.1401.1510)		ı l	l	1

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prepared: 5/26/2023 7:17 pm
	T' 11	11	0

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT 1.00 Impatient services 1.00 Impatient services 2.445, 922 1.00 2.00 3.00 0.00				10 12/31/2022	5/26/2023 7: 1	7 pm
PART Y - CALCULATION OF RETMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETMBURSEMENT			Title XVIII	Hospi tal		
PART Y - CALCULATION OF RETMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETMBURSEMENT				•		
PART Y - CALCULATION OF RETMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETMBURSEMENT					1. 00	
Impatient services 2,445,922 1,00		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
2.00 Nursing and Allied Health Managed Care payment (see instructions) 0 2.00 0 3.00 0 3.00 0 3.00 0 3.01 3.01 0 3.01 0 3.01 0 3.01 0 3.01 0 3.01 0 3.01 0 3.01 0 3.01 0 3.01 0 3.01 0 3.01 3.01 0 3.01	1. 00				2, 445, 922	1.00
Organ acquisition 0 3.00 3.01 Cellular therapy acquisition cost (see instructions) 2, 45, 922 4.00 3.01 Cellular therapy acquisition cost (see instructions) 2, 45, 922 4.00 3.01 5.00 7			ons)			
Cell ular therapy acquisition cost (see Instructions)						
Subtotal (sum of lines 1 through 3.01) 2, 445, 922 4.00 5.00 7		1 9 1			-	
Primary payer payments						
Total Cost (line 4 less line 5). For CAH (see instructions) 2,470,381 6.00		, ,				
COMPUTATION OF LESSER OF COST OR CHARGES						
Reasonable charges	0.00				2,470,301	0.00
Routine service charges						
Ancillary service charges 0	7 00				0	7 00
9.00 Organ acquisition charges, net of revenue 0 9.00 0						
10.00 Total reasonable charges 0 10.00						
Customary charges Agregate amount actually collected from patients liable for payment for services on a charge basis Agregate amount actually collected from patients liable for payment for services on a charge basis 0 12.00						
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00	10.00				0	10.00
12.00 Amount's that would have been realized from patients Hiable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 13.00 Ratio of Hine 11 to Hine 12 (not to exceed 1.000000) 13.00 14.00 15.00 15.00 15.00 15.00 Excess of customary charges (see instructions) 0.14.00 15	44.00					
had such payment been made in accordance with 42 CFR 413.13(e) 13. 00 Ratio of line 11 to line 12 (not to exceed 1.000000) 14. 00 Total customary charges (see instructions) 15. 00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see						
13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 13.00 14.00 14.00 15.00 Excess of customary charges (see instructions) 14.00 15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see 15.00 15	12. 00			on a charge basis	0	12.00
14.00			e)			
15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 17.00 17.00 17.00 18.00 18.00 19.0						
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 16.00 16.00 17.		, , ,			-	
16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT	15. 00	, ,	ly if line 14 exceeds li	ne 6) (see	0	15. 00
Instructions 17.00 COST of physicians' services in a teaching hospital (see instructions) 17.00 COST of physicians' services in a teaching hospital (see instructions) 17.00 COST of covered services (sum of lines 6, 17 and 18) 18.00 18.00 19.00 Cost of covered services (sum of lines 6, 17 and 18) 2.470, 381 19.00 20.00 Deductibles (exclude professional component) 273, 568 20.00 21.00 20.00		/				
17.00	16. 00		ly if line 6 exceeds lir	ne 14) (see	0	16. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet E-4, line 49) 0 18.00 19.		/				
18. 00	17. 00		ructions)		0	17. 00
19.00 Cost of covered services (sum of lines 6, 17 and 18) 2, 470, 381 39.00 20.00 Deductibles (exclude professional component) 273, 568 20.00 21.00 Excess reasonable cost (from line 16) 273, 568 20.00 22.00 Subtotal (line 19 minus line 20 and 21) 2, 196, 813 22.00 23.00 Coinsurance 23.00 24.00 Subtotal (line 22 minus line 23) 2, 196, 813 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 31, 014 25.00 20						
20. 00 Deductibles (exclude professional component) 273, 568 20. 00 21. 00 Excess reasonable cost (from line 16) 0 21. 00 22. 00 23. 00 23. 00 23. 00 23. 00 24. 00 24. 00 25. 00 24. 00 25. 00 25. 00 25. 00 25. 00 26. 00 26. 00 27. 00 27. 00 28. 00		, , ,	4, line 49)			
21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 2, 196, 813 22.00 23.00 23.00 24.00 Subtotal (line 22 minus line 23) 22.00 23.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 22.166, 813 24.00 25.00 Allowable bad debts (see instructions) 20.159 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 20.159 26.00 29.00						
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23. 00 Coinsurance 0 23. 00 24. 00 Subtotal (line 22 minus line 23) 2, 196, 813 24. 00 25. 00 Al lowable bad debts (exclude bad debts for professional services) (see instructions) 31, 014 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 20, 159 26. 00 27. 00 Al lowable bad debts for dual eligible beneficiaries (see instructions) 8, 661 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 2, 216, 972 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 2, 216, 972 28. 00 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 29. 98 Recovery of accelerated depreciation. 0 29. 99 29. 99 Demonstration payment adjustment amount before sequestration 0 29. 99 30. 00 Subtotal (see instructions) 2, 216, 972 30. 00 30. 01 Sequestration adjustment (see instructions) 27, 933 30. 01 30. 02 Sequestration adjustment amount after sequestration 0 30. 03 31. 00 Interim payments 2, 696, 541 31	21.00				-	
24.00 Subtotal (line 22 minus line 23) 2, 196, 813 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 31,014 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 20,159 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 8,661 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 2,216,972 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0,29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0,29.50 29.98 Recovery of accelerated depreciation. 0,29.50 30.00 Subtotal (see instructions) 2,216,972 30.01 Sequestration adjustment (see instructions) 2,216,972 30.01 Sequestration adjustment (see instructions) 27,933 30.02 Sequestration adjustment amount after sequestration 27,933 30.03 Sequestration adjustment (see instructions) 27,933 31.01 Interim payments adjustment (see instructions) 2,696,541 31.01 Tentative settlement (for contractor use only) 32.01	22. 00	Subtotal (line 19 minus line 20 and 21)			2, 196, 813	22.00
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26. 00 Adj usted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment amount after sequestration 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments 32. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement (for contractor use only) 33. 01 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 20. 11 Contractor 1 CMS Pub. 15-2, chapter 1, 20. 12 Contractor 1 CMS Pub. 15-2, chapter 1, 20. 14 CMS Pub. 15-2, chapter 1, 20. 15 2 26. 00 22. 216, 972 28. 00 29. 90 20. 10 20.	24.00	Subtotal (line 22 minus line 23)			2, 196, 813	24.00
26. 00 Adj usted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment amount after sequestration 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments 32. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement (for contractor use only) 33. 01 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 20. 11 Contractor 1 CMS Pub. 15-2, chapter 1, 20. 12 Contractor 1 CMS Pub. 15-2, chapter 1, 20. 14 CMS Pub. 15-2, chapter 1, 20. 15 2 26. 00 22. 216, 972 28. 00 29. 90 20. 10 20.	25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		31, 014	25.00
27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 29. 99 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment -PARHM or CHART 31. 00 Interim payments 31. 01 Interim payments-PARHM or CHART 32. 00 Tentative settlement (for contractor use only) 33. 01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 8, 661 27. 00 2, 216, 972 28. 00 2, 216, 972 28. 00 2, 216, 972 28. 00 2, 216, 972 28. 00 2, 216, 972 28. 00 2, 216, 972 28. 00 2, 216, 972 28. 00 2, 216, 972 28. 00 2, 216, 972 28. 00 29. 90 20. 00	26.00				20, 159	26.00
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29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM or CHART 30.03 Sequestration adjustment-PARHM or CHART 31.00 Interim payments 1. Interim payments 1. Interim payments 1. Interim payments (for contractor use only) 32.01 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM or CHART (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00			,		· ·	
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29. 98 Recovery of accelerated depreciation. 29. 98 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM or CHART 31. 00 Interim payments Interim payments-PARHM or CHART Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM or CHART (for contractor use only) 33. 00 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 29. 98 0 29. 99 2, 216, 972 30. 00 27, 933 30. 01 27, 933 30.			(s)		-	
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34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00	33. 01		and 26, minus lines 30.0)3, 31.01, and		33. 01
	0.4	1 /			_	
9115. 2	34.00	,	ince with CMS Pub. 15-2,	cnapter 1,	0	34.00
		[9115. 2		l		

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	Peri od: Worksheet E-3
		From 01/01/2022 Part VII

			Fo 12/31/2022		
		Title XIX	Hospi tal	Cost	
	· · · · · · · · · · · · · · · · · · ·		I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		158, 357		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		158, 357	0	4.00
5.00	Inpatient primary payer payments		O		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		158, 357	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		156, 221		8.00
9.00	Ancillary service charges		280, 432	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		436, 653	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for serv	ices on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for paym		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42 CFR	§413. 13(e)			45.00
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
	Total customary charges (see instructions)	11 47 1.	436, 653	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	278, 296	0	17. 00
10.00	line 4) (see instructions)	line 4 evecede line		0	18. 00
18. 00	Excess of reasonable cost over customary charges (complete only if 16) (see instructions)	Title 4 exceeds fille	;	U	16.00
19 00	Interns and Residents (see instructions)			0	19. 00
	Cost of physicians' services in a teaching hospital (see instruction	ns)		0	20.00
		113)	158, 357	0	1
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	eted for PPS provid			21.00
22.00	Other than outlier payments	0104 101 110 p. 011 C] ol	0	22.00
	Outlier payments		o	0	23.00
	Program capital payments		o		24.00
	Capital exception payments (see instructions)		o		25.00
	Routine and Ancillary service other pass through costs		o	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		O	0	27. 00
	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29.00	Titles V or XIX (sum of lines 21 and 27)		158, 357	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		158, 357	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		158, 357	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
38. 00	Subtotal (line 36 ± line 37)		158, 357	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		158, 357	0	1
	Interim payments		159, 407	0	41.00
	Balance due provider/program (line 40 minus line 41)		-1, 050	0	
43.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				l

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 Pe

Peri od: Worksheet G
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/26/2023 7:17 pm

UIII y)					5/26/2023 7:1	7 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	0.00	1. 00	
1.00	Cash on hand in banks	9, 054, 689	0	0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3. 00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24, 340, 028	1	0	0	4.00
5. 00 6. 00	Other receivable Allowances for uncollectible notes and accounts receivable	2, 299, 779 -16, 474, 806		0	0	5. 00 6. 00
7. 00	Inventory	983, 834	1	0	0	7.00
8. 00	Prepai d expenses	271, 139	1	0	Ö	8.00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	20, 474, 663	0	0	0	11.00
10.00	FI XED ASSETS	F0/ 01/		0	0	10.00
12. 00 13. 00	Land Land improvements	596, 216 513, 782		0	0	12. 00 13. 00
14. 00	Accumulated depreciation	-468, 485		0	0	14.00
15. 00	Bui I di ngs	29, 635, 140		0	Ő	15.00
16.00	Accumulated depreciation	-17, 447, 459	1	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00 22. 00	Automobiles and trucks	0		0	0	21.00
23. 00	Accumulated depreciation Major movable equipment	16, 309, 970		0	0	22. 00 23. 00
24. 00	Accumul ated depreciation	-12, 041, 580		0	0	24.00
25. 00	Mi nor equipment depreciable	12,041,300	0	0	Ö	25.00
26. 00	Accumulated depreciation	0	o	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	17, 097, 584	0	0	0	30.00
31. 00	OTHER ASSETS Investments	10, 651, 643	0	0	0	31.00
32. 00	Deposits on Leases	10,031,049	0	0	0	32.00
33. 00	Due from owners/officers	0	o	0	Ō	33.00
34.00	Other assets	1, 920, 398	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	12, 572, 041	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	50, 144, 288	0	0	0	36. 00
27.00	CURRENT LI ABI LI TI ES	2 545 0/2		0	0	1 27 00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	3, 545, 063 2, 088, 998	1	0	0	37. 00 38. 00
39. 00	Payrol I taxes payable	2,000,770		0	0	39.00
40.00	Notes and Loans payable (short term)	675, 253	o	0	Ō	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44. 00	Other current liabilities	1, 925, 208	·	0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	8, 234, 522	0	0	0	45. 00
46. 00	Mortgage payable		ol	0	0	46.00
47. 00	Notes payable	7, 922, 818		0	0	47.00
48. 00	Unsecured Loans	0	Ö	0		48. 00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7, 922, 818	0	0		50.00
51.00	Total liabilities (sum of lines 45 and 50)	16, 157, 340	0	0	0	51.00
F0 00	CAPITAL ACCOUNTS		1			
52.00	General fund balance	33, 986, 948	0			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted	-	١	0		53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			3	0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	33, 986, 948	1	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50, 144, 288		0	0	60.00
	J <i>~</i> ′/	I	ı		ı	I

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

Period: Worksheet G-1 From 01/01/2022 Provi der CCN: 15-1313

					To 12/31/20		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0	35, 095, 753 -1, 108, 805 33, 986, 948		0 0 0 0	0	5. 00 6. 00 7. 00 8. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 33, 986, 948 0 33, 986, 948		0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 11.00 12.00 13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0 0		0 0 0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

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

		[1	o 12/31/2022	Date/Time Pre 5/26/2023 7:1	
	Cost Center Description	I npati ent	Outpati ent	Total	, piii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	4, 147, 635	i	4, 147, 635	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			0	5.00
6.00	Swing bed - NF			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, 147, 635	5	4, 147, 635	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	472, 615		472, 615	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	s 472, 615		472, 615	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4, 620, 250		4, 620, 250	17. 00
18.00	Ancillary services	12, 671, 748	126, 723, 841	139, 395, 589	18. 00
19. 00	Outpati ent servi ces		16, 648	16, 648	19.00
20.00	RURAL HEALTH CLINIC		1, 443, 555	1, 443, 555	20.00
20. 01	RURAL HEALTH CLINIC II		5, 215, 701	5, 215, 701	20. 01
20.02	RURAL HEALTH CLINIC III		2, 544, 344	2, 544, 344	20. 02
20. 03	RURAL HEALTH CLINIC IV		594, 270	594, 270	20. 03
20.04	RURAL HEALTH CLINIC V		957, 524	957, 524	20. 04
20.05	RURAL HEALTH CLINIC VI		3, 410, 185	3, 410, 185	20. 05
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21.00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER OUTPATIENT		1, 075, 974	1, 075, 974	
27. 01	PROFESSI ONAL FEES			4, 163, 215	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W	kst. 17, 291, 998		163, 437, 255	28. 00
20.00	G-3, line 1)		1 107 1 107 207	100/ 107/200	20.00
	PART II - OPERATING EXPENSES	'	'		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63, 941, 049		29. 00
30.00	ADD (SPECIFY)				30.00
31.00		()		31.00
32.00		(32.00
33. 00					33.00
34. 00					34.00
35. 00					35.00
36. 00	Total additions (sum of lines 30-35)		0		36.00
37. 00	ADJUST		-		37.00
38. 00					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)(tra	ansfer	63, 941, 049		43.00
.5. 50	to Wkst. G-3, line 4)		33, 7.1., 017		10.00
	1	1	'		1

	Fig. 1. C. J. C. J. C. J. C. J. C. J. C. J. C.	ODI TAI		. C. E OHC	2550 40
	Financial Systems WOODLAWN HOS MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1313	Period:	u of Form CMS-2 Worksheet G-3	
SIAIL	IENT OF REVENUES AND EXPENSES	Trovider con. 13 1313	From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
				5/20/2023 /. 1	/ pili
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		163, 437, 255	1. 00
2.00	Less contractual allowances and discounts on patients' accou	nts		109, 618, 236	2.00
3.00	Net patient revenues (line 1 minus line 2)			53, 819, 019	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		63, 941, 049	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-10, 122, 030	5.00
	OTHER INCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			94, 872	7. 00
8. 00	Revenues from telephone and other miscellaneous communicatio	n services		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 13. 00	Parking lot receipts			0	12. 00 13. 00
14. 00	Revenue from laundry and linen service			127, 077	14.00
15. 00	Revenue from meals sold to employees and guests Revenue from rental of living quarters			127,077	15.00
16. 00		than nationts		0	16.00
17. 00		than patrents		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				0	20.00
21. 00				9	21. 00
22. 00	Rental of hospital space			2, 950	
23. 00	Governmental appropriations			0	23. 00
24. 00	OTHER OPERATING INCOME			8, 800, 562	24. 00
24. 01				-20, 660	24. 01
24. 02	DONATIONS FROM FOUNDATION			8, 415	24. 02
24. 50	COVI D-19 PHE Funding			0	24. 50
25.00	Total other income (sum of lines 6-24)			9, 013, 225	25. 00
	Total (line 5 plus line 25)			-1, 108, 805	26.00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00				0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			-1, 108, 805	29. 00

	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	WOODLAWN H	HOSPI TAL Provi der C	CN: 15-1313	Peri od:	u of Form CMS-: Worksheet M-1	
			Component	CCN: 15-8551	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
					RHC I	Cost	7 pili
		Compensation	Other Costs	Total (col	1 Reclassificat	Recl assi fi ed	
		compensati on	other costs	+ col . 2)	ions	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	451, 521	0	451, 52	1 0	451, 521	1.00
2.00	Physici an Assistant	. 0	0		0 0	0	2.00
3.00	Nurse Practitioner	78, 610	0	78, 61	0 0	78, 610	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	40, 844	0	40, 84	.4 0	40, 844	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	114, 186	0	114, 18	6 0	114, 186	9. 00
10.00	Subtotal (sum of lines 1 through 9)	685, 161	0	685, 16	1 0	685, 161	10.00
11.00	Physician Services Under Agreement	0	602, 147	602, 14	.7	602, 147	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	602, 147	602, 14	.7	602, 147	14.00
15.00	Medical Supplies	0	1, 202			1, 202	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1, 202	1, 20	0	1, 202	21.00
22. 00	Total Cost of Health Care Services (sum of	685, 161	603, 349	1, 288, 51	0	1, 288, 510	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
	1	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	
25. 02	5	0	0		0	0	
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 through 27)	0	0		0 0	0	28. 00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7, 801	7, 80	1 0	7, 801	29. 00
30.00	Administrative Costs	49, 662	159, 671			224, 446	30.00
31 00	Total Facility Overhead (sum of lines 29 and	49 662	167 472	217 13	4 15 113	232 247	31 00

49, 662

734, 823

Total Facility Overhead (sum of lines 29 and

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

217, 134

1, 505, 644

159, 671 167, 472

770, 821

224, 446 232, 247

1, 520, 757

15, 113

15, 113

31.00

32.00

Health Financial Systems	WOODLAWN H	OSPI TAL		In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CCN: 1		Peri od: From 01/01/2022	Worksheet M-1	
		Component CCN:	15-8551	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
				RHC I	Cost	
		–				

			Component CCN: 15-855	1 10	12/31/2022	Date/IIME Pre	
					RHC I	Cost	т ріп
		Adjustments	Net Expenses		KIIO I	0031	
		naj astilionts	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-226, 599	224, 922				1.00
2. 00	Physician Assistant	0	o				2.00
3.00	Nurse Practitioner	-9, 759	68, 851				3.00
4. 00	Visiting Nurse	0	0				4. 00
5. 00	Other Nurse	0	40, 844				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	Ö				8.00
9. 00	Other Facility Health Care Staff Costs	0	114, 186				9.00
10.00	Subtotal (sum of lines 1 through 9)	-236, 358	448, 803				10.00
11. 00	Physician Services Under Agreement	200, 000	602, 147				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	602, 147				14.00
15. 00	Medical Supplies	0	1, 202				15.00
16. 00	Transportation (Health Care Staff)	0	0				16.00
	Depreciation-Medical Equipment	0	Ö				17.00
18. 00	Professional Liability Insurance	0	0				18.00
	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs	U	0				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	1, 202				21.00
22. 00	Total Cost of Health Care Services (sum of	-236, 358					22.00
22.00	lines 10, 14, and 21)	-230, 330	1,032,132				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23 00	Pharmacy	0	0				23.00
24. 00	Dental	0	Ö				24.00
25. 00	Optometry	0	0				25.00
25. 01	Tel eheal th	0	0				25. 01
25. 02	4	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26.00
27. 00	Nonal Lowable GME costs	O					27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
20.00	through 27)	O					20.00
	FACILITY OVERHEAD		<u> </u>				1
29.00	Facility Costs	0	7, 801				29.00
30. 00	Admi ni strati ve Costs	0	224, 446				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	n	232, 247				31.00
5 00	30)	J					55
32. 00	Total facility costs (sum of lines 22, 28	-236, 358	1, 284, 399				32.00
	and 31)	, 000	, == :, = : :				
	1 /		1				

Heal th Financi al Systems								
Component CN: 15-852			WOODLAWN H					
Component CCN: 15-8552 To 12/31/2022 Date/Time Prepared: 5/26/2033 7: 17 pm 16/2023 7: 17 pm 1	ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co			Worksheet M-1	
Compensation Other Costs Total (col. 1 Reclassificat Facility Reclassification Pacility Reclassification Reclassification Pacility				Component				
FACILITY HEALTH CARE STAFF COSTS							Cost	
FACILITY HEALTH CARE STAFF COSTS			Compensation	Other Costs				
FACILITY HEALTH CARE STAFF COSTS					+ col. 2)	i ons		
FACILITY HEALTH CARE STAFF COSTS							•	
FACILITY HEALTH CARE STAFF COSTS 1.00			4 00	0.00	0.00	4.00		
1.00		FACILITY HEALTH CARE STAFE COSTS	1.00	2.00	3.00	4.00	5.00	
2.00 Physician Assistant 0 0 0 0 0 0 0 0 0	1 00		2 420 242	E 000	2 424 05	1	2 424 OE1	1 00
3.00 Nurse Practitioner 218, 721 0 218, 721 0 0 0 0 0 0 0 0 0		,						
4. 00 Visiting Nurse 0 0 0 0 0 0 4. 00			O		l '	-	_	
5. 00 Other Nurse		4	210, 721	0	210,72		· ·	
6.00 Clinical Sychologist 0 0 0 0 0 0 0 0 0			252 023	0	252 02	٥	_	
7. 00 Clinical Social Worker 0 0 0 0 0 0 0 0 0		4	202, 020	0	202, 02	0		
8.00 Laboratory Technician			0	0		0		
9.00 Other FacIlity Health Care Staff Costs 0 0 0 0 0 0 0 0 0			0	0		0	0	
10. 00 Subtotal (sum of lines 1 through 9) 2,898,987 5,808 2,904,795 0 2,904,795 10. 00 11. 00 Physician Services Under Agreement 0 0 0 0 0 0 12. 00 Physician Supervision Under Agreement 0 0 0 0 0 13. 00 Other Costs Under Agreement 0 0 0 0 0 14. 00 Subtotal (sum of lines 11 through 13) 0 0 0 0 0 15. 00 Medical Supplies 0 428,203 428,203 0 428,203 15. 00 16. 00 Transportation (Health Care Staff) 0 0 0 0 0 0 17. 00 Depreciation-Medical Equipment 0 0 0 0 0 0 17. 00 Depreciation-Medical Equipment 0 0 0 0 0 0 18. 00 Professional Liability Insurance 0 0 0 0 0 0 19. 00 Other Health Care Costs 0 0 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff) 0 0 0 0 19. 00 Other Health Care Staff 0 0 0 0 19. 00 Other Health Care Staff 0 0 0 0 19. 00 Other Health Care Staff 0 0 0 0 19. 00 Other Health			0	0		0	0	
12.00 Physician Supervision Under Agreement 0 0 0 0 0 0 0 12.00			2, 898, 987	5, 808	2, 904, 79	5 0	2, 904, 795	10.00
13.00 Other Costs Under Agreement 0 0 0 0 0 0 0 13.00 14.00 Subrotal (sum of lines 11 through 13) 0 0 0 0 0 0 0 15.00 Medical Supplies 0 428,203 428,203 0 428,203 15.00 16.00 Transportation (Health Care Staff) 0 0 0 0 0 0 17.00 Depreciation-Medical Equipment 0 0 0 0 0 0 18.00 Professional Liability Insurance 0 0 0 0 0 0 18.00 Professional Liability Insurance 0 0 0 0 0 19.00 Other Health Care Costs 0 0 0 0 0 20.00 All lowable GME Costs 0 0 0 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 428,203 428,203 0 428,203 21.00 22.00 Total Cost of Health Care Services (sum of 2,898,987 434,011 3,332,998 0 3,332,998 22.00 Total Cost of Health Care Services (sum of 2,898,987 434,011 3,332,998 0 3,332,998 23.00 Pharmacy 0 0 0 0 0 0 24.00 Dental 0 0 0 0 0 0 25.00 Optometry 0 0 0 0 0 0 25.01 Tel eheal th 0 0 0 0 0 25.02 Chronic Care Management 0 0 0 0 0 26.00 All other nonreimbursable costs 0 0 0 0 27.00 Nonal lowable GME costs 0 0 0 0 27.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 27.00 Facility OverHead 27) Facility OverHead 29.00 30.00 Administrative Costs 369,493 527,477 896,970 -43,936 853,034 30.00	11.00	Physician Services Under Agreement	0	0			0	11.00
14.00 Subtotal (sum of lines 11 through 13)	12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
15.00 Medical Supplies	13.00	Other Costs Under Agreement	0	0		0	0	13.00
16.00 Transportation (Health Care Staff) 0 0 0 0 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 0 0 0 18.00 Professional Liability Insurance 0 0 0 0 0 19.00 Other Health Care Costs 0 0 0 0 20.00 Other Health Care Costs 0 0 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 428,203 428,203 0 428,203 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 0 0 23.00 24.00 Dental 0 0 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 0 0 25.00 25.01 Tel eheal th 0 0 0 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 0 0 0 0 27.00 Nonall owable GME costs 0 0 0 0 0 0 28.00 Transportation (Health Care Sequence 0 0 0 0 27.00 Transportation (Health Care Sequence 0 0 0 0 28.00 Transportation (Health Care Sequence 0 0 0 0 29.00 Each 10 10 10 10 20.01 10 10 10 10 20.02 10 10 10 10 20.03 10 10 10 20.04 10 10 10 20.04 10 10 10 20.05 10 10 10 20.05 10 10 10 20.05 10 10 10 20.05 10 10 20	14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
17.00 Depreciation-Medical Equipment 0 0 0 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 0 0 0 19.00 Other Heal th Care Costs 0 0 0 0 0 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 428,203 428,203 0 428,203 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 20.00 23.00 Dental 0 0 0 0 0 0 0 25.00 Optometry 0 0 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 0 0 25.00 25.01 Tel eheal th 0 0 0 0 0 0 25.02 Chronic Care Management 0 0 0 0 0 0 25.02 Chronic Care Management 0 0 0 0 0 26.00 All other nonreimbursable costs 0 0 0 0 0 27.00 Nonallowable GME costs 0 0 0 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 29.00 Administrative Costs 0 0 564,198 564,198 -564,198 0 29.00 30.00 Administrative Costs 369,493 527,477 896,970 -43,936 853,034 30.00			0	428, 203	428, 20	3 0	428, 203	
18.00			0	0		0	_	
19.00 Other Health Care Costs 0 0 0 0 0 0 19.00 20.00 20.00 20.00 Allowable GME Costs 0 428,203 428,203 0 428,203 21.00 20.00			0	0		0		1
20.00			0	0		0	, and the second	
21.00 Subtotal (sum of lines 15 through 20) 0 428,203 428,203 0 428,203 21.00		1	0	0	(0	0	
Total Cost of Health Care Services (sum of lines 10, 14, and 21) 3, 332, 998 0 3, 332, 998 22.00				400.000	400.00		400,000	
Lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES			0 000 007					
COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 0 0 0 23.00	22.00	`	2, 898, 987	434, 011	3, 332, 998	3	3, 332, 998	22.00
23. 00 Pharmacy		COSTS OTHER THAN PHC/FOHC SERVICES						
24.00 Dental 0 0 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 0 0 0 25.00 25.01 Tel eheal th 0 0 0 0 0 0 0 0 25.01 25.02 Chronic Care Management 0 0 0 0 0 0 0 25.01 26.00 All other nonreimbursable costs 0 0 0 0 0 0 0 26.00 27.00 Nonal I owable GME costs 0 0 0 0 0 0 0 0 28.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 28.00 27.00 Facility OverHead 29.00 Facility Costs 0 564, 198 564, 198 -564, 198 0 29.00 30.00 Administrative Costs 369, 493 527, 477 896, 970 -43, 936 853, 034 30.00	23 00		0	0		0	0	23 00
25. 00 Optometry 0 0 0 0 0 0 0 25. 00 25. 01 Tel eheal th 0 0 0 0 0 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 0 0 0 25. 02 27. 00 Nonal I owable GME costs 0 0 0 0 0 0 0 0 28. 00 27. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 28. 00 27. 00 28. 00 27. 00 28. 00 29. 00 2			Ü	_		-	_	
25. 01 Tel eheal th 0 0 0 0 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 0 0 26. 00 27. 00 Nonal I owable GME costs Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 28. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0		0		
26. 00		, ,	0	0		0	0	
27. 00 Nonal Lowable GME costs 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 28. 00 through 27) FACILITY OVERHEAD 29. 00 Facility Costs 0 564, 198 564, 198 -564, 198 0 29. 00 30. 00 Administrative Costs 369, 493 527, 477 896, 970 -43, 936 853, 034 30. 00	25. 02	Chronic Care Management	0	0		0	0	25. 02
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 28.00 through 27) FACILITY OVERHEAD 29.00 Facility Costs 0 564, 198 564, 198 -564, 198 0 29.00 30.00 Administrative Costs 369, 493 527, 477 896, 970 -43, 936 853, 034 30.00	26.00	All other nonreimbursable costs	0	0		0	0	26.00
through 27) FACILITY OVERHEAD 29. 00 Facility Costs 0 564, 198 564, 198 -564, 198 0 29. 00 30. 00 Administrative Costs 369, 493 527, 477 896, 970 -43, 936 853, 034 30. 00	27.00	Nonallowable GME costs						27.00
FACILITY OVERHEAD 29. 00 Facility Costs 0 564, 198 564, 198 -564, 198 0 29. 00 30. 00 Administrative Costs 369, 493 527, 477 896, 970 -43, 936 853, 034 30. 00	28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
29. 00 Facility Costs 0 564, 198 564, 198 -564, 198 0 29. 00 30. 00 Administrative Costs 369, 493 527, 477 896, 970 -43, 936 853, 034 30. 00]
30.00 Administrative Costs 369, 493 527, 477 896, 970 -43, 936 853, 034 30.00								
			-					
		4				· ·	•	
31.00 Total Facility Overhead (sum of lines 29 and 369, 493 1, 091, 675 1, 461, 168 -608, 134 853, 034 31.00	31.00		369, 493	1, 091, 675	1, 461, 16	-608, 134	853, 034	31.00

3, 268, 480

1, 525, 686

4, 794, 166

-608, 134

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

4, 186, 032

32.00

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 01/01/2022	Worksheet M-1
	Component CCN: 15-8552		Date/Time Prepared: 5/26/2023 7:17 pm
		DUIG 1.1	-

			Component	JUN. 15-0552	10	12/31/2022	5/26/2023 7:	
						RHC II	Cost	
		Adjustments	Net Expenses					
			for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	-218, 102	2, 215, 949					1.00
2.00	Physician Assistant	0	0					2.00
3.00	Nurse Practitioner	-4, 091	214, 630					3. 00
4.00	Visiting Nurse	0	0					4. 00
5.00	Other Nurse	0	252, 023					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)	-222, 193	2, 682, 602					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	428, 203					15. 00
16. 00	Transportation (Health Care Staff)	0	0					16. 00
17. 00	, .	0	0					17. 00
18. 00	,	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	428, 203					21.00
22. 00	Total Cost of Health Care Services (sum of	-222, 193	3, 110, 805					22. 00
	lines 10, 14, and 21)							_
22 00	COSTS OTHER THAN RHC/FQHC SERVICES	٥	0					22.00
23. 00	, ,	U	0					23. 00 24. 00
24. 00	Dental	0	0					25. 00
25. 00 25. 01	Optometry Telehealth	0	0					25. 00
25. 01	Chronic Care Management	0	0					25. 01
26. 00	All other nonreimbursable costs	0	0					26. 00
27.00	Nonallowable GME costs	U	U					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28.00
20.00	through 27)	U	U					20.00
	FACILITY OVERHEAD							-
29 00	Facility Costs	0	0					29. 00
30.00	Admi ni strati ve Costs	0	853, 034					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	853, 034 853, 034					31.00
51.50	30)	Ĭ	333, 034					31.00
32.00	1 /	-222, 193	3, 963, 839					32.00
	and 31)	,	., ,					
	•			•				•

Haal th	Financial Systems	WOODLAWN F	INT IDPON		Inlie	u of Form CMS-2	2552_10
	SIS OF HOSPITAL-BASED RHC/FOHC COSTS	WOODLAWN	Provi der C	CN: 15-1313	Peri od:	Worksheet M-1	
					From 01/01/2022 To 12/31/2022		pared:
					RHC III	Cost	7 рііі
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat		
		•		+ 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, 041, 563	4, 398	1, 045, 96		,	1.00
2.00	Physician Assistant	0	0	1	0	0	
3. 00	Nurse Practitioner	187, 807	0	187, 80		187, 807	3. 00
4. 00	Visiting Nurse	0	0	1	0	0	
5. 00	Other Nurse	80, 627	0	80, 62		80, 627	5.00
6. 00	Clinical Psychologist	0	0	1	0	0	
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	1 200 207	0	1	0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	1, 309, 997	4, 398	1, 314, 39		1, 314, 395	
11.00	Physician Services Under Agreement	0	0		0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13. 00 14. 00	Other Costs Under Agreement	0	0		0 0	0	
15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	111, 449		-	111, 449	
16. 00	Transportation (Health Care Staff)	0	111, 449	111,44	0 0	111, 449	
17. 00	Depreciation-Medical Equipment	0	0		0 0		1
18. 00	Professional Liability Insurance	0	0		0 0	0	18.00
19. 00	Other Health Care Costs	0	0		0 0		
20.00	Allowable GME Costs	J	O			ĺ	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	111, 449	111, 44	.9	111, 449	
22. 00	Total Cost of Health Care Services (sum of	1, 309, 997	115, 847			1, 425, 844	1
22.00	lines 10, 14, and 21)	1,007,777	1.07017	., .23, 3		1, 120, 011	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			•	,		
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	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	0)	0	0	28. 00
	through 27)					<u> </u>	
	FACILITY OVERHEAD			1			
29. 00	Facility Costs	0	180, 882				
30.00	Administrative Costs	158, 703	600, 194		· ·		30.00
31. 00	Total Facility Overhead (sum of lines 29 and 30)	158, 703	781, 076	939, 77	9 -1, 762	938, 017	31.00
	1.307			1	1	1	1

1, 468, 700

896, 923

2, 365, 623

-1, 762

2, 363, 861

32.00

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		Peri od: From 01/01/2022	Worksheet M-1
	Component CCN: 15-8550		
		RHC III	Cost

			Component CCN: 15-	8550 10	12/31/2022	Date/IIME Pre	
					RHC III	Cost	т ріп
	·	Adjustments	Net Expenses		MIO III	0031	
		Adj d3tillo11t3	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1. 00	Physi ci an	-79, 967	965, 994				1.00
2. 00	1 3	- / 7, 70 /	0				2.00
	Physician Assistant	4 004					1
3.00	Nurse Practitioner	-4, 804	183, 003				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	80, 627				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)	-84, 771	1, 229, 624				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	111, 449				15.00
16.00	Transportation (Health Care Staff)	0	o				16.00
17.00	Depreciation-Medical Equipment	0	o				17.00
18.00	Professional Liability Insurance	0	o				18.00
19.00	Other Health Care Costs	0	o				19.00
20.00	Allowable GME Costs	-					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	111, 449				21.00
22. 00	Total Cost of Health Care Services (sum of	-84, 771	1, 341, 073				22. 00
22.00	lines 10, 14, and 21)	0.,,,,	., 511, 575				1 22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		'				
23 00	Pharmacy	0	0				23.00
24. 00	Dental	0	ol				24.00
25. 00	Optometry	0	ol				25. 00
25. 01	Tel eheal th	0	0				25. 01
25. 02	4	0	0				25. 02
26. 00	All other nonreimbursable costs	0	o o				26.00
27. 00	Nonallowable GME costs	O	9				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
20.00	through 27)	U	٩				20.00
	FACILITY OVERHEAD						+
20 00	Facility Costs	0	140, 796				29.00
30.00	Administrative Costs	0	797, 221				30.00
		0					
31. 00	Total Facility Overhead (sum of lines 29 and	U	938, 017				31.00
32. 00	30)	-84, 771	2, 279, 090				32.00
3∠. ∪∪	Total facility costs (sum of lines 22, 28	-84, //1	2, 219, 090				32.00
	and 31)		I I				1

	Financial Systems	WOODLAWN F		on 15 1010		u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	UN: 15-1313	Peri od: From 01/01/2022	Worksheet M-1	
			Component	CCN: 15-8549	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
					RHC IV	Cost	
		Compensation	Other Costs		1 Reclassificat	Reclassified	
				+ 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	2.00	3.00	4.00	3.00	
1.00	Physi ci an	259, 850	2, 700	262, 55	0 0	262, 550	1.00
2.00	Physician Assistant	0	0		0 0	0	
3.00	Nurse Practitioner	23, 042	0	23, 04	2 0	23, 042	3.00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	20, 567	0	20, 56	0	20, 567	5. 00
6.00	Clinical Psychologist	0	0		0	0	1
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	20/ 45	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	303, 459	2, 700	306, 15		306, 159	
11.00	Physician Services Under Agreement	0	0		0 0	0	
12. 00 13. 00	Physician Supervision Under Agreement Other Costs Under Agreement	0	0		0 0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15. 00	Medical Supplies	0	47, 603	47, 60	0	47, 603	
16. 00	Transportation (Health Care Staff)	0	47,003 N	47,00	0 0	0	1
17. 00	Depreciation-Medical Equipment	0	0		0 0	Ö	
18. 00	Professional Liability Insurance	0	0		o o	Ō	1
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	47, 603	47, 60	0	47, 603	21.00
22. 00	Total Cost of Health Care Services (sum of	303, 459	50, 303	353, 76	0	353, 762	22. 00
	lines 10, 14, and 21)						
00.00	COSTS OTHER THAN RHC/FQHC SERVICES	0		T			00.00
23. 00	Pharmacy	0	0		0	1	
24. 00 25. 00	Dental Optometry	0	0		0 0	0	
25. 00	Tel eheal th	0	0		0 0	0	
25. 01	Chronic Care Management	0	0		0 0	0	1
26. 00	All other nonreimbursable costs	0	0		0 0	0	
27. 00	Nonallowable GME costs	O				Ĭ	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	
20.00	through 27)	Ŭ				[=0.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	11, 845	11, 84	5 40, 086	51, 931	29. 00
30.00	Administrative Costs	22, 301	55, 969	78, 27		87, 733	
31.00	Total Facility Overhead (sum of lines 29 and	22, 301	67, 814	90, 11	5 49, 549	139, 664	31.00
	(30)			I		I	1

325, 760

118, 117

443, 877

49, 549

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

32.00

493, 426

Health Financial Systems	WOODLAWN	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1313	Peri od: From 01/01/2022	Worksheet M-1	
		Component	CCN: 15-8549		Date/Time Pre 5/26/2023 7:1	
				RHC IV	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				
		(col. 5 +				

					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	262, 550	•			1.00
2.00	Physician Assistant	0	0	ı			2.00
3.00	Nurse Practitioner	0	23, 042	•			3. 00
4. 00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	20, 567				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	306, 159				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	47, 603				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	47, 603				21.00
22.00	Total Cost of Health Care Services (sum of	0	353, 762				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	,				29. 00
30.00	Administrative Costs	0	87, 733				30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	139, 664				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	493, 426				32.00
	and 31)						

	Financial Systems	WOODLAWN F		ON 45 4040		u of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CO	JN: 15-1313	Peri od: From 01/01/2022	Worksheet M-1	
			Component (CCN: 15-8547	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
					RHC V	Cost	
		Compensation	Other Costs		1 Reclassificat	Reclassified	
				+ 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	2.00	3.00	4.00	3.00	
1. 00	Physi ci an	406, 599	8, 511	415, 11	0 0	415, 110	1.00
2.00	Physician Assistant	0	0		0 0	0	
3.00	Nurse Practitioner	115, 058	0	115, 05	68	115, 058	3.00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	0	0		0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	1
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	500 4	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	521, 657	8, 511	530, 1 <i>6</i>		530, 168	
11.00	Physician Services Under Agreement	0	0		0	0	
12. 00 13. 00	Physician Supervision Under Agreement	0	0		0 0	0	
14. 00	Other Costs Under Agreement Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15. 00	Medical Supplies	0	20, 617	20, 61	0	20, 617	
16. 00	Transportation (Health Care Staff)	0	20, 017	20, 01	0 0	20,017	1
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	
18. 00	Professional Liability Insurance	Ö	0		0 0	o o	1
19. 00	Other Health Care Costs	Ö	0		0 0	Ō	
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20, 617	20, 61	7 0	20, 617	21.00
22.00	Total Cost of Health Care Services (sum of	521, 657	29, 128	550, 78	35 0	550, 785	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	_1	_				
23.00	Pharmacy	0	0		0	1	
24. 00	Dental	0	0		0 0	0	
25. 00 25. 01	Optometry Telehealth	0	0		0 0	0	
25. 01	Chronic Care Management	0	0		0 0	0	1
26. 00	All other nonreimbursable costs	0	0		0 0	0	
27. 00	Nonallowable GME costs	U	U		٥	U	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	
20.00	through 27)	Ö	J			Ĭ	20.00
	FACILITY OVERHEAD						1
29.00	Facility Costs	0	16, 775	16, 77	75 0	16, 775	29. 00
30.00	Admi ni strati ve Costs	69, 079	176, 138	245, 21			30.00
31.00	Total Facility Overhead (sum of lines 29 and	69, 079	192, 913	261, 99	-11, 868	250, 124	31.00
	(30)					l	1

590, 736

222, 041

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

32.00

800, 909

-11, 868

812, 777

Health Financial Systems WOODLAWN HOSPITAL			In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1313	Peri od: From 01/01/2022	Worksheet M-1	
		Component	CCN: 15-8547			
				RHC V	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				

FACILITY HEALTH CARE STAFF COSTS			Adjustments	Net Expenses	KIIC V COST	
Al Location Cool 5 Cool 6 Cool			Auj ustilierits			
FACILITY HEALTH CARE STAFF COSTS						
FACILITY HEALTH CARE STAFF COSTS						
FACILITY HEALTH CARE STAFF COSTS						
FACILITY HEALTH CARE STAFF COSTS			6.00			
1.00		EACLLLTY HEALTH CARE STAFE COSTS	0.00	7.00		
2. 00 Phýsician Assistant 0 0 0 3.00 Nurse Practitioner -8,606 106,452 3.00 4. 00 Visiting Nurse 0 0 0 4.00 5. 00 Other Nurse 0 0 0 5.00 6. 00 Clinical Psychologist 0 0 0 6.00 7. 00 Clinical Social Worker 0 0 0 7.00 8. 00 Laboratory Technician 0 0 0 8.00 9. 00 Other Facility Health Care Staff Costs 0 0 0 9.00 11. 00 Physician Services Under Agreement 0 0 0 11.00 <	1 00		_12 579	402 531		1 00
3.00 Nurse Practitioner -8,606 106,452 3.00 0 0 0 0 0 0 0 0 0			12, 377	· ·	•	
4.00 Visiting Nurse 0 0 0 0 0 0 0 0 0			-8 606		1	
5.00 Other Nurse 0 0 5.00 6.00 Clinical Psychologist 0 0 0 7.00 Clinical Social Worker 0 0 0 8.00 Laboratory Technician 0 0 0 9.00 Other Facility Health Care Staff Costs 0 0 0 10.00 Subtotal (sum of lines 1 through 9) -21,185 508,983 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 12.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 13.00 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 0 20,617 15.00 15.00 Transportation (Health Care Staff) 0 0 17.00 16.00 Transportation (Health Care Staff) 0			-0, 000 ∩	100, 432		
6.00 Clinical Psychologist 0 0 0 0 7.00 Clinical Social Worker 0 0 0 0 7.00 0 9.00 0 9.00 0 9.00 0 0 9.00 0 0 0 9.00 0 0 0 9.00 0 0 0 0 0 0 0 0 0			0			
7. 00 Clinical Social Worker 0 0 0 0 8. 00 Laboratory Technician 0 0 0 0 0 0 0 0 0			0			
8.00 Laboratory Technician 0 0 0 0 0 0 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) -21, 185 508, 983 11. 00 Physician Supervision Under Agreement 0 0 0 12. 00 13. 00 Other Costs Under Agreement 0 0 0 0 0 13. 00 Other Costs Under Agreement 0 0 0 0 0 0 0 0 0			0	0		
10.00 Subtotal (sum of lines 1 through 9) -21,185 508,983 10.00 11.00 Physician Services Under Agreement 0 0 12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 20,617 16.00 Transportation (Heal th Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Health Care Costs 0 0 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 20,617 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 10.00 Costs Of Health Care Services (sum of lines 10, 14, and 21) 23.00 Pharmacy 0 0 24.00 Optometry 0 0 25.00 Optometry 0 0 25.01 Tel eheal th 0 0 25.02 Chronic Care Management 0 0 26.00 All owable GME costs 0 27.00 Nonal I owable GME costs 0 27.00 Nonal I owable GME costs 0 27.00 Onal I owable GME costs 0 27.00 Onal I owable GME costs 0 27.00 Onal I owable GME costs 0 28.00 0 29.00 0 29.00 0 29.00 0 29.00 0 29.00 29.00 0 29.00 20.00 20			0	_	l .	
11.00			01 105	_	I .	
12.00		, , , , , , , , , , , , , , , , , , , ,	-21, 185		1	1
13.00			0		l .	
14.00 Subtotal (sum of lines 11 through 13) 0 0 0 0 15.00 Medical Supplies 0 20,617 15.00 16.00 Transportation (Heal th Care Staff) 0 0 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 0 18.00 19.00 Other Health Care Costs 0 0 0 0 19.00 19.00 20.00 Allowable GME Costs 20.00 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 23.00 24.00 Dental 0 0 0 24.00 25.00 25.01 Tel eheal th 0 0 0 0 25.00 25.01 Tel eheal th 0 0 0 0 25.00 25.01 26.00 All other nonreimbursable costs 0 0 0 26.00 27.00 Nonal Lowable GME costs 27.00 27.00 Nonal Lowable GME costs 27.00 27.00 Costs 27.00 C			0	_	l .	
15.00 Medical Supplies 0 20,617 15.00 16.00 Transportation (Heal th Care Staff) 0 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 18.00 19.00 Other Heal th Care Costs 0 0 0 19.00 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 20,617 21.00 22.00 Total Cost of Heal th Care Services (sum of -21,185 529,600 22.00 21.00 Deptal 0 0 0 0 23.00 24.00 Dental 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 24.00 25.01 Tel eheal th 25.01 25.00 26.00 All other nonreimbursable costs 0 0 0 0 25.00 27.00 Nonallowable GME costs 0 0 0 0 0 26.00 27.00 Nonallowable GME costs 0 0 0 0 0 27.00			0		l .	1
16.00 Transportation (Heal th Care Staff) 0 0 0 0 17.00 17.00 17.00 17.00 18.00 Professi onal Liability Insurance 0 0 0 18.00 19.00 20.00 All owable GME Costs 20.00			0	_	1	
17.00 Depreciation-Medical Equipment 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 19.00 Other Health Care Costs 0 0 0 20.00 Allowable GME Costs 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 20,617 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 0 0 0 23.00 Pharmacy 0 0 0 24.00 Dental 0 0 0 25.00 Optometry 0 0 0 25.01 Tel eheal th 5 0 0 25.01 Tel eheal th 5 0 0 25.01 Chronic Care Management 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonallowable GME costs 0 0 27.00 Total Cost of Health 0 0 25.01 Tel eheal costs 0 0 26.00 27.00 0 27.00 Nonallowable GME costs 0 0 27.00 18.00 0 20.00 0 0 20.00 0 20.617 0 20.00 0 20.617 0 21.00 0 22.00 0 23.00 0 24.00 0 25.01 0 26.00 0 27.00 0 27.00 0 28.00 0 29.00 0 20.00			0		l .	
18.00			0		•	
19.00 Other Health Care Costs 0 0 0 19.00 20.00 All owable GME Costs 20.00 Subtotal (sum of lines 15 through 20) 0 20,617 21.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00 Pharmacy 0 0 0 0 23.00 24.00 Dental 0 0 0 0 0 25.00 Optometry 0 0 0 0 0 25.00 Optometry 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	_	l .	
20.00			0	_	l .	1
21.00 Subtotal (sum of lines 15 through 20) 0 20,617		· ·	0	0		
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00 23.00 24.00 25.00 26.00 25.00 26.00 26.00 27.00 2						1
Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy			0			
COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 23.00 24.00 Dental 0 0 0 24.00 25.00 Optometry 0 0 0 25.00 25.01 Tel eheal th 0 0 0 0 25.01 25.02 Chronic Care Management 0 0 0 25.01 26.00 All other nonrel mbursable costs 0 0 0 0 26.00 27.00 Nonal Lowable GME costs 27.00 Cost 27.00 Cost 27.00 Cost 27.00 Cost 27.00 Cost 28.00 27.00 Cost 2	22. 00		-21, 185	529, 600		22. 00
23.00 Pharmacy 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 25.01 Tel eheal th 0 0 0 0 25.01 25.01 Chronic Care Management 0 0 0 25.01 26.00 All other nonrel mbursable costs 0 0 Nonal I owable GME costs 27.00						
24. 00 Dental 0 0 24. 00 25. 00 Optometry 0 0 25. 00 25. 01 Tel eheal th 0 0 0 25. 02 Chroni c Care Management 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 26. 00 27. 00 Nonal lowable GME costs 27. 00						
25. 00 Optometry 0 0 25. 01 Tel eheal th 0 0 25. 02 Chroni c Care Management 0 0 26. 00 All other nonreimbursable costs 0 0 27. 00 Nonal I owable GME costs 27. 00			0	_	•	
25. 01 Tel eheal th 0 0 25. 02 Chroni c Care Management 0 0 26. 00 All other nonreimbursable costs 0 0 27. 00 Nonal lowable GME costs 27. 00		1	0	0		
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		1'	0	0		
26. 00 All other nonreimbursable costs 0 0 26. 00 27. 00 Nonallowable GME costs 27. 00		4	0	0		
27.00 Nonallowable GME costs 27.00			0	0		
	26.00	All other nonreimbursable costs	0	0		
00 00 Tabab Nasarabab asalah 20 00 0 0 0 0 0	27.00	Nonallowable GME costs				
28.00 Total Nonrelmbursable Costs (sum of lines 23)	28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
through 27)]
FACILITY OVERHEAD						
29.00 Facility Costs 0 16,775 29.00	29. 00	Facility Costs	0			29. 00
30.00 Administrative Costs 0 233,349 30.00			0		•	
31.00 Total Facility Overhead (sum of lines 29 and 0 250,124 31.00	31.00		0	250, 124		31.00
30)		1 '				
32.00 Total facility costs (sum of lines 22, 28 -21,185 779,724 32.00	32.00		-21, 185	779, 724		32.00
and 31)		and 31)				

	Financial Systems	WOODLAWN H		ON 15 1010		u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	UN: 15-1313	Peri od: From 01/01/2022	Worksheet M-1	
			Component	CCN: 15-8548	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
					RHC VI	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	Physician	721, 170	0	721, 17	70 0	721, 170	1.00
2. 00	Physician Assistant	721, 170	0	/21, 17	0 0	/21, 1/0	2.00
3.00	Nurse Practitioner	203, 431	0	203, 43	٥	203, 431	
4. 00	Visiting Nurse	203, 431	0	203, 40	0	203, 431	4.00
5. 00	Other Nurse	39, 597	0	39, 59	9	39, 597	
6. 00	Clinical Psychologist	37, 377	0	37, 3	0	0	1
7. 00	Clinical Social Worker	0	0		0	Ö	1
8. 00	Laboratory Techni ci an	0	0			0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0			Ö	
10.00	Subtotal (sum of lines 1 through 9)	964, 198	0	964. 19	98	964, 198	
11. 00	Physician Services Under Agreement	0	646, 014			646, 014	
12. 00	Physician Supervision Under Agreement	O	0		0 0	0	12.00
13. 00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	o	646, 014	646, 01	14 0	646, 014	14.00
15.00	Medical Supplies	0	167, 706	167, 70	06	167, 706	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	167, 706			167, 706	
22. 00	Total Cost of Health Care Services (sum of	964, 198	813, 720	1, 777, 91	0 0	1, 777, 918	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	ما		ı			
23. 00	1	0	0		0	0	
24. 00	Dental	0	0		0 0	0	24.00
25. 00	Optometry	0	0		0 0	0	1
25. 01	Tel eheal th	0	0		0	0	
25. 02	3	U	0			0	
26. 00 27. 00	All other nonreimbursable costs Nonallowable GME costs	O	0			0	26. 00 27. 00
		0	0		0	_	
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	٩	0			0	28. 00
	FACILITY OVERHEAD						1
29 00	Facility Costs	0	36, 258	36, 25	58 0	36, 258	29. 00
	Administrative Costs	161 679				500, 018	1

161, 679

1, 125, 877

36, 258 357, 350

393, 608

1, 207, 328

36, 258 519, 029

555, 287

2, 333, 205

36, 258 500, 018

536, 276

2, 314, 194

-19, 011

-19, 011

-19, 011

30.00

31.00

32.00

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	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1313	Peri od: From 01/01/2022	Worksheet M-1
	Component CCN: 15-8548	To 12/31/2022	Date/Time Prepared: 5/26/2023 7:17 pm
		RHC VI	Cost

Adjustments				Component	CN. 13-0340	10	12/31/2022	5/26/2023 7: 1	
Adjustments							RHC VI		<u> </u>
FACILITY HEALTH CARE STAFF COSTS			Adjustments	Net Expenses					
COL			•	for					
FACILITY HEALTH CARE STAFF COSTS				Allocation					
FACILITY HEALTH CARE STAFF COSTS				(col. 5 +					
FACILITY HEALTH CARE STAFF COSTS				col. 6)					
1.00			6. 00	7. 00					
2.00		FACILITY HEALTH CARE STAFF COSTS							
3.00	1.00	Physi ci an	-15, 340	705, 830					1.00
4.00	2.00	Physician Assistant	0	0					2.00
5.00 Other Nurse 0 39,597 6.00 6.00 Clinical Sychologist 0 0 0 7.00 Laboratory Technician 0 0 0 8.00 Laboratory Technician 0 0 0 10.00 Subtotal (sum of lines 1 through 9) -31,408 932,790 10.00 11.00 Physician Services Under Agreement 0 646,014 11.00 12.00 Physician Services Under Agreement 0 0 0 13.00 14.00 Physician Services Under Agreement 0 0 0 13.00 14.00 Physician Services Under Agreement 0 0 0 13.00 15.00 Medical Supplies 0 167,706 15.00 15.00 15.00 Medical Supplies 0 167,706 15.00 16.00 17.00 Depreciation (Health Care Staff) 0 0 18.00 17.00 18.00 Oreressional Liability insurance 0 0 0	3.00	Nurse Practitioner	-16, 068	187, 363					3.00
6.00	4.00	Visiting Nurse	0	0					4.00
7.00	5.00	Other Nurse	0	39, 597					5.00
8.00 Cher Facility Heal th Care Staff Costs 0 0 0 0 0 0 0 0 0	6.00	Clinical Psychologist	0	0					6.00
9.00 Other Facility Heal th Care Staff Costs 0 0 10.00 Subtotal (sum of lines 1 through 9) -31,408 932,790 10.00 11.00 Physician Services Under Agreement 0 646,014 11.00 12.00 Physician Supervision Under Agreement 0 0 12.00 13.00 Other Costs Under Agreement 0 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 646,014 14.00 15.00 Medical Supplies 0 167,706 15.00 17.00 Medical Supplies 0 0 16.00 17.00 Depreciation-Medical Equipment 0 0 0 17.00 18.00 Other Health Care Costs 0 0 0 17.00 19.00 Other Health Care Costs 0 0 0 19.00 20.00 Allowable GME Costs 0 0 0 19.00 20.00 Allowable GME Costs 0 0 19.00 22.00 Total Cost of Health Care Services (sum of 1.7,406,510 11.00 22.00 23.00 Parmacy 0 0 0 24.00 25.01 Total Cost of Health Care Services (sum of 1.00 0	7.00	Clinical Social Worker	0	0					7.00
10. 00 Subtotal (sum of lines 1 through 9) -31,408 932,790 10. 00	8.00	Laboratory Techni ci an	0	0					8.00
11. 00 Physician Services Under Agreement 0 646,014 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 00 17. 00 16.	9.00	Other Facility Health Care Staff Costs	0	0					9. 00
12.00	10.00	Subtotal (sum of lines 1 through 9)	-31, 408	932, 790					10.00
13. 00 Other Costs Under Agreement 0 0 0 0 14. 00 14. 00 Subtotal (sum of lines 11 through 13) 0 646, 014 14. 00 15. 00 Medical Supplies 0 167, 706 15. 00 16. 00 17 ansportation (Heal th Care Staff) 0 0 0 0 17. 00 0 17. 00 0 0 18. 00 19. 00 0 0 0 0 18. 00 19. 00 0 0 0 0 0 0 18. 00 19. 00 0 0 0 0 0 0 0 0 0	11.00	Physician Services Under Agreement	0	646, 014					11.00
14. 00 Subtotal (sum of lines 11 through 13) 0 646,014 15. 00 Medical Supplies 0 167,706 16. 00 Transportation (Heal th Care Staff) 0 0 17. 00 Depreciation-Medical Equipment 0 0 18. 00 Professional Liability Insurance 0 0 19. 00 Other Heal th Care Costs 0 0 20. 01 Allowable GME Costs 0 0 21. 02 Subtotal (sum of lines 15 through 20) 0 167,706 21. 00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22.00 22. 00 Destruction of lines 10, 14, and 21 0 0 23. 00 Pharmacy 0 0 24.00 24. 00 Deptometry 0 0 25.01 25. 01 Teleheal 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 0 0 27.00 28. 00 Total Nonreimbursable costs (sum of lines 23 0 0 0 70. 00 Total Nonreimbursable costs 0	12.00	Physician Supervision Under Agreement	0	0					12.00
15.00	13.00	Other Costs Under Agreement	0	0					13.00
16. 00	14.00	Subtotal (sum of lines 11 through 13)	0	646, 014					14.00
17. 00	15.00	Medical Supplies	0	167, 706					15.00
18. 00 Professional Liability Insurance 0 0 0 0 19. 00 0 19. 00 0 19. 00 0 0 0 0 0 0 0 0 0	16.00	Transportation (Health Care Staff)	0	0					16.00
19.00 Other Health Care Costs 0 0 0 0 0 0 0 0 0	17.00	Depreciation-Medical Equipment	0	0					17.00
20.00 21.00 Subtotal (sum of lines 15 through 20) 0 167,706 21.00 22.00	18.00	Professional Liability Insurance	0	0					18.00
21.00 Subtotal (sum of lines 15 through 20) 0 167,706 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22.00 Total Facility Costs (sum of lines 22, 28 -31,408 1,746,510 21.00 22.00	19.00	Other Health Care Costs	0	0					19.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00	20.00	Allowable GME Costs							20.00
I ines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES	21.00	Subtotal (sum of lines 15 through 20)	0	167, 706					21.00
COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 0 24.00 Dental 0 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 Nonal lowable GME costs 0 0 0 0 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0	22.00	Total Cost of Health Care Services (sum of	-31, 408	1, 746, 510					22.00
23.00 Pharmacy									
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 Chronic Care Management 0 0 0 0 26.00 All other nonreimbursable costs 0 0 0 27.00 Nonal lowable GME costs 0 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		COSTS OTHER THAN RHC/FQHC SERVICES							
25. 00	23.00	Pharmacy	0	0					23.00
25. 01 Tell eheal th	24.00	Dental	0	0					24.00
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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25.00	Optometry	0	0					25.00
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 0 0 0 0 0	25. 01	Tel eheal th	0	0					
27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 28. 00	25. 02		0	0					25. 02
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00	All other nonreimbursable costs	0	0					26.00
through 27) FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -31, 408 2, 282, 786) 29.00 36, 258 29.00 30.00 31.00 32.00	27.00	Nonallowable GME costs							27. 00
FACILITY OVERHEAD 29. 00 Facility Costs	28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
29.00 Facility Costs									
30.00 Administrative Costs 0 500,018 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -31,408 2,282,786 32.00									
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 -31,408 2,282,786) 31.00 536,276 31.00			0						
30) 32.00 Total facility costs (sum of lines 22, 28 -31,408 2,282,786 32.00		4	0						
32.00 Total facility costs (sum of lines 22, 28 -31, 408 2, 282, 786 32.00	31. 00		0	536, 276					31.00
and 31)	32. 00	,	-31, 408	2, 282, 786					32.00
		and 31)	ļ						1

ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	u of Form CMS-2 Worksheet M-2		
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1		
					RHC I	Cost		
		Number of FTE	Total Visits			Greater of		
		Personnel		Standard (1)	Visits (col.	col. 2 or		
					1 x col. 3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00		
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
. 00	Physi ci an	0. 44			1 0		1.00	
. 00	Physician Assistant	0.00			1 0		2.0	
. 00	Nurse Practitioner	0. 45			1 0		3.00	
. 00	Subtotal (sum of lines 1 through 3)	0. 89			0	2, 135	4.0	
. 00	Visiting Nurse	0.00				0	5.0	
. 00	Clinical Psychologist	0.00				0	6.0	
. 00	Clinical Social Worker	0.00	l .			0	7.0	
. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.0	
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 0	
	onl y)							
3. 00	Total FTEs and Visits (sum of lines 4	0. 89	2, 135			2, 135	8. 0	
	through 7)							
. 00	Physician Services Under Agreements		3, 909			3, 909	9.0	
						1.00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOCDITAL DACE	ED DUC/FOUR CEI	2/// 050		1. 00		
0. 00	Total costs of health care services (from Wk			RVICES		1, 052, 152	10.0	
1. 00	Total nonreimbursable costs (from Wkst. M-1,					1,032,132	11.0	
2. 00	Cost of all services (excluding overhead) (s	·	,			1, 052, 152		
3.00	Ratio of hospital-based RHC/FQHC services (I					1, 052, 152		
4.00				ino 21)		232, 247		
5. 00								
6. 00	3 (*** ***)							
7. 00	Allowable GME overhead (see instructions)					864, 489 0	16. 0 17. 0	
8.00	` ` '					864, 489		
	Litter the amount from time to	·						
19. 00	Overhead applicable to hospital-based RHC/FC	NHC carvicas (Li	ina 13 v lina '	19)		864, 489	19.0	

	Financial Systems	WOODLAWN I				u of Form CMS-2	2552-10
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1					
1.00	Physi ci an	4. 05			1 4		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	1. 48			1		3.00
4.00	Subtotal (sum of lines 1 through 3)	5. 53			5	18, 819	
5.00	Visiting Nurse	0.00				0	
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	5. 53	18, 819			18, 819	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					3, 110, 805	
11. 00		·	,			0	
12. 00	Cost of all services (excluding overhead) (s					3, 110, 805	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr		853, 034				
15. 00	Parent provider overhead allocated to facili		1, 832, 486				
16. 00	Total overhead (sum of lines 14 and 15)		2, 685, 520				
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00						2, 685, 520	
	Overhead applicable to hospital-based RHC/FQ					2, 685, 520	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 10	0 and 19)		5, 796, 325	20.00

	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 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
					RHC III	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1. 95		1	1 2		1.00
2.00	Physici an Assistant	0.00		1	1 0		2.00
3.00	Nurse Practitioner	0. 36			1 0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 31			2	12, 890	
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		1		0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00		1		0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0	1		0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	2. 31	12, 890	1		12, 890	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9.00
						4 00	
	DETERMINATION OF ALLOWARIE COOT ARRIVAGABLE T	0 1100D1 T11 D10	ED DUG (EQUID OF	DI // 050		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		4 044 070	10.00
	Total costs of health care services (from Wk					1, 341, 073	
		·	,			0	
12. 00	Cost of all services (excluding overhead) (s					1, 341, 073	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		938, 017	
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			664, 046	
16. 00	Total overhead (sum of lines 14 and 15)					1, 602, 063	
17. 00	Allowable GME overhead (see instructions)					0	
						1, 602, 063	
	Overhead applicable to hospital-based RHC/FQ					1, 602, 063	
20.00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (sum of lines 1	u and 19)		2, 943, 136	20.00

	Financial Systems	WOODLAWN I	HOSPI TAL			u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 15-8549	From 01/01/2022 To 12/31/2022	Date/Time Pre	narod:
			Component	CCN. 13-0349	10 12/31/2022	5/26/2023 7: 1	
					RHC IV	Cost	
	·	Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions	1		T	-1 -1		
1.00	Physi ci an	0. 43		1	1 0		1.00
2.00	Physician Assistant	0.00		1	1 0		2.00
3.00	Nurse Practitioner	0. 36			1 0	0.500	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.79			0	3, 528	
5.00	Visiting Nurse	0. 00 0. 00				0	
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0.00				0	6. 00 7. 00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00	l .			0	7.01
7.02	only)	0.00	0			U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	0. 79	3, 528			3, 528	8.00
0.00	through 7)	0.77	0,020			0,020	0.00
9.00	Physician Services Under Agreements		0			0	9.00
	<u> </u>		-				
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			353, 762	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)			353, 762	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		139, 664	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			145, 474	
16.00	Total overhead (sum of lines 14 and 15)					285, 138	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					285, 138	
	Overhead applicable to hospital-based RHC/FC					285, 138	
20.00	Total allowable cost of hospital-based RHC/F	UHC services (sum of lines 1	u and 19)	ļ	638, 900	20.00

	Financial Systems	WOODLAWN I				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 15-8547	From 01/01/2022 To 12/31/2022	Date/Time Pre	pared.
			oomportorre	00111 10 0017		5/26/2023 7:1	
					RHC V	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
		1.00	0.00		1 x col . 3)	col . 4	
	WICHTO AND DEODUCTIVIETY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	0.04	2 000		1 1		1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	0. 86 0. 00		1	1		1.00 2.00
2. 00 3. 00	Nurse Practitioner	1. 01			1 0		3.00
4. 00	Subtotal (sum of lines 1 through 3)	1. 01			1 2	5, 004	4.00
5. 00	Visiting Nurse	0.00			2	0,004	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	Di abetes Self Management Training (FQHC	0.00				0	7. 02
	only)						
8. 00	Total FTEs and Visits (sum of lines 4	1. 87	5, 004			5, 004	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0)		0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					529, 600	
11.00	,					0	11.00
12.00	Cost of all services (excluding overhead) (s					529, 600	
13.00	Ratio of hospital -based RHC/FQHC services (I			: 21)		1.000000	
14. 00 15. 00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		250, 124 368, 945	
16. 00	Parent provider overhead allocated to facili Total overhead (sum of lines 14 and 15)	ty (see mstru	Ctrons)			619, 069	
17. 00	Allowable GME overhead (see instructions)					019,009	17.00
	Enter the amount from line 16					619, 069	
	Overhead applicable to hospital-based RHC/FC	HC services (ine 13 x line	18)		619, 069	
	Total allowable cost of hospital-based RHC/F					1, 148, 669	
_5. 55	1. Stat. a Shabi e cost of hospital based Mio/i	2 301 VI 003 (Ja 01 111103 1	5 and 17)		1, 110,007	, 20.

	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: 15-8548	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
					RHC VI	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	0. 56		•	1 1		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	1. 60			1 2		3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 16			3	10, 816	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	2. 16	10, 816			10, 816	8. 00
	through 7)						
9. 00	Physician Services Under Agreements		6, 864			6, 864	9.00
	DETERMINATION OF ALLOWARIE COOT ARRIVABLE T	0 1100D1 T41 D40	ED DUO (EQUA OF	21/1 050		1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES		4 74/ 540	10.00
	Total costs of health care services (from Wk					1, 746, 510	
	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s					1, 746, 510	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		536, 276	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			916, 460	
16.00	Total overhead (sum of lines 14 and 15)					1, 452, 736	
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16			4.0)		1, 452, 736	
	Overhead applicable to hospital-based RHC/FQ					1, 452, 736	
20.00	Total allowable cost of hospital-based RHC/F	UHC services (sum of lines 1	u and 19)	l	3, 199, 246	20.00

	Financial Systems WOODLAWN HOS		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 01/01/2022	Worksheet M-3	
SERVI (JE S	Component CCN: 15-8551	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		Title XVIII	RHC I	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)		1, 916, 641	1.00
2.00	Cost of injections/infusions and their administration (from W			15, 381	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)		1, 901, 260	1
4. 00 5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		2, 135 3, 909	
6. 00	Total adjusted visits (line 4 plus line 5)	1111c 7)		6, 044	1
7. 00	Adjusted cost per visit (line 3 divided by line 6)			314. 57	
			Cal cul ati on	of Limit (1)	
				Rate Period 1	
			N/A	(01/01/2022	
				through 12/31/2022)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	269. 69	8.00
9. 00	Rate for Program covered visits (see instructions)		0.00	269. 69	9.00
10.00	CALCULATION OF SETTLEMENT			1 501	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	1, 581 426, 380	1
12. 00	Program covered visits for mental health services (from contr		o o	420, 300	1
13.00	Program covered cost from mental health services (line 9 x li	•	0	0	1
14.00	Limit adjustment for mental health services (see instructions	•	0	0	
15.00	Graduate Medical Education Pass Through Cost (see instruction			407, 200	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	426, 380 263, 217	1
16. 02	Total program preventive charges (see instructions) (from prov			3, 369	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		5, 457	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		309, 582	16. 04
1/ 05	(Titles V and XIX see instructions.)			215 020	1/ 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	315, 039 0	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		33, 946	1
	records)	(22, 112	
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		45, 133	19.00
20. 00	Net Medicare cost excluding vaccines (see instructions)			315, 039	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		5, 472	1
22. 00	, , ,			320, 511	1
23. 00 23. 01	Allowable bad debts (see instructions)			227	1
24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		148 0	1
25. 00	,	r de trons)		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)			320, 659	1
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			4, 041 0	1
27. 00	Interim payments			305, 734	
	Tentative settlement (for contractor use only)			0	1
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			10, 884	29.00
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II	,	0	30.00

	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 01/01/2022	Worksheet M-3	
SERVI (JE S	Component CCN: 15-8552	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		Title XVIII	RHC II	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)		5, 796, 325	1.00
2.00	Cost of injections/infusions and their administration (from W			230, 346	
3.00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	inus line 2)		5, 565, 979	
4. 00 5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		18, 819 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	11116 7)		18, 819	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			295. 76	
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
				through	
			1.00	12/31/2022) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	403. 23	8.00
9. 00	Rate for Program covered visits (see instructions)		0.00	295. 76	9.00
	CALCULATION OF SETTLEMENT				
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	514 152, 021	
12. 00	Program covered visits for mental health services (from contr	,	0	152, 021	
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	14.00
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	152, 021	
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov			83, 124 6, 305	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		11, 531	
16.04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		103, 680	16. 04
	(Titles V and XIX see instructions.)				
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	115, 211 0	16. 05 17. 00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		10, 890	
	records)	(asta.		.0,070	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		13, 186	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			115, 211	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		3, 006	
22. 00	, , ,			118, 217	
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00	,	r de trons)		0	
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)			118, 217	
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			1, 490 0	1
27. 00	Interim payments			149, 984	
	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.			-33, 257	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II	, [0	30.00

Heal th	Financial Systems WOODLAWN HOS	PI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1313	Peri od:	Worksheet M-3	
SERVIC	ES	Component CCN: 15-8550	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		2, 943, 136	1.00
2.00	Cost of injections/infusions and their administration (from W			133, 099	
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		2, 810, 037	3.00
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		12, 890 0	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	1111e 9)		12, 890	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			218. 00	
			Cal cul ati on	of Limit (1)	
				Rate Period 1	
			N/A	(01/01/2022	
				through 12/31/2022)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	242. 36	8.00
9. 00	Rate for Program covered visits (see instructions)		0.00	218. 00	9. 00
10.00	CALCULATION OF SETTLEMENT			0.474	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	•	0	2, 174 473, 932	
12. 00	Program covered visits for mental health services (from contr	•	o	473, 732	1
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	•		470.000	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	and 3) *	0	473, 932 336, 122	1
16. 01	Total program preventive charges (see instructions)(from prov			4, 783	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		6, 744	1
16.04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		335, 713	16. 04
4, 05	(Titles V and XIX see instructions.)			0.40 457	4, 05
16. 05 17. 00	Total program cost (see instructions)		0	342, 457 0	16. 05 17. 00
18.00	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		47, 547	
.0.00	records)	(1. o.m ooner doto.		17,017	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		56, 735	19. 00
20.00	Net Medicare cost excluding vaccines (see instructions)			342, 457	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		47, 752	
22. 00	Total reimbursable Program cost (line 20 plus line 21)			390, 209	1
23. 00	Allowable bad debts (see instructions)			288	
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		187 0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26.00	Net reimbursable amount (see instructions)			390, 396	1
26. 01	Sequestration adjustment (see instructions)			4, 919	1
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 366, 044	
28. 00	1			300, 044	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		19, 433	
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 HOS			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1313	Peri od: From 01/01/2022	Worksheet M-3	
SERVI (JE 5	Component CCN: 15-8549	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		Title XVIII	RHC I V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			638, 900	
2. 00 3. 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m	· · · · · · · · · · · · · · · · · · ·		11, 794 627, 106	2. 00 3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	illus IIIle 2)		3, 528	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			3, 528	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			177. 75	7.00
			Cal cul ati on	of Limit (1)	
				Rate Period 1	
			N/A	(01/01/2022 through	
				12/31/2022)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0. 00	242. 50	
9. 00	Rate for Program covered visits (see instructions)		0.00	177. 75	9.00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	O	651	10.00
11. 00	Program cost excluding costs for mental health services (line		o o	115, 715	
12.00	Program covered visits for mental health services (from contr	,	o	0	1
13.00	Program covered cost from mental health services (line 9 x li	•	0	0	
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	115, 715	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re	•		100, 797	
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 (Titles V and XIX see instructions.)	3 and 18) times .80)		77, 743	16. 04
16. 05	Total program cost (see instructions)		o	77, 743	16. 05
17.00	Pri mary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		18, 536	18.00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		16, 452	19.00
	records)				
20.00	Net Medicare cost excluding vaccines (see instructions)	M 4 line 14)		77, 743	
21. 00 22. 00	Program cost of vaccines and their administration (from Wkst. Total reimbursable Program cost (line 20 plus line 21)	M-4, TTHE 16)		4, 699 82, 442	
23. 00	Allowable bad debts (see instructions)			02, 112	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00 25. 50		6)		0	
25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	5)		0	1
26. 00	Net reimbursable amount (see instructions)			82, 442	1
26. 01	Sequestration adjustment (see instructions)			1, 039	26. 01
26. 02	, , , , , , , , , , , , , , , , , , , ,			0	
27.00	Interim payments Tentative settlement (for contractor use only)			103, 193	
29. 00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 26.	02. 27. and 28)		0 -21, 790	28. 00 29. 00
30.00				0	1
	chapter I, §115.2				1

Health Fin	nancial Systems WOODLAWN HOS	PITAL	In Lie	u of Form CMS-2	2552-10
	ON OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1313	Peri od:	Worksheet M-3	
SERVI CES		Component CCN: 15-8547	From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
		Compensive Cont. 10 CC 17	10 12/01/2022	5/26/2023 7:1	
		Title XVIII	RHC V	Cost	
				1 00	
DETI	FOMENATION OF DATE FOR HOSPITAL DASED DUC/FOHC SERVICES			1. 00	
	ERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES tal Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M_2 line 20)		1, 148, 669	1.00
1	st of injections/infusions and their administration (from W			33, 681	2.00
1	tal allowable cost excluding injections/infusions (line 1 m			1, 114, 988	
	tal Visits (from Wkst. M-2, column 5, line 8)			5, 004	4.00
5. 00 Phy	sicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
	tal adjusted visits (line 4 plus line 5)			5, 004	6.00
7. 00 Adj	usted cost per visit (line 3 divided by line 6)			222. 82	7.00
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
				through	
				12/31/2022)	
0.00 D.	s visit normant limit (from CNC Dub. 400 04 shorts 0 CCC		1.00	2. 00	0.00
1	r visit payment limit (from CMS Pub. 100–04, chapter 9, §20 te for Program covered visits (see instructions)	. 6 or your contractor)	0. 00 0. 00	293. 71 222. 82	8. 00 9. 00
	CULATION OF SETTLEMENT		0.00	222.02	7.00
	ogram covered visits excluding mental health services (from	contractor records)	0	771	10.00
	ogram cost excluding costs for mental health services (line		0	171, 794	
12.00 Pro	ogram covered visits for mental health services (from contr	actor records)	0	0	12.00
1	ogram covered cost from mental health services (line 9 x li	•	0	0	13.00
	nit adjustment for mental health services (see instructions	•	0	0	14.00
	aduate Medical Education Pass Through Cost (see instruction	•		474 704	15.00
	tal Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	171, 794	
1	tal program charges (see instructions)(from contractor's re tal program preventive charges (see instructions)(from prov			120, 849 11, 141	
1	tal program preventive charges (see Thatractions)(Tram provental program preventive costs ((line 16.02/line 16.01) times	•		15, 838	
1	tal Program non-preventive costs ((line 16 minus lines 16.0			110, 139	1
	tles V and XIX see instructions.)	,			
16. 05 Tot	tal program cost (see instructions)		0	125, 977	16. 05
	mary payer amounts			0	17.00
	ss: Beneficiary deductible for RHC only (see instructions)	(from contractor		18, 282	18.00
1	cords) neficiary coinsurance for RHC/FQHC services (see instructio	uns) (from contractor		18, 285	19.00
	cords)	ilis) (ITOIII COITTI actor		10, 200	19.00
1	t Medicare cost excluding vaccines (see instructions)			125, 977	20.00
21.00 Pro	ogram cost of vaccines and their administration (from Wkst.	M-4, line 16)		11, 350	21.00
22. 00 Tot	tal reimbursable Program cost (line 20 plus line 21)			137, 327	22.00
1	owable bad debts (see instructions)			0	
-	usted reimbursable bad debts (see instructions)			0	23.01
	owable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.00
	HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) oneer ACO demonstration payment adjustment (see instruction	ie)		0	25. 00 25. 50
	nonstration payment adjustment amount before sequestration			0	
	t reimbursable amount (see instructions)			137, 327	
	questration adjustment (see instructions)			1, 730	1
	monstration payment adjustment amount after sequestration			0	
1	terim payments			161, 944	
1	ntative settlement (for contractor use only)			0	28.00
1	ance due component/program (line 26 minus lines 26.01, 26.	•		-26, 347	
30.00 Pro	otested amounts (nonallowable cost report items) in accorda apter I, §115.2	nce with CMS Pub. 15-II	,	0	30.00

	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 01/01/2022	Worksheet M-3	
SERVIC	JE S	Component CCN: 15-8548	To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		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 (fro	m Wkst. M-2, line 20)		3, 199, 246	1.00
2.00	Cost of injections/infusions and their administration (from W			125, 350	
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		3, 073, 896	
4. 00 5. 00	Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	lino ()		10, 816 6, 864	4. 00 5. 00
6. 00	Total adjusted visits (line 4 plus line 5)	111le <i>4)</i>		17, 680	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			173. 86	
			Cal cul ati on	of Limit (1)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
				through	
			1.00	12/31/2022) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	212. 16	8.00
9.00	Rate for Program covered visits (see instructions)	,	0. 00	173. 86	
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	•	0	2, 318	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr		0	403, 007 0	1
13. 00	Program covered cost from mental health services (line 9 x li	,	l ől	0	
14.00	Limit adjustment for mental health services (see instructions	•	o	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	403, 007	1
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov			374, 804 53, 892	
16. 02	Total program preventive charges (see instructions) (from prov Total program preventive costs ((line 16.02/line 16.01) times	•		57, 947	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	•		238, 896	1
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	296, 843	
17. 00 18. 00	Primary payer amounts	(from contractor		0 46, 440	17. 00 18. 00
16.00	Less: Beneficiary deductible for RHC only (see instructions) records)	(110m contractor		40, 440	10.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		54, 895	19.00
20.00	records) Net Medicare cost excluding vaccines (see instructions)			296, 843	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		35, 775	1
22.00	,	,		332, 618	
23. 00	Allowable bad debts (see instructions)			0	23. 00
23. 01	` ` '			0	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	Demonstration payment adjustment amount before sequestration	•		0	
26. 00	Net reimbursable amount (see instructions)			332, 618	1
26. 01	Sequestration adjustment (see instructions)			4, 191	1
26. 02 27. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 349, 514	
	Tentative settlement (for contractor use only)			349, 514	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		-21, 087	
				0	1
30.00	chapter I, §115.2				

	Financial Systems WOODLAWN ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	HOSPITAL Provider CO	CN: 15-1313	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component (CCN: 15-8551	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
			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 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	448, 803 0. 000654	448, 80 0. 00834		448, 803 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	294	3, 74		0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	856	3, 54		0	4.00
. 00	Direct cost of injections/infusions (line 3 plus line 4)	1, 150	7, 29		0	5.0
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 052, 152	1, 052, 1			6.0
. 00 . 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct	864, 489 0. 001093	864, 48 0. 00693			7. 0 8. 0
	cost (line 5 divided by line 6)	0.45	F 0/			
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	945 2, 095	5, 99 13, 28		0	9. 0 10. 0
1. 00	Total number of injections/infusions (from your records)	8	1(02	o	11.0
2. 00	Cost per injection/infusion (line 10/line 11)	261. 88	130. 2		0.00	
3. 00	Number of injection/infusion administered to Program beneficiaries	1		10 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	262	5, 2	0	0	14.0
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	col umns 1,		15, 381	15. 0
4 00	Total Program cost of injections/infusions and their admin		c (sum of		5, 472	16 0

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co	CN: 15-1313	Peri od:	Worksheet M-4	
		Component (CCN: 15-8552	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/26/2023 7:1	
		Title	XVIII	RHC II	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	
. 00 ?. 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	2, 682, 602 0. 006656			2, 682, 602 0. 000000	1. 0 2. 0
. 00	Injection/infusion health care staff cost (line 1 x line 2)	17, 855	29, 7	45 0	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	49, 304	26, 7	19 0	0	4.0
. 00	Direct cost of injections/infusions (line 3 plus line 4)	67, 159	56, 40	64 0	0	5.0
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3, 110, 805	3, 110, 80	3, 110, 805	3, 110, 805	6.0
. 00	Total overhead (from Wkst. M-2, line 19)	2, 685, 520				7.0
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 021589		0. 000000	0. 000000	8. (
. 00	Overhead cost - injection/infusion (line 7 x line 8)	57, 978			0	9. (
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	125, 137	•		0	10.0
1. 00	Total number of injections/infusions (from your records)	461		68 0	0	11. 0
2. 00	Cost per injection/infusion (line 10/line 11)	271. 45			0. 00	
3. 00	Number of injection/infusion administered to Program beneficiaries	3		16 0	0	13. (
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees		0.4	0	0	13. (
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	814	2, 1	92 0	0	14.0
					COST OF INJECTIONS /	
					INFUSIONS AND ADMINISTRATIO	
					N	
- 00	Total and of the state of the s		6	1. 00	2. 00	45.
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			230, 346	
5. 00	Total Program cost of injections/infusions and their admin		s (sum of 3, line 21)		3, 006	16.

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	CN: 15-1313	Peri od:	Worksheet M-4	
		Component C	CCN: 15-8550	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		Title	XVIII	RHC III	Cost	, p
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
. 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	1, 229, 624 0. 005215	1, 229, 6: 0. 0170:		1, 229, 624 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	6, 412	20, 9	36 0	0	3.00
. 00	Injections/infusions and related medical supplies costs (from your records)	16, 149	17, 1!	51 0	0	4.00
. 00	Direct cost of injections/infusions (line 3 plus line 4)	22, 561	38, 0		0	5.00
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 341, 073	1, 341, 0	73 1, 341, 073		
. 00	Total overhead (from Wkst. M-2, line 19)	1, 602, 063	1, 602, 0			
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 016823	0. 02840		0. 000000	
. 00	Overhead cost - injection/infusion (line 7 x line 8)	26, 952	45, 49		0	
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	49, 513	83, 58		0	
1.00	Total number of injections/infusions (from your records)	151		93 0	0	
2. 00	Cost per injection/infusion (line 10/line 11)	327. 90	169. !			12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	66	1!	54 0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	24 (44	07.4	0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	21, 641	26, 1	0	0	14.0
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				1.00	N	
F 00	Tatal and as initiation /infortant and their activities of		21 1	1. 00	2. 00	15.0
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			133, 099	
6.00	Total Program cost of injections/infusions and their admin	istration costs	s (sum of		47, 752	16. C

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	N: 15-1313	Peri od:	Worksheet M-4	
		Component C	CCN: 15-8549	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/26/2023 7:1	
		Title	XVIII	RHC IV	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	
. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health	306, 159 0. 000763	306, 15 0. 00810		306, 159 0. 000000	
3. 00	care staff time Injection/infusion health care staff cost (line 1 x line 2)	234	2, 48	0	0	3.00
. 00	Injections/infusions and related medical supplies costs (from your records)	856	2, 95	57 0	0	4.00
. 00	Direct cost of injections/infusions (line 3 plus line 4)	1, 090	5, 44	10 0	0	5.00
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	353, 762	353, 76	·	353, 762	
. 00	Total overhead (from Wkst. M-2, line 19)	285, 138	285, 13		285, 138	
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 003081	0. 01537		0. 000000	
. 00	Overhead cost - injection/infusion (line 7 x line 8)	879	4, 38		0	
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	1, 969	9, 82		0	
1.00	Total number of injections/infusions (from your records)	8		35 0	0	
2. 00	Cost per injection/infusion (line 10/line 11)	246. 13	115. 5			12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	5	3	0	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	4 004		0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1, 231	3, 46	58 0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
				4.00	N	
E 00	Total cost of injections/infusions and their administration	n costs (sum of	F columns 1	1. 00	2. 00 11, 794	15. 0
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			·	
6 00	Total Program cost of injections/infusions and their admin	istration costs	(SUM OF		4, 699	16.0

	Financial Systems WOODLAWN I ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CO	CN: 15-1313	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component (CCN: 15-8547	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
	Title 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	508, 983 0. 001077	508, 98 0. 00934		508, 983 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	548			0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	2, 674			0	
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	3, 222	12, 30		0	
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	529, 600		·	529, 600	
7. 00	Total overhead (from Wkst. M-2, line 19)	619, 069			619, 069	
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 006084	0. 02323		0. 000000	
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	3, 766	14, 38		0	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6, 988			0	
11.00	Total number of injections/infusions (from your records)	25	21		0	
12.00	Cost per injection/infusion (line 10/line 11)	279. 52	123. (12.00 13.00
13.00	Number of injection/infusion administered to Program beneficiaries	12		55 0	0	
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	3, 354	7, 99	96 0	0	14.00
	and 13.01, as applicable)				2027 25	
					COST OF	
					INFUSIONS AND	
					ADMI NI STRATI O	
					N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		33, 681	15.00
16. 00			s (sum of		11, 350	16.00
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	nt to Wkst. M-3	3, line 21)			

COMPUT	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der CC	N: 15-1313	Peri od:	Worksheet M-4	
		Component C	CCN: 15-8548	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 7:1	
		Title	XVIII	RHC VI	Cost	, biii
		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	932, 790 0. 006751	932, 7 ^o 0. 0209	·	932, 790 0. 000000	1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	6, 297	19, 5	61 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	21, 176	21, 39	96 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	27, 473	40, 9	57 0	0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 746, 510	1, 746, 5			
7. 00	Total overhead (from Wkst. M-2, line 19)	1, 452, 736	1, 452, 7			7.0
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 015730	0. 0234!		0. 000000	
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	22, 852	34, 0		0	9.00
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	50, 325	75, 0		0	
11.00	Total number of injections/infusions (from your records)	198		15 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	254. 17	121. 9			12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	63	10	62 0	0	13.0
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	17, 010	10.7	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)	16, 013	19, 70	52 0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI 0	
				1.00	N	
E 00	Total cost of injections/infusions and their administratio	n costs (sum of	F columns 1	1. 00	2. 00 125, 350	15 0
5.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		125, 350	15.0
6 00	Total Program cost of injections/infusions and their admin		(SUM OF		35, 775	16.0
5. 55	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				33,773	0

Health Financial Systems	WOODLAWN HOSI	PITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQH SERVICES RENDERED TO PROGRAM BENEFICIARIES	C PROVIDER FOR	Provider CCN: 15-1313 Component CCN: 15-8551	From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 pm
			RHC I	Cost

		Component CCN: 15-8551	10 12/31/2022	5/26/2023 7: 17	
			RHC I	Cost	, р
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			305, 734	1. (
. 00	Interim payments payable on individual bills, either submitt	ted or to be submitted to		0	2. (
00	the contractor for services rendered in the cost reporting p			ا	
	"NONE" or enter a zero	701.104. 1.1 1.01.0, 111.10			
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				ol	3.
03				ol	3.
04				ol ol	3.
05				0	3.
	Provider to Program			-	
50				0	3
51				ol	3
52				ol	3
53				ol	3
54				ol	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	98)		ol	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transf		e	305, 734	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after desk	review. Also show date o	of		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		<u>.</u>		
01				0	5
)2				0	5
03				0	5.
	Provi der to Program				
50				0	5
1				0	5
52				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	98)		0	5
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6
)1	SETTLEMENT TO PROVIDER			10, 884	6
)2	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			316, 618	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		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 SERVICES RENDERED TO PROGRAM BENEFICIA		Provi der CCN: 15-1313 Component CCN: 15-8552	From 01/01/2022	
			DHC 11	Cost

				5/26/2023 7: 1	7 pm
			RHC II	Cost	•
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			149, 984	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.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01	g			0	3.
02				l ol	3.
03				0	3.
04				l ol	3.
05				0	3.
05	Provider to Program			U	J 3.
50	Frovider to Frogram			0	3
50 51					3
					3
52				0	
53				1 -1	3
54		00)		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	ster to Worksheet M-3, line		149, 984	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				_
00	List separately each tentative settlement payment after des	sk review. Also show date o	F		5
	each payment. If none, write "NONE" or enter a zero. (1)				
24	Program to Provider		1		_
)1				0	5
)2				0	5
)3				0	5
	Provider to Program			_	_
50				0	5
51				0	5
52				0	5
9	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
)1	SETTLEMENT TO PROVI DER			0	6
)2	SETTLEMENT TO PROGRAM			33, 257	6
00	Total Medicare program liability (see instructions)			116, 727	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
			1 00	0.00	
		0	1. 00	2.00	

Health Financial Systems	WOODLAWN HOS	PI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1313 Component CCN: 15-8550	From 01/01/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 pm
			RHC III	Cost

		component con: 15-8550	10 12/31/2022	5/26/2023 7: 17	
			RHC III	Cost	, p
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			366, 044	1. (
. 00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2. (
00	the contractor for services rendered in the cost reporting process the cost				
	"NONE" or enter a zero	oci rod. Tr none, wir to			
00	List separately each retroactive lump sum adjustment amount	hased on subsequent			3.
00	revision of the interim rate for the cost reporting period.				٥.
	payment. If none, write "NONE" or enter a zero. (1)	711 30 3110W date of each			
	Program to Provider				
01	11 ogram to 11 ovrder			0	3.
02				o o	3.
03				0	3.
04				0	3.
05				0	3.
US	Dravi dan ta Dragnam			U	3.
EΟ	Provider to Program			0	3.
50					
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 3.50-3.4			0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line	9	366, 044	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR		_		_
00	List separately each tentative settlement payment after desi	k 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 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
01	SETTLEMENT TO PROVIDER			19, 433	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			385, 477	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
			Number	(WO/Day/II)	
		0	1. 00	2.00	

Health Financial Systems	WOODLAWN HOSPIT	ΓAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI	ES .		From 01/01/2022 To 12/31/2022	
			RHC IV	Cost

		Component CCN: 15-8549	10 12/31/2022	5/26/2023 7: 17	
			RHC IV	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			103, 193	1.00
2. 00	Interim payments payable on individual bills, either submithe contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2.00
3. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider			-	
3. 01				0	3. 01
3. 02				0	3. 02 3. 03
3. 03 3. 04				0	3. 04
3. 05				0	3. 05
3. 03	Provider to Program			0	3. 0.
3. 50	1 TOVI GET LO TTOGI GIII			0	3. 50
3. 51				0	3. 51
3. 52				0	3. 52
3.53				0	3. 53
3.54				0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	е	103, 193	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date (DT		5. 00
E 01	Program to Provider			0	5. 01
5. 01 5. 02				0	5.02
5. 02				0	5. 02
5. 05	Provider to Program			0	3. 0.
5. 50	Trovider to rrogium			0	5. 50
5. 51				0	5. 51
5. 52				0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER			0	6. 0´
6. 02	SETTLEMENT TO PROGRAM			21, 790	6. 02
7. 00	Total Medicare program liability (see instructions)			81, 403	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
0.00	N C. O I I	0	1. 00	2. 00	0.63
8. 00	Name of Contractor			l	8.00

Health Financial Systems	WOODLAWN HOSPI	TAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH SERVICES RENDERED TO PROGRAM BENEFICIARIE	S		From 01/01/2022 To 12/31/2022	Worksheet M-5 Date/Time Prepared: 5/26/2023 7:17 pm
			RHC V	Cost

		Component CCN: 15-8547	10 12/31/2022	5/26/2023 7: 17	
			RHC V	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1, 00	2.00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			161, 944	1. (
. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2.0
00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. (
01	1 rogi am to 11 ovi dei			0	3. (
. 02				l ől	3. 0
03				l ől	3. (
04					3. (
05					3.
05	Provider to Program			U	٥.
50	Provider to Program			0	3.
51					3.
51 52					3.
53				0	3.
54		00)		0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	ster to Worksheet M-3, line	9	161, 944	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5.
	Program to Provider				
01				0	5.
02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
01	SETTLEMENT TO PROVIDER			o	6.
02	SETTLEMENT TO PROGRAM			26, 347	6.
	Total Medicare program liability (see instructions)			135, 597	7.
	Time main table program Table ty (000 The trade th		Contractor	NPR Date	
00_					
00					
00		0	Number 1.00	(Mo/Day/Yr) 2.00	

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	of Form CMS-2	552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC SERVICES RENDERED TO PROGRAM BENEFICIARIES		Peri od: From 01/01/2022 To 12/31/2022		pared:
		RHC VI	Cost	

		Component CCN: 15-8548	10 12/31/2022	5/26/2023 7: 17	
			RHC VI	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			349, 514	1. C
. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2.0
00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. (
01	11 ogi ami to 11 ovi dei			0	3. (
. 02				l ől	3. 0
03				l ől	3. (
04					3. (
05					3. (
05	Provider to Program			U	٥.١
50	Provider to Program			0	3.
51					3.
52					3.
53				0	3.
54		00)		0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans 27)	ster to worksheet M-3, line	9	349, 514	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	of		5.
	Program to Provider				
01				0	5.
02				0	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
01	SETTLEMENT TO PROVIDER	, . ,		0	6.
02	SETTLEMENT TO PROGRAM			21, 087	6.
00	Total Medicare program liability (see instructions)			328, 427	7.
	, , , , , , , , , , , , , , , , , , , ,		Contractor	NPR Date	
			Number	i (Mo/Dav/yr) i	
		0	Number 1.00	(Mo/Day/Yr) 2.00	