PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WOODLAWN HOSPITAL (15-1313) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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 regul ati ons.

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

> JOHN KRAFT (Si aned) Officer or Administrator of Provider(s)

> > VICE PRESIDENT OF FINANCE/CFO

Title

(Dated when report is electronically signed.)

number of times reopened = 0-9.

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
Hospi tal	0	532, 224	-443, 646	0	28, 173	1. 00
Subprovi der - IPF	0	0	0		0	2. 00
Subprovider - IRF	0	0	0		0	3. 00
Swing bed - SNF	0	47, 324	0		0	5. 00
Swing bed - NF	0				0	6. 00
Total	0	579, 548	-443, 646	0	28, 173	200. 00
	PART III - SETTLEMENT SUMMARY Hospital Subprovider - IPF Subprovider - IRF Swing bed - SNF Swing bed - NF	1.00	Cost Center Description	1.00 2.00 3.00	Cost Center Description	Cost Center Description

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

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1313 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/13/2020 4:35 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1400 EAST 9TH STREET 1.00 PO Box: 1.00 State: IN 2.00 City: ROCHESTER Zi p Code: 46975-County: FULTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 WOODLAWN HOSPITAL 151313 99915 01/01/1966 Ν 0 0 3.00 Hospi tal 4.00 Subprovider - IPF 4.00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF WOODLAWN HOSPITAL 15Z313 99915 10/23/2001 N 0 N 7 00 SWI NGBED 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 8 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

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

reporti n	g period different from the method used in tl	ne prior cos	st					
reporti n	g period? In column 2, enter "Y" for yes or	"N" for no.						
		In-State	In-State	Out-of	Out-of	Medi cai	d Other	
		Medi cai d	Medi cai d	State	State	HMO days	s Medicaid	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24.00 If this	provider is an IPPS hospital, enter the	0	0	0	0		0 0	24. 00
i n-state	Medicaid paid days in column 1, in-state							
Medi cai d	eligible unpaid days in column 2,							
out-of-s	tate Medicaid paid days in column 3,							
out-of-s	tate Medicaid eligible unpaid days in column							
4, Medic	aid HMO paid and eligible but unpaid days in							
column 5	, and other Medicaid days in column 6.							

					Count		
		1.00	2. 00	3. 00	4.00		
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0. 00		61. 20	
					1.00		
	ACA Provisions Affecting the Health Resources and Sei						
62. 00	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc		reporting peri	od for which	0.00	62. 00	
62. 01							
	during in this cost reporting period of HRSA THC prog	gram. (see instruction	ns)	· .			
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings					
63. 00	Has your facility trained residents in nonprovider se				N	63. 00	
	"Y" for yes or "N" for no in column 1. If yes, comple	<u>ete lines 64 through 6</u>					
			Unwei ghted	Unwei ghted	Ratio (col. 1/		
			FTEs	FTEs in	(col. 1 + col.		
			Nonprovi der	Hospi tal	2))		
			Si te				
			1. 00	2.00	3. 00		
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and before		This base year	is your cost i	reporting		
64. 00	Enter in column 1, if line 63 is yes, or your facilit		0.00	0. 00	0. 000000	64 00	
04.00	in the base year period, the number of unweighted nor		0.00	0.00	0.000000	04.00	
	resident FTEs attributable to rotations occurring in						
	settings. Enter in column 2 the number of unweighted						
	resident FTEs that trained in your hospital. Enter in						
	of (column 1 divided by (column 1 + column 2)). (see						
		,	1	1	1	l	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1313 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/13/2020 4:35 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 66.00 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

	inancial Systems WOODLAWN HO	Provi der CCN: 15-1313	Peri od: From 01/01/2019 To 12/31/2019	u of Form CMS- Worksheet S-2 Part I Date/Time Pro 5/13/2020 4:3	2 epared:		
				1.00			
	ong Term Care Hospital PPS				4		
1.00 1 5	s this a long term care hospital (LTCH)? Enter "Y" for yes s this a LTCH co-located within another hospital for part o Y" for yes and "N" for no. EFRA Providers		ng period? Enter	N N	80. 00		
5. 00 I s 6. 00 Di	ETRA FIGURE S s this a new hospital under 42 CFR Section §413.40(f)(1)(i) id this facility establish a new Other subprovider (exclude 413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	85. 0 86. 0		
7.00 1 5	s this hospital an extended neoplastic disease care hospita 886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified under section	n	N	87. 0		
			V 1. 00	XI X 2. 00			
_	itle V and XIX Services						
	oes this facility have title V and/or XIX inpatient hospita es or "N" for no in the applicable column.	l services? Enter "Y" for	N N	Y	90.0		
1. 00 lís	s this hospital reimbursed for title V and/or XIX through t ull or in part? Enter "Y" for yes or "N" for no in the appl		N	Υ	91.0		
2. 00 Ar	re title XIX NF patients occupying title XVIII SNF beds (dunstructions) Enter "Y" for yes or "N" for no in the applica	al certification)? (see		N	92.00		
3. 00 Do	oes this facility operate an ICF/IID facility for purposes of Y" for yes or "N" for no in the applicable column.		N	N	93.00		
94. 00 Do	oes title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no in the	N	N	94.00		
5. 00 I i	fline 94 is "Y", enter the reduction percentage in the app		0.00	0.00	95. 0		
ap	oes title V or XIX reduce operating cost? Enter "Y" for yes $\operatorname{pplicable}$ column.		N	0. 00	96. 0		
8. 00 Do	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in						
8. 01 Do	olumn 1 for title V, and in column 2 for title XIX. oes title V or XIX follow Medicare (title XVIII) for the re , Pt. !? Enter "Y" for yes or "N" for no in column 1 for ti			Y	98. 0		
8. 02 Do	itle XIX. oes title V or XIX follow Medicare (title XVIII) for the ca ed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o		Y	Y	98. 0		
8. 03 Do	or title V, and in column 2 for title XIX. oes title V or XIX follow Medicare (title XVIII) for a crit eimbursed 101% of inpatient services cost? Enter "Y" for ye			N	98. 0		
8. 04 Do	or title V, and in column 2 for title XIX. oes title V or XIX follow Medicare (title XVIII) for a CAH utpatient services cost? Enter "Y" for yes or "N" for no in		N ad	N	98. 0		
8. 05 Do	n column 2 for title XIX. oes title V or XIX follow Medicare (title XVIII) and add ba kst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c			Y	98. 0		
8. 06 Do	olumn 2 for title XIX. oes title V or XIX follow Medicare (title XVIII) when cost ts. I through IV? Enter "Y" for yes or "N" for no in column olumn 2 for title XIX.		Y	Y	98. 0		
	ural Providers		V		105.0		
06. 00 I 1	oes this hospital qualify as a CAH? f this facility qualifies as a CAH, has it elected the all-	inclusive method of payme	ent N		105. 0 106. 0		
07. 00 l 1 tı	or outpatient services? (see instructions) f this facility qualifies as a CAH, is it eligible for cost raining programs? Enter "Y" for yes or "N" for no in column es, the GME elimination is not made on Wkst. B, Pt. I, col.	1. (see instructions) If			107. 0		
08. 00 I s	eimbursed. If yes complete Wkst. D-2, Pt. II. s this a rural hospital qualifying for an exception to the FR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee schedule? See 4	2 N		108. 0		
JCI	A Section 9412. ITS(C). Eittel T TOI YES OF N TOT NO.	Physical Occupation		Respiratory			
th	f this hospital qualifies as a CAH or a cost provider, are herapy services provided by outside supplier? Enter "Y" or yes or "N" for no for each therapy.	1.00 2.00 N N	3. 00 N	4.00 N	109. 0		
				1.00			
		I Demonstration project (1.00 N			

	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.	į	

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 01/01/2019 Part I 12/31/2019 Date/Time Prepared: To 5/13/2020 4:35 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143.00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν 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. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 N 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 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 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. []]167 ດດ

168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),	enter the		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	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions)	"), enter the	0.0	0169. 00
in and the reaction of the reaction of	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

	Financial Systems WOODLAWN I TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1313	Peri od:	u of Form CMS- Worksheet S-2	
		1.1.2.1.2		From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	epared:
				Y/N	5/13/2020 4:3 Date	35 pm
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	sponses. Ente			
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c	column 2 (see	instructions)			1.0
	proporting period. It yes, enter the date of the change in the	301 dilli1 2. (300	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.0
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
			1. 00	2. 00	3. 00	
00	Financial Data and Reports	rieii Dubli-	Υ	^		٠, ١
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.0
. 00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit rec	conciliation.		V (1)		
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	e provider is	, N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		l during the	N N		7. C
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		al education	N		9. 0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current	N		10.0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11. (
	Teaching Program on Worksheet A? If yes, see instructions.				V/ /51	
					Y/N 1. 00	
	Bad Debts				1.00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Υ	12. (
3. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N	13. 0
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structions.	N	14. (
5. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,	yes, see inst		N t B	15. (
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
	PS&R Data					
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	Y	04/01/2020	Y	04/01/2020	16.0
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. (
. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. (

Description Y/N Y/N 2016 N N N N N N N N N	S-2552-10 S-2 Prepared:
20.00 If I ine 16 or 17 is yes, were adjustments made to PS&R N N N N Report data for Other? Describe the other adjustments: V/N Dete Y/N De	. 35 pili
Report data for Other? Describe the other adjustments: 1.00	
21.00 Was the cost report prepared only using the provider's N N N N N N N N N N N N N N N N N N N	20.00
1.00 1.00	
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held by the cost report preparer in columns 1, 2, and 3, respectively.	41.00
respecti vel y.	
12.00 Enter the employer/company name of the cost report BLUE & CO. LLC	42. 00
preparer.	
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	43.00

Heal th	Financial Systems WOODL	HOSPI TAL	In Lieu of Form CMS-2552-				
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1313			Worksheet S-2 Part II Date/Time Pre 5/13/2020 4:3	pared:
			3.00				
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and respectively.		SENI OR MANAGER				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 correport preparer in columns 1 and 2, respectively.	st					43. 00

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems WOO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1313

					-	To 12/31/2019	Date/Time Pre 5/13/2020 4:3	
							I/P Days / 0/P	J piii
							Visits / Trips	
	Component	Worksheet A	No.	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		0.00	Avai I abl e	4.00	F 00	
4 00		1.00		2.00	3.00	4.00	5.00	1 00
1.00	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and	30. 00		21	7, 66	53, 496. 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						Ö	6.00
7. 00	Total Adults and Peds. (exclude observation			21	7, 66	53, 496. 00		7. 00
7.00	beds) (see instructions)			21	,, 00	00, 170.00		7.00
8.00	INTENSIVE CARE UNIT	31. 00		4	1, 46	0 13, 152. 00	0	8. 00
9. 00	CORONARY CARE UNIT					10, 1121		9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			25	9, 12	5 66, 648. 00	0	14.00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			25	1		_	27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31.00
32. 00	Labor & delivery days (see instructions)			0	'	0		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions)							33. 00
	LTCH non-covered days LTCH site neutral days and discharges						1	33. 00
33.01	LIGHT SI LE HEULT AT MAYS AND UI SCHALLYES		I		I	1	I	33.01

				'	0 12/31/2019	5/13/2020 4: 3	
		I/P Days	/ O/P Visits	/ Trips	Full Time	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	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	864	90	2, 229			1.00
2.00	HMO and other (see instructions)	650	127				2. 00
3.00	HMO IPF Subprovider	o	0				3. 00
4.00	HMO IRF Subprovider	o	O				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	161	o	165			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	131			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 025	90	2, 525			7. 00
8.00	INTENSIVE CARE UNIT	239	0	548			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	326			13. 00
14.00	Total (see instructions)	1, 264	90	3, 399	0.00	393. 09	14.00
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)				0.00	393. 09	27. 00
28. 00	Observation Bed Days		122	885			28. 00
29. 00	· ·	0					29. 00
30. 00				0			30.00
31. 00				0			31.00
32. 00		0	46	100			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00		0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: | To 12/31/2019 | Date/Time Prepared: | To 12/31/2020 | Part | Part

				10) 12/31/2019	Date/IIme Pre 5/13/2020 4:3	
		Full Time	•	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	12.00	14.00	Pati ents	
1 00	Hospital Adults & Dods (columns E 4 7 and	11.00	12.00	13. 00	14.00	15. 00	1 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	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider HOSpital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)		0	301 158	37 51 0 0	872	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 23. 00 24. 00 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 01	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00	0	301	37	872	
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges			0			33. 00 33. 01

Health Financial Systems	WOOD	DLAWN HOSPITAL		In Lie	eu of Form CMS-2	2552-10	
HOSPITAL UNCOMPENSATED AND IN	NDIGENT CARE DATA	Provi der Co		Peri od:	Worksheet S-10		
				From 01/01/2019 To 12/31/2019	Date/Time Prep 5/13/2020 4:3		
					1 00		
Uncompensated and indi	gent care cost computation				1. 00		
	Worksheet C, Part I line 202 co	lumn 3 divided by Li	ne 202 column	8)	0. 321611	1.00	
Medicaid (see instruct		· · · · · · · · · · · · · · · · · · ·		/	0.02.00.		
2.00 Net revenue from Medic	cai d				951, 839	2. 00	
	supplemental payments from Med				Y	3. 00	
1	s line 2 include all DSH and/or	11 1 2		i d?	Y	4. 00 5. 00	
	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid 0 5.0 Medicaid charges 18,573,965 6.0						
3							
	revenue and costs for Medicaid	program (line 7 min	us sum of lin	es 2 and 5: if	5, 021, 752	1	
< zero then enter zero		program (Trito 7 min	uo ou o	00 2 and 0,	0,02.,,02	0.00	
Children's Health Insu	rance Program (CHIP) (see instr	uctions for each lin	e)				
9.00 Net revenue from stand					0		
10.00 Stand-alone CHIP charg					0		
•	(line 1 times line 10)	one CUID (line 11 mi	nuc lino Oci	f . zoro thon	0		
12.00 Difference between net enter zero)	revenue and costs for stand-al	one CHIP (TIME IT IIII	nus ime 9; i	i < Zero then	U	12.00	
	overnment indigent care program	(see instructions f	or each line)				
	e or local indigent care program)	0	13.00	
14.00 Charges for patients of	covered under state or local ind	ligent care program (Not included	in lines 6 or	0	14.00	
10)							
ı	nt care program cost (line 1 tim	•	41.1	45	0		
16.00 Difference between net 13; if < zero then ent	revenue and costs for state or	local indigent care	program (lin	e 15 minus line	0	16. 00	
	total unreimbursed cost for Med	icaid, CHIP and stat	e/local indig	ent care progran	ns (see		
instructions for each							
	ons, or endowment income restri propriations or transfers for su					17. 00 18. 00	
	st for Medicaid , CHIP and state			(sum of lines	5, 021, 752		
8, 12 and 16)	or recommended and print and exact	and rood rindigone	oa. o p. og. amo	(54 61 111165	0,02.,,02		
			Uni nsured	Insured	Total (col. 1		
			patients	pati ents	+ col . 2)		
Uncomponented Caro (co	a instructions for each line)		1.00	2. 00	3. 00		
	e instructions for each line) and uninsured discounts for the		1 242 22				
				4 0	1 243 234	20.00	
(see instructions)	and annibared ar security for the	entire raciiity	1, 243, 23	4 0	1, 243, 234	20. 00	
1 7	oved for charity care and uninsu	, and the second	399, 83		,,		
21.00 Cost of patients approinstructions)	oved for charity care and uninsu	red discounts (see	399, 83	8 0	399, 838	21. 00	
21.00 Cost of patients approinstructions)22.00 Payments received from		red discounts (see	399, 83		399, 838	21. 00	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care	oved for charity care and uninsu	red discounts (see	399, 83	8 0	399, 838	21. 00 22. 00	
21.00 Cost of patients approinstructions)22.00 Payments received from	oved for charity care and uninsu	red discounts (see	399, 83	8 0	399, 838	21. 00 22. 00	
21.00 Cost of patients approinstructions)22.00 Payments received from charity care	oved for charity care and uninsu	red discounts (see	399, 83	8 0	399, 838	21. 00 22. 00	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care 23.00 Cost of charity care (oved for charity care and uninsu	red discounts (see y written off as	399, 83 399, 83	8 0 0 0 8 0	399, 838 0 399, 838	21. 00 22. 00 23. 00	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care 23.00 Cost of charity care (24.00 Does the amount on lin imposed on patients could be considered as a constant of the co	oved for charity care and uninsung patients for amounts previously (line 21 minus line 22)	red discounts (see y written off as for patient days bey gent care program?	399, 83 399, 83 ond a Length	8 0 0 8 0 of stay limit	399, 838 0 399, 838	21. 00 22. 00 23. 00 24. 00	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care 23.00 Cost of charity care (24.00 Does the amount on lin imposed on patients co 25.00 If line 24 is yes, ent stay limit	oved for charity care and uninsum patients for amounts previously (line 21 minus line 22) The 20 column 2, include charges overed by Medicaid or other indicater the charges for patient days	for patient days bey gent care program?	399, 83 399, 83 ond a Length care program	8 0 0 8 0 of stay limit	399, 838 0 399, 838 1.00 N	21. 00 22. 00 23. 00 24. 00 25. 00	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care 23.00 Cost of charity care (24.00 Does the amount on linimposed on patients could limin be stay limit 26.00 Total bad debt expense	oved for charity care and uninsum patients for amounts previously (line 21 minus line 22) The 20 column 2, include charges overed by Medicaid or other indicater the charges for patient days at for the entire hospital comple	for patient days bey gent care program? beyond the indigent ox (see instructions)	399, 83 399, 83 ond a Length care program	8 0 0 8 0 of stay limit	399, 838 0 399, 838 1.00 N 0 4, 327, 972	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care 23.00 Cost of charity care (24.00 Does the amount on linimposed on patients collified by limit to the colliniary care (25.00 If line 24 is yes, ent stay limit to the colliniary care (26.00 Medicare reimbursable	oved for charity care and uninsum patients for amounts previousl (line 21 minus line 22) The 20 column 2, include charges overed by Medicaid or other indicater the charges for patient days are for the entire hospital complements bad debts for the entire hospit	for patient days bey gent care program? beyond the indigent (x (see instructions) al complex (see inst	399, 83 399, 83 ond a Length care program ructions)	8 0 0 8 0 of stay limit	399, 838 0 399, 838 1.00 N 0 4, 327, 972 656, 712	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care 23.00 Cost of charity care (24.00 Does the amount on linimposed on patients could lift line 24 is yes, ent stay limit 26.00 Total bad debt expense 27.00 Medicare reimbursable 27.01 Medicare allowable bad	oved for charity care and uninsum patients for amounts previously (line 21 minus line 22) The 20 column 2, include charges overed by Medicaid or other indicate the charges for patient days are for the entire hospital debts for the entire hospital	for patient days bey gent care program? beyond the indigent (x (see instructions) al complex (see inst	399, 83 399, 83 ond a Length care program ructions)	8 0 0 8 0 of stay limit	399, 838 0 399, 838 1.00 N 0 4, 327, 972 656, 712 1, 010, 326	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care 23.00 Cost of charity care (24.00 Does the amount on linimposed on patients collification of the composition of the c	oved for charity care and uninsum patients for amounts previousl (line 21 minus line 22) The 20 column 2, include charges overed by Medicaid or other indicater the charges for patient days are for the entire hospital complements bad debts for the entire hospit	for patient days bey gent care program? beyond the indigent (see instructions) al complex (see instructions) complex (see instructions)	399, 83 399, 83 ond a length care program ructions) tions)	8 0 0 8 0 of stay limit	399, 838 0 399, 838 1.00 N 0 4, 327, 972 656, 712 1, 010, 326 3, 317, 646	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00	
21.00 Cost of patients approinstructions) 22.00 Payments received from charity care 23.00 Cost of charity care (24.00 Does the amount on linimposed on patients collification of the composition of the c	poved for charity care and uninsum patients for amounts previous (line 21 minus line 22) The 20 column 2, include charges povered by Medicaid or other indicate the charges for patient days are for the entire hospital comple bad debts for the entire hospital expense (see instructions)	for patient days bey gent care program? beyond the indigent as (see instructions) al complex (see instructions) debt expense (see	399, 83 399, 83 ond a length care program ructions) tions)	8 0 0 8 0 of stay limit	399, 838 0 399, 838 1.00 N 0 4, 327, 972 656, 712 1, 010, 326	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 27. 01 28. 00 29. 00	

Health Financial Systems	WOODLAWN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der Co	CN: 15-1313	Peri od:	Worksheet A	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre	
Cook Cooker Doorwinking	C-1:	0+1	T-+-1 (1 1	DI: 6:+:	5/13/2020 4: 3	5 PM
Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassified	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	4.00		0.00	4.00	col . 4)	
OFWERN OFFWARE COOT OFWERDS	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT		2, 323, 909			2, 189, 929	1. 00
1. 02 00102 AKRON BUI LDI NG		48, 137			48, 137	1. 02
1. 03 00103 ARGOS BUI LDI NG		114, 728			114, 728	1. 03
1. 04 00101 CLAYS BUILDING		29, 783	29, 78	3 133, 980	163, 763	1. 04
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 087, 588	4, 087, 58	8 0	4, 087, 588	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	3, 168, 257	6, 206, 459	9, 374, 71	6 -289, 391	9, 085, 325	5.00
7.00 00700 OPERATION OF PLANT	370, 957	1, 198, 968	1, 569, 92	5 1, 395, 741	2, 965, 666	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	14, 818	121, 614	136, 43		136, 432	8. 00
9. 00 00900 HOUSEKEEPI NG	373, 898	201, 413			574, 658	9. 00
10. 00 01000 DI ETARY	403, 398	351, 492			278, 528	10.00
11. 00 01100 CAFETERI A	0	001, 172	1	0 469, 543	469, 543	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	180, 191	75, 944			670, 869	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	160, 171	75, 744	250, 13	0 414,734	070,809	14. 00
	200 002	4 E10 241	4 017 22	4 51 (15		
15. 00 01500 PHARMACY	398, 093	4, 519, 241				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	615, 688	422, 561	1, 038, 24	9 -44, 746	993, 503	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 190, 347	895, 360			2, 417, 018	30. 00
31.00 03100 INTENSIVE CARE UNIT	479, 151	243, 617	722, 76		575, 347	31. 00
43. 00 04300 NURSERY	0	0		0 208, 292	208, 292	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	737, 523	1, 328, 731	2, 066, 25	4 -40, 169	2, 026, 085	50.00
51.00 05100 RECOVERY ROOM	342, 500	162, 733	505, 23	3 0	505, 233	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 287, 862	287, 862	52.00
53. 00 05300 ANESTHESI OLOGY	0	950, 262	950, 26	2 -775	949, 487	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 706, 544	1, 522, 648	3, 229, 19	2 -312, 511	2, 916, 681	54.00
60. 00 06000 LABORATORY	919, 294	1, 682, 673			2, 529, 574	60.00
65. 00 06500 RESPI RATORY THERAPY	991, 670	352, 426			1, 330, 533	65. 00
66. 00 06600 PHYSI CAL THERAPY	712, 830	228, 972			937, 119	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	246, 121	50, 929			297, 050	67. 00
68. 00 06800 SPEECH PATHOLOGY	82, 804	19, 727			102, 531	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	02,004	17, 727			0	71. 00
72. 00 07100 IMPL. DEV. CHARGED TO PATIENTS	0	784, 277		-	784, 277	71.00
73.00 O7300 DRUGS CHARGED TO PATTENTS	0	704, 277		0 0	764, 277	
OUTPATIENT SERVICE COST CENTERS	U	U		0 0	U	73. 00
	1 (22 (40	2 20/ 002	2 020 /5	100.004	2 725 /57	01 00
91. 00 09100 EMERGENCY	1, 622, 648	2, 206, 003	3, 828, 65	1 -102, 994	3, 725, 657	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART						92. 00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	3, 246, 295	1, 829, 437			4, 603, 442	93. 00
93. 01 04951 SHAFER MEDICAL CENTER	3, 243, 288	1, 138, 792	4, 382, 08	0 0	4, 382, 080	93. 01
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE		0	1	0 0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	22, 046, 315	33, 098, 424	55, 144, 73	9 77, 917	55, 222, 656	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0		o o	0	192.00
192. 01 19201 FCMC	1, 527, 174	1, 025, 639	2, 552, 81	3 ol	2, 552, 813	192. 01
192.02 19202 ARGOS MEDICAL CENTER	1, 552, 791	520, 075			2, 072, 866	192. 02
192. 03 19203 AKRON MEDICAL CENTER	549, 793	249, 664			799, 457	
193. 00 19300 NONPALD WORKERS	, 0	, 501		ol ŏl		193. 00
194. 00 07950 ADVERTI SI NG	69, 246	329, 427	398, 67	3 -77, 917	320, 756	
200.00 TOTAL (SUM OF LINES 118 through 199)	25, 745, 319	35, 223, 229	1		60, 968, 548	
200.00 TOTAL (SOM OF LINES THE CHIOUGH 177)	20, 170, 017	55, 225, 227	1 00, 700, 34	9	00, 700, 540	200.00

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 5/13/2020 4: 35 pm

				5/13/2020 4: 3	5 pili
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				1
1.00	00100 CAP REL COSTS-BLDG & FIXT	-60, 002	2, 129, 927		1. 00
1.02	00102 AKRON BUILDING	0	48, 137		1. 02
1.03	00103 ARGOS BUILDING	0	114, 728		1. 03
1.04	00101 CLAYS BUILDING	0	163, 763		1. 04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 087, 588		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 024, 997	6, 060, 328		5. 00
7.00	00700 OPERATION OF PLANT	0	2, 965, 666		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0	574, 658		9. 00
10.00	01000 DI ETARY	-25, 477			10. 00
11. 00	01100 CAFETERI A	-128, 506			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	120,000			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0			14. 00
15. 00	01500 PHARMACY	-227, 985	, and a	l .	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-21, 178			16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-21,170	712, 323		10.00
30. 00	03000 ADULTS & PEDIATRICS	0	2, 417, 018		30.00
31. 00	03100 INTENSIVE CARE UNIT				31. 00
43. 00	04300 NURSERY	0			43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS		200, 292		43.00
50. 00	05000 OPERATING ROOM		2, 026, 085		50. 00
51. 00	05100 RECOVERY ROOM	0			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		287, 862		52. 00
53. 00	05300 ANESTHESI OLOGY	-892, 947		l .	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-268, 610			54.00
60.00	06000 LABORATORY	-208, 010			60.00
65. 00	06500 RESPIRATORY THERAPY	-64, 530			65. 00
66. 00	06600 PHYSI CAL THERAPY	1		l .	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-65, 940 0	871, 179 297, 050		67. 00
68. 00	06800 SPEECH PATHOLOGY	0			68.00
		0	102, 531		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	l .	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	784, 277		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0		73. 00
91. 00	09100 EMERGENCY	-1, 679, 716	2, 045, 941		91.00
		-1,079,710	2,043,941		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2 2/2 207	2 240 455		92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	-2, 363, 287			93. 00
93. 01	04951 SHAFER MEDI CAL CENTER	-2, 785, 604	1, 596, 476		93. 01
440.00	SPECIAL PURPOSE COST CENTERS				440.00
	11300 INTEREST EXPENSE	0		l control of the cont	113. 00
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	-11, 608, 779	43, 613, 877		118. 00
400.00	NONREI MBURSABLE COST CENTERS				100.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	l control of the cont	190.00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	l control of the cont	192. 00
	19201 FCMC	0	2, 552, 813		192. 01
	19202 ARGOS MEDICAL CENTER	0	2, 072, 866	·	192. 02
	3 19203 AKRON MEDICAL CENTER	0	799, 457	·	192. 03
	19300 NONPALD WORKERS	0	0		193. 00
	07950 ADVERTI SI NG	0	320, 756	l .	194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-11, 608, 779	49, 359, 769		200. 00

| Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS WOODLAWN HOSPITAL Provider CCN: 15-1313

					Т	o 12/31/2019	Date/Time Prepared: 5/13/2020 4:35 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - CAFETERIA						
1.00	CAFETERI A	11. 00	250, 914	218, 629			1. 00
	0		250, 914	218, 629			
	B - ADVERTISING						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	1 <u>3, 1</u> 41	6 <u>2, 5</u> 18			1.00
	0		13, 141	62, 518			
	C - DEPRECIATION						
1.00	CLAYS BUILDING	1. 04	0	13 <u>3, 9</u> 80			1.00
	0		0	133, 980			
	D - NURSERY						
1.00	NURSERY	43. 00	146, 762	61, 530			1. 00
2.00	DELIVERY ROOM & LABOR ROOM	5200	202, 827	8 <u>5, 0</u> 35			2. 00
	0		349, 589	146, 565			
	E - NURSING SUPERVISOR						
1. 00	NURSING ADMINISTRATION	13. 00	417, 010	0			1.00
2.00		0.00	0	0			2. 00
3. 00		0.00	0	0			3. 00
4.00		0.00		0			4. 00
	U DECLACE		417, 010	ō			
1 00	F - MAINTENANCE RECLASS OPERATION OF PLANT	7 00	O	1 205 741			1.00
1. 00 2. 00	OPERATION OF PLANT	7. 00 0. 00	0	1, 395, 741 0			1. 00 2. 00
3.00		0.00	0	0			3.00
4. 00		0.00	O O	0			4. 00
4. 00 5. 00		0.00	0	0			5. 00
6. 00		0.00	0	0			6. 00
7. 00		0.00	0	0			7. 00
8. 00		0.00	0	0			8. 00
9. 00		0.00		0			9. 00
10. 00		0.00	0	o			10.00
11. 00		0.00		0			11.00
12. 00		0.00	0	0			12. 00
13. 00		0.00	0	0			13.00
14. 00		0.00	ol Ol	0			14.00
15. 00		0.00	ol Ol	0			15. 00
16. 00		0.00	ol	0			16. 00
17. 00		0.00	ol	0			17. 00
20	TOTALS — — — —	— — °+	 	1, 395, 741			177.00
500.00	Grand Total: Increases		1, 030, 654	1, 957, 433			500. 00

Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 5/13/2020 4:35 pm

						5/13/2020 4:	35 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFETERIA						
1.00	DI ETARY	1000	<u>250, 9</u> 14	21 <u>8, 6</u> 29	0		1.00
	0		250, 914	218, 629			
	B - ADVERTISING						
1.00	ADVERTI SI NG	194. 00	13, 141	62, 518	0		1. 00
	0		13, 141	62, 518			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	133, 980	9		1.00
				133, 980			1
	D - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	349, 589	146, 565	0		1.00
2.00		0.00	o	0	0		2.00
			349, 589	146, 565			
	E - NURSING SUPERVISOR	<u> </u>					
1.00	ADULTS & PEDIATRICS	30.00	131, 741	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	142, 693	0	o		2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	46, 424	0	o		3.00
4.00	EMERGENCY	91.00	96, 152	0	o		4.00
			417, 010	_			
	F - MAINTENANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	365, 050	0		1.00
2.00	HOUSEKEEPI NG	9.00	O	653	0		2.00
3.00	DI ETARY	10.00	O	6, 819	o		3.00
4.00	NURSING ADMINISTRATION	13.00	O	2, 276	O		4. 00
5.00	PHARMACY	15. 00	O	51, 615	O		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	O	44, 746	O		6.00
7.00	ADULTS & PEDIATRICS	30.00	O	40, 794	o		7.00
8.00	INTENSIVE CARE UNIT	31.00	O	4, 728	O		8.00
9.00	OPERATING ROOM	50.00	O	40, 169	o		9.00
10.00	ANESTHESI OLOGY	53.00	O	775	o		10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	o	266, 087	o		11.00
12.00	LABORATORY	60.00	o	72, 393	o		12.00
13.00	RESPI RATORY THERAPY	65.00	o	13, 563	o		13.00
14.00	PHYSI CAL THERAPY	66.00	o	4, 683			14.00
15.00	EMERGENCY	91.00	o	6, 842			15. 00
16. 00	WOODLAWN MEDICAL	93.00	ol	472, 290			16. 00
	PROFESSI ONALS						
17. 00	ADVERTI SI NG	194.00	o	2, 258	o		17. 00
	TOTALS	— — [—] †	— —	1, 395, 741			
F00 00	Grand Total: Decreases		1, 030, 654	1, 957, 433			500.00

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

				Ic	12/31/2019	Date/lime Prep 5/13/2020 4:3	
				Acqui si ti ons		07 107 2020 1: 0	D DIII
		Begi nni ng	Purchases	Donation	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	596, 216	0	0	0	0	1. 00
2.00	Land Improvements	510, 775	0	0	0	0	2. 00
3.00	Buildings and Fixtures	27, 302, 119	0	0	0	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	9, 779, 463	1, 166, 000	0	1, 166, 000	424, 403	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	38, 188, 573	1, 166, 000	0	1, 166, 000		8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	38, 188, 573	1, 166, 000	0	1, 166, 000	424, 403	10. 00
		Ending Balance	Fully				
			Depreciated				
		6.00	Assets 7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		7.00				
1. 00	Land	596, 216	0				1.00
2.00	Land Improvements	510, 775	0				2.00
3.00	Buildings and Fixtures	27, 302, 119	0				3.00
4. 00	Building Improvements	27,302,117	0				4.00
5. 00	Fixed Equipment	0	0				5.00
6. 00	Movable Equipment	10, 521, 060	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	38, 930, 170	0				8.00
9. 00	Reconciling Items	0	ol				9. 00
10.00	Total (line 8 minus line 9)	38, 930, 170	Ö				10.00
	, ,						'

Health Financial Systems	WOODLAWN HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider Co		From 01/01/2019 To 12/31/2019	Worksheet A-7 Part II Date/Time Prep 5/13/2020 4:3	
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		

						5/13/2020 4:3	o piii
			SU	IMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10. 00	11.00	12.00	13. 00	
	DART II DECONCILIATION OF AMOUNTS FROM WORK				12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	· · · · · · · · · · · · · · · · · · ·	N 2, LINES I a				
1. 00	CAP REL COSTS-BLDG & FLXT	1, 205, 026	0	528, 230	578, 084		1. 00
1.02	AKRON BUILDING	28, 466	0	0	0	11, 134	1. 02
1.03	ARGOS BUILDING	51, 792	0	0	27, 748	14, 472	1. 03
1.04	CLAYS BUILDING	0	0	0	0	13, 850	1. 04
3.00	Total (sum of lines 1-2)	1, 285, 284	0	528, 230	605, 832	52, 025	3. 00
		SUMMARY OF	CAPI TAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	2, 323, 909				1. 00
1.02	AKRON BUILDING	8, 537	48, 137				1. 02
1.03	ARGOS BUILDING	20, 716	114, 728				1. 03
1. 04	CLAYS BUILDING	15, 933	29, 783				1. 04
3. 00	Total (sum of lines 1-2)	45, 186					3. 00
5.00	Total (Suil of Titles 1-2)	45, 160	2, 310, 337	I			5.00

Heal th	Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 To 12/31/2019	5/13/2020 4: 35	
		COME	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	30, 399, 446				0	1. 00
1.02	AKRON BUILDING	950, 483				0	1. 02
1.03	ARGOS BUILDING	2, 036, 750	0	2, 036, 75			1. 03
1.04	CLAYS BUILDING	5, 543, 491		5, 543, 49		0	1. 04
3. 00	Total (sum of lines 1-2)	38, 930, 170	TION OF OTHER (38, 930, 17		O F CAPITAL	3. 00
		ALLUCA	IION OF OTHER O	CAPITAL	SUIVIIVIART	r CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	0001 0011101 B0001 1 p 1 1 0 1 1		Capi tal -Relate		2001.001.011	20000	
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 1, 064, 104	0	1.00
1.02	AKRON BUILDING	0	0		0 28, 466		1. 02
1.03	ARGOS BUILDING	0	0		0 51, 792	•	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, 278, 342	0	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
	DART LLL DESCRIPTION OF CARLEY COOTS OF	11.00	12. 00	13. 00	14. 00	15.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		E70, 004	10.54		2 120 027	1 00
1.00	CAP REL COSTS-BLDG & FLXT	475, 170				-,,	1. 00 1. 02
1. 02 1. 03	AKRON BUILDING ARGOS BUILDING	0	0 27, 748				1. 02 1. 03
1.03	CLAYS BUILDING		27, 748 	1			1. 03
3.00	Total (sum of lines 1-2)	475, 170	ĭ				3. 00
3.00	10tai (Suii 01 111165 1-2)	475, 170	1 000, 032	1 52,02	45, 100	2, 450, 555	3.00

| Period: | Worksheet A-8 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1313

				To	12/31/2019	Date/Time Prep 5/13/2020 4:35	pared:
				Expense Classification on N		37 137 2020 4. 33) piii
				To/From Which the Amount is t	o be Adjusted		
	Cost Center Description		Amount 2.00	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00 B		3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 11	1. 00
1. 02	COSTS-BLDG & FLXT (chapter 2) Investment income - AKRON		0	AKRON BUILDING	1. 02	0	1. 02
	BUILDING (chapter 2)						
1. 03	Investment income - ARGOS BUILDING (chapter 2)		0	ARGOS BUILDING	1. 03	0	1. 03
1.04	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
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		Ü				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	О	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7 00
7. 00	stations excluded) (chapter		U		0. 00	U	7. 00
8. 00	21) Television and radio service		0		0. 00	0	8. 00
	(chapter 21)		-				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -7, 990, 164		0. 00	0	9. 00 10. 00
11 00	adjustment Sale of scrap, waste, etc.				0. 00	0	11. 00
11. 00	(chapter 23)		Ü		0.00		11.00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13.00	Laundry and linen service		120 4/0	CAFETERIA	0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-128, 469 0	CAFETERI A	11. 00 0. 00	0	
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
10.00	supplies to other than		0		0.00	J	10.00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	21 170	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
16.00	abstracts	B	-21, 170	MEDICAL RECORDS & LIBRARY	18.00		16.00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
00.00	books, etc.)		0.7	CAFETERIA	44.00		00.00
20. 00 21. 00	Vending machines Income from imposition of	В	-3 <i>7</i> 0	CAFETERI A	11. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
05.00	limitation (chapter 14)				444.00		05.00
25. 00	Utilization review - physicians' compensation		Ü	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	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		26. 04
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
_ , . 50	, , , , , , , , , , , , , , , , , , , ,	ı I	O	ı l	3. 30	ΥI	50

-6, 942 CAP REL COSTS-BLDG & FIXT

10, 107 ADMINISTRATIVE & GENERAL

-38, 569 ADMI NI STRATI VE & GENERAL

-2, 375 ADMINISTRATIVE & GENERAL

-42, 591 ADMINI STRATI VE & GENERAL

-5, 572 ADMI NI STRATI VE & GENERAL

-46, 749 ADMI NI STRATI VE & GENERAL

-104, 538 ADMINISTRATIVE & GENERAL

-900 ADMINISTRATIVE & GENERAL

-2, 793, 810 ADMINI STRATI VE & GENERAL

-1, 102 PHYSI CAL THERAPY

-49, 838 PHYSI CAL THERAPY

-15,000 PHYSICAL THERAPY

-64, 530 RESPIRATORY THERAPY

-16, 741 DI ETARY

-8, 736 DI ETARY

-227, 985 PHARMACY

-11, 608, 779

1.00

5.00

5.00

5.00

5.00

5.00

10.00

10.00

15.00

66.00

66.00

66.00

65.00

5.00

5.00

5.00

5.00

32.00

33.00

35.00

36.00

37.00

38.00

39.00

40.00

41.00

43.00

44.00

45.01

45.02

45.03

50.00

0 34.00

0

0 42 00

0 45.00

| column 6, line 200.) | (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

В

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(2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

CAH HIT Adjustment for

PHYSICIAN RECRUITMENT

HOME MEAL PROGRAM

DIETARY SPEC EVENTS

PT - OTHER REVENUE

OCC THER OTH REV

MISC REV -OTH REV

IHA LOBBYING

LTC EXPENSES

EDUCATION OTHER REVENUE

CHAPLAIN - OTHER REVENUE

ATHLETIC TRAINING -OTH REV

STAFF RENTAL AGREEMENTS

PART B BILLING OFFSET

HAF EXPENSE

DRUG SALES

Depreciation and Interest PHYSICIAN RECRUITMENT

32.00

34.00

35.00

36.00

37.00

38 00

39.00

40.00

41.00

42 00

43.00

44.00

45.00

45.01

45.02

45.03

50.00

B. Amount Received - if cost cannot be determined.

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

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

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

					'	12/31/2019	5/13/2020 4:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				•	'		Hours	
	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	53. 00	ANESTHESI OLOGY	892, 947	892, 947	0	0	0	1. 00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	268, 610	268, 610	0	0	0	2. 00
3.00	91. 00	EMERGENCY	2, 342, 575	1, 679, 716	662, 859	0	0	3. 00
4.00	93. 00	WOODLAWN MEDICAL	2, 363, 287	2, 363, 287	0	0	0	4. 00
		PROFESSI ONALS						
5.00	93. 01	SHAFER MEDICAL CENTER	2, 785, 604	2, 785, 604	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9. 00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			8, 653, 023	7, 990, 164	662, 859		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &		of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	1. 00
2.00	54. 00	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	2. 00
3.00	91. 00	EMERGENCY	0	0	0	0	0	3. 00
4.00	93. 00	WOODLAWN MEDICAL	0	0	0	0	0	4. 00
		PROFESSI ONALS						
5.00	93. 01	SHAFER MEDICAL CENTER	0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ANESTHESI OLOGY	0	-		892, 947		1. 00
2. 00		RADI OLOGY-DI AGNOSTI C	0	_		268, 610		2. 00
3. 00		EMERGENCY	0	0	0	1, 679, 716		3. 00
4.00	93. 00	WOODLAWN MEDICAL	0	0	0	2, 363, 287		4. 00
		PROFESSI ONALS	_	_	_			
5.00		SHAFER MEDICAL CENTER	0	0	0	2, 785, 604		5. 00
6. 00	0. 00		0	0	0	0		6. 00
7. 00	0. 00		0	_	0	0		7. 00
8. 00	0. 00		0	0	0	0		8. 00
9. 00	0. 00		0	_	_	0		9. 00
10.00	0. 00		0	0	_	0		10.00
200.00			0	0	0	7, 990, 164		200. 00

				0 12/31/2017	5/13/2020 4:3	
			CAPITAL RE	LATED COSTS		
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
	Allocation					
	(from Wkst A					
	col . 7)					
CENERAL CERVICE COCT CENTERS	0	1.00	1. 02	1. 03	1. 04	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FLXT	2, 129, 927	2, 129, 927	,			1. 00
1. 02 00100 CAF KEE COSTS-BEDG & TTXT	48, 137	۷, ۱۷۶, ۶۷۱	48, 137			1. 00
1. 03 00102 ARRON BULLDI NG	114, 728		0	114, 728		1. 02
1. 04 00101 CLAYS BUILDING	163, 763	C	o o	0	163, 763	1. 04
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4, 087, 588	C	0	0	0	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	6, 060, 328	232, 872	5, 501	9, 178	128	5.00
7.00 O0700 OPERATION OF PLANT	2, 965, 666	202, 143		10, 463	37, 359	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	136, 432	6, 298		0	0	8. 00
9. 00 00900 HOUSEKEEPI NG	574, 658	22, 928	1	0	345	9. 00
10. 00 01000 DI ETARY	253, 051	38, 111	1	0	0	10.00
11. 00 01100 CAFETERIA	341, 037	62, 713	1	0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	670, 869	51, 316	1	0	0	13. 00 14. 00
15. 00 01500 PHARMACY	4, 637, 734	26, 885	1	0	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	972, 325	31, 204	1	_	34, 086	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	7727020	0.7.20			0.17000	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 417, 018	287, 064	0	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	575, 347	41, 346	0	0	0	31.00
43. 00 04300 NURSERY	208, 292	3, 767	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS			_	_		
50. 00 05000 OPERATING ROOM	2, 026, 085	159, 922		_	0	50.00
51. 00 05100 RECOVERY ROOM	505, 233	99, 397			0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	287, 862 56, 540	33, 564 2, 664		_	0	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 648, 071	233, 100		_	0	54. 00
60. 00 06000 LABORATORY	2, 529, 574	50, 764		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 266, 003	72, 474		0	3, 369	65. 00
66. 00 06600 PHYSI CAL THERAPY	871, 179	67, 318		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	297, 050	C	o	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	102, 531	C	0	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	C	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	784, 277	C	0	0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS	2 045 041	104 7/0	1 0		0	01 00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 045, 941	124, 760	0	0	0	91. 00 92. 00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	2, 240, 155	262, 535	0	0	29, 369	93. 00
93. 01 04951 SHAFER MEDICAL CENTER	1, 596, 476	202, 333	1	_	59, 107	93. 00
SPECIAL PURPOSE COST CENTERS	1/0/0/1/0		<u> </u>		377 107	70.01
113.00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	43, 613, 877	2, 113, 145	8, 802	19, 641	163, 763	118. 00
NONREI MBURSABLE COST CENTERS				I		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	C	0	0		190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	11, 131] 0	0		192.00
192. 01 19201 FCMC	2, 552, 813	C	0	05 007		192. 01
192. 02 19202 ARGOS MEDICAL CENTER 192. 03 19203 AKRON MEDICAL CENTER	2, 072, 866 799, 457	(39, 335	95, 087		192. 02 192. 03
193. 00 19300 NONPALD WORKERS	/77,43/) 37, 333)			192. 03
194. 00 07950 ADVERTI SI NG	320, 756	5, 651	,	0		194. 00
200.00 Cross Foot Adjustments	220,700	5,001				200. 00
201.00 Negative Cost Centers		C	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	49, 359, 769	2, 129, 927	48, 137	114, 728	163, 763	202. 00

			10	12/31/2019	Date/lime Pre 5/13/2020 4:3	
Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	J PIII
5550 55mtol 55550 1 pt 1 5m	BENEFITS	oub to tu.	& GENERAL	PLANT	LINEN SERVICE	
	DEPARTMENT					
	4. 00	4A	5. 00	7. 00	8. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 02 00102 AKRON BUI LDI NG						1. 02
1. 03 00103 ARGOS BUI LDI NG						1. 03
1. 04 00101 CLAYS BUI LDI NG						1. 04
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	4, 087, 588					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	635, 768	6, 943, 775				5. 00
7.00 O0700 OPERATION OF PLANT	74, 132	3, 293, 064	539, 098	3, 832, 162		7. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE	2, 961	145, 691	23, 851	14, 240	183, 782	8. 00
9. 00 00900 HOUSEKEEPI NG	74, 720	672, 651	110, 118	51, 839	14, 381	9. 00
10. 00 01000 DI ETARY	30, 472	321, 634		86, 169	2, 926	10. 00
11. 00 01100 CAFETERI A	50, 143	453, 893		141, 793	0	11. 00
13.00 O1300 NURSING ADMINISTRATION	36, 009	758, 194	124, 122	116, 024	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00 01500 PHARMACY	79, 555	4, 744, 174		60, 787	0	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	124, 775	1, 162, 390	190, 291	70, 552	0	16. 00
I NPATIENT ROUTINE SERVICE COST CENTERS			I			
30. 00 03000 ADULTS & PEDI ATRI CS	345, 722	3, 049, 804	499, 274	649, 039	29, 946	30.00
31. 00 03100 I NTENSI VE CARE UNI T	106, 671	723, 364	118, 420	93, 482	3, 237	31. 00
43. 00 04300 NURSERY	29, 329	241, 388	39, 517	8, 518	0	43.00
ANCILLARY SERVICE COST CENTERS			II			
50. 00 05000 OPERATI NG ROOM	147, 387	2, 333, 394	381, 993	361, 582	28, 202	50. 00
51. 00 05100 RECOVERY ROOM	68, 445	673, 075		224, 736	12, 016	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	40, 533	361, 959		75, 887	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	59, 204	9, 692	6, 023	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	341, 036	3, 222, 207	527, 498	527, 036	32, 311	54.00
60. 00 06000 LABORATORY	183, 712	2, 764, 050		114, 777	0	60.00
65. 00 06500 RESPI RATORY THERAPY	198, 175	1, 540, 021	252, 112	163, 862	17, 619	65.00
66. 00 06600 PHYSI CAL THERAPY	142, 452	1, 080, 949		152, 204	5, 292	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	49, 185	346, 235	56, 681	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	16, 548	119, 079		0	0	68. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	784, 277	128, 392	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS	040 400	0 400 040	407 404	000 004	07.050	04 00
91. 00 09100 EMERGENCY	310, 139	2, 480, 840	406, 131	282, 081	37, 852	91.00
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	154 401	2 (0(400	439, 797	F02 F07	0	92. 00 93. 00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.01 04951 SHAFER MEDICAL CENTER	154, 431	2, 686, 490		593, 587	0	93. 00
SPECIAL PURPOSE COST CENTERS	108, 705	1, 764, 288	288, 826	U	U	93.01
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 351, 005	42, 726, 090	5, 857, 795	3, 794, 218	183, 782	
NONREI MBURSABLE COST CENTERS	3, 331, 003	42, 720, 070	3, 037, 773	3, 774, 210	103, 702	110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	o	11, 131	1, 822	25, 167		192. 00
192. 01 19201 FCMC	305, 190	2, 858, 003		0		192. 01
192. 02 19202 ARGOS MEDICAL CENTER	310, 310	2, 478, 263		0		192. 02
192. 03 19203 AKRON MEDICAL CENTER	109, 871	948, 663	155, 303	0		192. 03
193. 00 19300 NONPALD WORKERS	0	0	0	ol		193. 00
194. 00 07950 ADVERTI SI NG	11, 212	337, 619	· ·	12, 777		194. 00
200.00 Cross Foot Adjustments	,	0	,	,	_	200. 00
201.00 Negative Cost Centers	o	0	o	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 087, 588	49, 359, 769	6, 943, 775	3, 832, 162	183, 782	202. 00
	'					

			1	0 12/31/2019	5/13/2020 4:3	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
'				ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	9. 00	10.00	11. 00	13. 00	14. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 02 00102 AKRON BUI LDI NG						1. 02
1. 03 00103 ARGOS BUI LDI NG						1. 03
1. 04 00101 CLAYS BUI LDI NG						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	848, 989					9. 00
10. 00 01000 DI ETARY	3, 102	466, 485				10. 00
11. 00 01100 CAFETERI A	14, 298	0	684, 289			11. 00
13.00 01300 NURSING ADMINISTRATION	2, 080	0	28, 655	1, 029, 075		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00 01500 PHARMACY	10, 932	0	20, 813	0	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	6, 695	0	49, 498	21, 439	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	206, 302	385, 920	102, 451	755, 736	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	51, 972	80, 565	38, 495	134, 819	0	31. 00
43. 00 04300 NURSERY	0	0	6, 441	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	99, 428	0	66, 524	0	0	50. 00
51.00 O5100 RECOVERY ROOM	69, 561	0	19, 560	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	8, 886	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	82, 157	0	88, 559	0	0	54.00
60. 00 06000 LABORATORY	26, 705	0	56, 535	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	31, 131	0	43, 862	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	17, 513	0	28, 387	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	9, 214	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	o	0	2, 803	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	. 0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u>'</u>		
91. 00 09100 EMERGENCY	94, 110	0	47, 619	117, 081	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	59, 235	0	63, 512	0	0	93. 00
93. 01 04951 SHAFER MEDICAL CENTER	70, 772	0	0	o	0	93. 01
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	845, 993	466, 485	681, 814	1, 029, 075	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	2, 232	0	0	0	0	190. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192. 00
192. 01 19201 FCMC	o	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	o	o	0	o	0	192. 03
193. 00 19300 NONPALD WORKERS	o	o	0	o	0	193. 00
194. 00 07950 ADVERTI SI NG	764	O	2, 475	o	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		O	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	848, 989	466, 485	684, 289	1, 029, 075	0	202. 00
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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1313 Peri od: Worksheet B From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 5/13/2020 4:35 pm Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 15.00 16.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00102 AKRON BUILDING 1.02 1.02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 01000 DI ETARY 10.00 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 5, 613, 340 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1,500,865 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 72, 332 5, 750, 804 5, 750, 804 30.00 03100 INTENSIVE CARE UNIT 0 17, 198 1, 261, 552 0 1, 261, 552 31.00 31.00 298, 586 43.00 04300 NURSERY 0 2, 722 298, 586 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 169,009 3, 440, 132 3, 440, 132 50.00 0 05100 RECOVERY ROOM 19,068 1, 128, 203 0 1, 128, 203 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000000 2, 960 508, 947 0 508, 947 52.00 05300 ANESTHESI OLOGY 22.099 97 018 97.018 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 341, 398 4, 821, 166 4, 821, 166 54.00 284, 372 06000 LABORATORY 3, 698, 933 3, 698, 933 60.00 0 0 0 0 0 60.00 06500 RESPIRATORY THERAPY 2, 145, 144 2, 145, 144 65.00 96. 537 65.00 29, 192 06600 PHYSI CAL THERAPY 1, 490, 496 1, 490, 496 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 12, 747 424, 877 424, 877 67.00 06800 SPEECH PATHOLOGY 68 00 5, 305 146, 681 146, 681 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 07200 IMPL. DEV. CHARGED TO PATIENTS 935, 398 72 00 0 22, 729 935, 398 72 00 285, 939 07300 DRUGS CHARGED TO PATIENTS 5, 613, 340 5, 899, 279 5, 899, 279 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 73, 281 3, 538, 995 0 3, 538, 995 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 20.57 3, 863, 192 0 3, 863, 192 93.00 04951 SHAFER MEDICAL CENTER 23, 406 2, 147, 292 2, 147, 292 93.01 93.01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 5, 613, 340 1, 500, 865 41, 596, 695 0 41, 596, 695 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 2, 232 0 2, 232 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 38, 120 0 38, 120 192. 00 192. 01 19201 FCMC 0 0 0 3, 325, 878 0 3, 325, 878 192. 01 192. 02 19202 ARGOS MEDICAL CENTER 2.883.972 2, 883, 972 192, 02 0 192. 03 19203 AKRON MEDICAL CENTER 0 1, 103, 966 1, 103, 966 192. 03 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 C 0 0 194. 00 07950 ADVERTI SI NG 408.906 408, 906 194, 00 C 0 200.00 200.00 Cross Foot Adjustments Ω 201.00 Negative Cost Centers 0 0 0 201.00

5, 613, 340

1, 500, 865

49, 359, 769

49, 359, 769 202. 00

202.00

TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2019	Part II
To 12/31/2019	Date/Time Prepared:
5/13/2020 4:35 pm	

Cost Center Description					0 12/31/201/	5/13/2020 4: 3	
Assigned Rove Related Costs 1.00 1.02 1.03 1.04			CAPITAL RELATED COSTS				
Assigned Rove Related Costs 1.00 1.02 1.03 1.04	Cost Center Description	Directly	BLDG & FLXT	AKRON BUILDING	ARGOS BUILDING	CLAYS BUILDING	
Related Costs	,	Assigned New					
GENERAL SERVICE COST CENTERS							
CEMERAL SERVICE COST CENTERS			1 00	1 02	1 03	1 04	
1.02 00102 ARRON BUILDING	GENERAL SERVICE COST CENTERS		1.00	1.02	1. 05	1.04	
1.03							
1.04							
4.00 00400 CMPLOYEE BENEFITS DEPARTMENT 0							
5.00		0	r		0	0	
8. 00 OBBOD LANINRY & LINEN SERVICE 0 6, 298 0 0 0 8. 00 0 10. 00 10.		ő	232, 872	5, 501	9, 178		
9.00 00900 HOUSEKEEPING		0			10, 463	37, 359	7. 00
10.00 01000 0157APY 0 38, 111 0 0 0 10.00 11.00 11.00 11.00 11.00 11.00 11.00 0100 0457APY 0 0 0 0 0 0 0 11.00 11.00 11.00 0100 0457APY 0 0 0 0 0 0 0 0 0		0			0		
11.0		0		1	0		
13.00 01300 NURSING ADMINISTRATION 0 51,316 0 0 0 114.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 26,885 0 0 0 0 14.00 14.00 01400 CENTRAL SERVICE COST CENTERS		0		1	0	-	
14. 00		0		1	0		
16. 00 01600 MEDICAL RECORDS & LIBRARY 0 31, 204 0 0 34,086 16. 00		o			0	-	
IMPATIENT ROUTINE SERVICE COST CENTERS		0	26, 885	5 O	0	0	15. 00
30.00		0	31, 204	0	0	34, 086	16. 00
31.00 03100 INTENSI WE CARE UNIT 0 41,346 0 0 0 31,00			207 044	1 0	٥	0	30.00
43.00 04300 NURSERY 0 3,767 0 0 0 43.00		1		1	_		
50.00				1			
51.00 05100 RECOVERY ROOM & LABOR ROOM 0 99, 397 0 0 0 51.00		,					
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 33,564 0 0 0 52.00		1		l .	0		
53.00 05300 ANESTHESI OLOGY 0 2,664 0 0 0 53.00		1		1	0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 233, 100 0 0 0 54. 00		0		1	0		
65. 00		o		1	O		
66. 00 06600 PHYSI CAL THERAPY 0 67, 318 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRIGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRIGS CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRIGS CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRIGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07100 EMERGENCY 0 124, 760 0 0 0 75. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 76. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 76. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 76. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 77. 00 07300 DRIGS CHARGED TO PATI ENTS 0 0 0 0 78. 00 09200 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 79. 01 09201 09200 0920	60. 00 06000 LABORATORY	0	50, 764	0	0		60. 00
67. 00 06700 OCCUPATIONAL THERAPY O O O O O O O 67. 00 68. 00 O6800 SPECH PATHOLOGY O O O O O O O 71. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O O O O O O 72. 00 O7200 IMPL. DEV. CHARGED TO PATIENTS O O O O O O O 73. 00 O7300 DRUGS CHARGED TO PATIENTS O O O O O O 73. 00 O7300 DRUGS CHARGED TO PATIENTS O O O O O O 73. 00 O7300 DRUGS CHARGED TO PATIENTS O O O O O 74. 00 O7300 DRUGS CHARGED TO PATIENTS O O O O O 75. 00 O7300 DRUGS CHARGED TO PATIENTS O O O O O 76. 00 O7300 DRUGS CHARGED TO PATIENTS O O O O 77. 00 O7300 DRUGS CHARGED TO PATIENTS O O O O 78. 00 O9200 O8SERVATI ON BEDS (NON-DISTINCT PART O O O O 79. 00 O9200 O8SERVATI ON BEDS (NON-DISTINCT PART O O O O O O 79. 01 O4951 SHAFER MEDICAL CENTER O O O O O O 79. 01 O4951 SHAFER MEDICAL CENTER O O O O O 79. 01 O4951 SHAFER MEDICAL CENTERS O O O O 79. 02 O19000 GIFT FLOWER COFFEE SHOP & CANTEEN O O O O 79. 03 O19000 GIFT FLOWER COFFEE SHOP & CANTEEN O O O O 79. 04 O19000 O19000 O19000 O19000 O19000 O19000 79. 05 O19000 O19000 O19000 O19000 O19000 79. 06 O19000 O19000 O19000 O19000 79. 07 O19000 O19000 O19000 O19000 79. 08 O19000 O19000 O19000 79. 09 O19000 O19000 O19000 79. 09 O19000 O19000 79. 00 O19000 O19000 O19000 79. 00 79. 00 O19000 79. 00 79. 00 79. 00 O19000 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00		0		1	0		
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72. 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	67, 318	0	0		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71. 00 72. 00 772. 00 772. 00 772. 00 772. 00 772. 00 772. 00 772. 00 772. 00 773. 00		0			0		
72.00		0			0		
91.00 09100 EMERGENCY 0 124,760 0 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92.00 93.00 04950 WOODLAWN MEDI CAL PROFESSI ONALS 0 262,535 0 0 0 29,369 93.00 93.01 04951 SHAFER MEDI CAL CENTER 0 0 0 0 0 59,107 93.01 SPECIAL PURPOSE COST CENTERS		0	C	0	0	0	
91. 00		0	C	0	0	0	73. 00
92. 00			124 7/0		ما	0	01 00
93. 00		0	124, 760	٥	U	Ü	
93. 01 04951 SHAFER MEDI CAL CENTER 0 0 0 0 59, 107 93. 01		0	262, 535	o 0	0	29, 369	
113. 00 118. 00 119. 0		0		1	0		
118. 00							
NONRET MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00			2 112 145	0.002	10 (41	1/2 7/2	
190. 00 1900 GIFT FLOWER COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 192. 00 192.00 192.00 192.00 192.01 1920 FCMC 0 0 0 0 0 192. 01 192. 01 1920 192.02 1920		l ol	2, 113, 145	0 8, 802	19, 641	163, 763	118.00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES		0	C	0	O	0	190. 00
192. 02 19202 ARGOS MEDICAL CENTER 0 0 0 95, 087 0 192. 02 19203 19203 AKRON MEDICAL CENTER 0 0 0 39, 335 0 0 192. 03 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	192.00 19200 PHYSICIANS PRIVATE OFFICES	0	11, 131	0	0	0	192. 00
192. 03		1	C	0	0		
193. 00 19300 NONPAI D WORKERS		0	C	0	95, 087		
194. 00 07950 ADVERTISING 0 5, 651 0 0 194. 00 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00				39, 335	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00			5. 651	í	0		
			2, 30 .				200. 00
202.00 TOTAL (sum lines 118 through 201) 0 2,129,927 48,137 114,728 163,763 202.00			C	0	О		
	202.00 TOTAL (sum lines 118 through 201)	0	2, 129, 927	' 48, 137	114, 728	163, 763	202. 00

			10	0 12/31/2019	Date/lime Pre 5/13/2020 4:3	
Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	J PIII
oost contor boson per on		BENEFITS	& GENERAL	PLANT	LINEN SERVICE	
		DEPARTMENT				
	2A	4. 00	5. 00	7. 00	8. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 02 00102 AKRON BUI LDI NG						1. 02
1. 03 00103 ARGOS BUI LDI NG						1. 03
1. 04 00101 CLAYS BUI LDI NG						1. 04
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	C				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	247, 679	C	247, 679			5. 00
7.00 00700 OPERATION OF PLANT	253, 266	C	19, 228	272, 494		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	6, 298	C	851	1, 013	8, 162	8. 00
9. 00 00900 HOUSEKEEPI NG	23, 273	C	3, 928	3, 686	639	9. 00
10. 00 01000 DI ETARY	38, 111	C	.,	6, 127	130	10.00
11. 00 01100 CAFETERI A	62, 713	C	2, 650	10, 083	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	51, 316	C	4, 427	8, 250	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	C	0	0	0	14.00
15. 00 01500 PHARMACY	26, 885	C	27, 714	4, 322	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	65, 290	C	6, 787	5, 017	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	287, 064	C	17, 808	46, 151	1, 330	30.00
31.00 03100 INTENSIVE CARE UNIT	41, 346	C	4, 224	6, 647	144	31.00
43. 00 04300 NURSERY	3, 767	C	1, 409	606	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	159, 922	C	13, 625	25, 711	1, 253	50.00
51.00 05100 RECOVERY ROOM	99, 397	C	3, 930	15, 980	534	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 564	C	2, 113	5, 396	0	52.00
53. 00 05300 ANESTHESI OLOGY	2, 664	C	346	428	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	233, 100	C	18, 814	37, 476	1, 435	54.00
60. 00 06000 LABORATORY	50, 764	C	16, 139	8, 161	0	60.00
65. 00 06500 RESPIRATORY THERAPY	75, 843	C	8, 992	11, 652	782	65.00
66. 00 06600 PHYSI CAL THERAPY	67, 318	C	6, 312	10, 823	235	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	2, 022	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	C	695	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	o o	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	4, 579	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS	•		•			
91. 00 09100 EMERGENCY	124, 760	C	14, 486	20, 058	1, 680	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	291, 904	C	15, 686	42, 208	0	93.00
93. 01 04951 SHAFER MEDICAL CENTER	59, 107	C	10, 302	0	0	93. 01
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 305, 351	C	208, 945	269, 795	8, 162	118. 00
NONREI MBURSABLE COST CENTERS	•					
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	C	0	0	0	190. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	11, 131	C	65	1, 790	0	192. 00
192. 01 19201 FCMC	0	C	16, 688	0	0	192. 01
192. 02 19202 ARGOS MEDICAL CENTER	95, 087	C	14, 471	0	0	192. 02
192.03 19203 AKRON MEDICAL CENTER	39, 335	C	5, 539	0	0	192. 03
193.00 19300 NONPALD WORKERS	0	C		O		193. 00
194. 00 07950 ADVERTI SI NG	5, 651	C	1, 971	909	0	194. 00
200.00 Cross Foot Adjustments	0		1			200. 00
201.00 Negative Cost Centers	O	C	o o	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 456, 555	C	247, 679	272, 494	8, 162	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1313

				Ť	o 12/31/2019	Date/Time Pre 5/13/2020 4:3	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	5 pili
		9. 00	10.00	11. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.02	00102 AKRON BUILDING						1. 02
1.03	00103 ARGOS BUILDING						1. 03
1.04	00101 CLAYS BUILDING						1. 04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	31, 526					9. 00
10. 00	01000 DI ETARY	115	46, 361				10. 00
11. 00	01100 CAFETERI A	531	0	75, 977			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	77	0	3, 182		_	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15.00	01500 PHARMACY	406	0	2, 311	0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	249	0	5, 496	1, 401	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7.//0	20. 25.4	11 274	40.200	0	20.00
30.00	03000 ADULTS & PEDI ATRI CS	7, 660	38, 354	11, 374		0	
31. 00 43. 00	03100 I NTENSI VE CARE UNI T 04300 NURSERY	1, 930 0	8, 007	4, 274		0	
43.00	ANCI LLARY SERVI CE COST CENTERS	U U	0	715	0	U	43. 00
50. 00	05000 OPERATING ROOM	3, 692	0	7, 386	O	0	50. 00
51.00	05100 RECOVERY ROOM	2, 583	0	2, 172		0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2,303	0	987	0	0	
53. 00	05300 ANESTHESI OLOGY	0	o	707		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 051	Ö	9, 833	0	0	54. 00
60.00	06000 LABORATORY	992	Ö	6, 277	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	1, 156	Ö	4, 870	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	650	Ö	3, 152	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	o	1, 023	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	o	311	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	o	C	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	C	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	C	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	3, 495	0	5, 287	7, 651	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	2, 200	0	7, 052		0	
93. 01	04951 SHAFER MEDI CAL CENTER	2, 628	0	C	0	0	93. 01
	SPECIAL PURPOSE COST CENTERS				,		
	11300 INTEREST EXPENSE						113. 00
118.00	122 2 2 (22 2 2 2 2 2 2 2 2 2 2 2 2 2 2	31, 415	46, 361	75, 702	67, 252	0	118. 00
400.00	NONREI MBURSABLE COST CENTERS	0.0	ما				100.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	83	0	O			190. 00 192. 00
	19200 PHYSICIANS PRIVATE OFFICES 19201 FCMC	0		0			192. 00
	19201 FCMC 219202 ARGOS MEDICAL CENTER		0	0			192. 01
	19202 ARGOS MEDICAL CENTER 19203 AKRON MEDICAL CENTER		0	0			192. 02
	19203 ARRON MEDICAL CENTER 19300 NONPALD WORKERS		0	C			192. 03
	07950 ADVERTI SI NG	28	0	275			194. 00
200.00		20	٥	2/3	١	0	200. 00
200.00				0	٨	0	201. 00
202.00		31, 526	46, 361	75, 977	67, 252		202. 00
202.00	1.5 (3diii 111165 116 tiii 6dgii 201)	31, 320	10, 501	, 5, 711	37, 202	O	1-02.00

Heal th	Financial Systems	WOODLAWN H	OSPI TAL		In Lieu	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der CC		eriod: rom 01/01/2019 o 12/31/2019	Worksheet B Part II Date/Time Pre 5/13/2020 4:3	pared:
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	5 piii
		15. 00	16. 00	24. 00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS						
	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						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY	61, 638					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	84, 240				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	4, 058	463, 188	0	463, 188	30.00
	03100 INTENSIVE CARE UNIT	0	965	76, 348	0	76, 348	31. 00
43.00	04300 NURSERY	0	153	6, 650	0	6, 650	43. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	9, 482	221, 071	0	221, 071	50. 00
	05100 RECOVERY ROOM	0	1, 070	125, 666	0	125, 666	1
	05200 DELIVERY ROOM & LABOR ROOM	0	166	42, 226	0	42, 226	
	05300 ANESTHESI OLOGY	0	1, 240	4, 678	0	4, 678	1
	05400 RADI OLOGY-DI AGNOSTI C	0	19, 190	322, 899	0	322, 899	1
	06000 LABORATORY	0	15, 954	98, 287	0	98, 287	60.00
	06500 RESPI RATORY THERAPY	0	5, 416	108, 711	0	108, 711	65. 00
	06600 PHYSI CAL THERAPY	0	1, 638	90, 128	0	90, 128	1
	06700 OCCUPATIONAL THERAPY	0	715 298	3, 760	0	3, 760	1
	06800 SPEECH PATHOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	290	1, 304 0	0	1, 304 0	68. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 275	5, 854	0	5, 854	71.00
	07300 DRUGS CHARGED TO PATIENTS	61, 638	16, 042	77, 680	0	77, 680	1
73.00	OUTPATIENT SERVICE COST CENTERS	01,030	10, 042	77,000	<u> </u>	77,000	73.00
91. 00	09100 EMERGENCY	0	4, 111	181, 528	0	181, 528	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		.,	101, 020	ő	101, 020	92. 00
	04950 WOODLAWN MEDICAL PROFESSIONALS	0	1, 154	360, 204	o	360, 204	93. 00
	04951 SHAFER MEDICAL CENTER	o	1, 313	73, 350	o	73, 350	1
	SPECIAL PURPOSE COST CENTERS	-	,	-,	- 1	.,	
	11300 NTEREST EXPENSE						113. 00
118. 00	l	61, 638	84, 240	2, 263, 532	0	2, 263, 532	118. 00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	83	0	83	190. 00
192.00	19200 PHYSICIANS PRIVATE OFFICES	0	o	12, 986	o	12, 986	192. 00
192.01	19201 FCMC	0	0	16, 688	0	16, 688	192. 01
	19202 ARGOS MEDICAL CENTER	0	0	109, 558	O	109, 558	
	19203 AKRON MEDICAL CENTER	0	0	44, 874	0	44, 874	
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 ADVERTI SI NG	0	0	8, 834	0		194. 00
200.00				0	0		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	61, 638	84, 240	2, 456, 555	0	2, 456, 555	202. 00

WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1313 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 5/13/2020 4:35 pm CAPITAL RELATED COSTS AKRON BUILDING ARGOS BUILDING CLAYS BUILDING BLDG & FIXT **EMPLOYEE** Cost Center Description (SQUARE FEET) **BENEFITS** (SQUARE FEET) (SQUARE FEET) (SQUARE FEET) DEPARTMENT (GROSS SALARI ES) 1.00 1. 02 1.03 1. 04 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 111, 942 1 00 1.02 00102 AKRON BUILDING 3, 500 1.02 1.03 00103 ARGOS BUILDING 0 7,500 1.03 00101 CLAYS BUILDING 0 1 04 1 04 20.414 r C 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 0 20, 454, 313 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 12, 239 400 600 16 3, 181, 398 5.00 7.00 00700 OPERATION OF PLANT 240 370, 957 7.00 10.624 684 4.657 00800 LAUNDRY & LINEN SERVICE 14, 818 8 00 331 C 0 0 8 00 9.00 00900 HOUSEKEEPI NG 1, 205 C 0 43 373, 898 9.00 01000 DI ETARY 10.00 2,003 0 0 0 152, 484 10.00 01100 CAFETERI A 250, 914 11.00 3.296 0 0 11.00 0 01300 NURSING ADMINISTRATION 0 13.00 2,697 Ω 0 180, 191 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 14.00 0 398, 093 01500 PHARMACY 15.00 1.413 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 4, 249 624, 376 16.00 1,640 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 15, 087 1, 729, 996 30.00 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 173 C 0 0 533, 780 31.00 04300 NURSERY 198 0 0 146, 762 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 8,405 737, 523 50.00 05100 RECOVERY ROOM 5, 224 0 0 0 342, 500 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 764 0 0 o 52.00 202, 827 52.00 53.00 05300 ANESTHESI OLOGY 140 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 12, 251 1, 706, 544 54.00 o 60.00 06000 LABORATORY 0 0 919, 294 60.00 2.668 06500 RESPIRATORY THERAPY 65.00 3.809 C 0 420 991, 670 65.00 06600 PHYSI CAL THERAPY 66.00 3,538 0 712, 830 66,00 0 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 246, 121 67.00 06800 SPEECH PATHOLOGY 0 0 68 00 0 C 82,804 68.00 71.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 6.557 0 0 0 1, 551, 939 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93 00 13 798 C 0 3 661 772, 772 93 00 04951 SHAFER MEDICAL CENTER 93.01 0 7, 368 543, 959 93.01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 111,060 640 1, 284 20, 414 16, 768, 450 118. 00 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190. 00 0 0 192. 00 19200 PHYSICIANS PRIVATE OFFICES 0 585 0 0 0 192. 00 1, 527, 174 192. 01 192. 01 19201 FCMC 0 Ω 0 192. 02 19202 ARGOS MEDICAL CENTER 0 6, 216 0 1, 552, 791 192. 02 192. 03 19203 AKRON MEDICAL CENTER 0 0 549, 793 192. 03 2,860 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 0 194. 00|07950| ADVERTI SI NG 297 0 0 56, 105 194, 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201 00 2, 129, 927 163, 763 4, 087, 588 202. 00 202.00 Cost to be allocated (per Wkst. B, 48, 137 114, 728 Part I) 0. 199840 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 19.027059 13.753429 15. 297067 8.022093 204.00 Cost to be allocated (per Wkst. B, 0 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 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,

Parts III and IV)

207.00

| Peri od: | Worksheet B-1 | To | 12/31/2019 | T Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1313

				T	rom 01/01/2019 o 12/31/2019	Date/Time Pre 5/13/2020 4:3	
	Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPI NG (HOURS OF S ERVI C)	
		5A	5. 00	7. 00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS		ı				1 00
1. 00 1. 02	OO100 CAP REL COSTS-BLDG & FLXT OO102 AKRON BUILDING						1. 00 1. 02
1. 02	00103 ARGOS BUILDING						1. 02
1. 04	00101 CLAYS BUILDING						1. 04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-6, 943, 775					5. 00
7. 00	00700 OPERATION OF PLANT	0	3, 293, 064				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	145, 691	331		110 004	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	672, 651 321, 634			112, 224 410	1
11. 00	01100 CAFETERI A	0	453, 893			1, 890	1
13. 00	01300 NURSING ADMINISTRATION	Ö	758, 194		0	275	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	0	4, 744, 174			1, 445	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	1, 162, 390	1, 640	0	885	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	3, 049, 804	15, 087	481	27, 270	30. 00
31. 00	03100 NTENSI VE CARE UNIT	0	723, 364			6, 870	
43. 00	04300 NURSERY	Ö				0,070	1
	ANCILLARY SERVICE COST CENTERS		· ·				1
50.00	05000 OPERATING ROOM	0	_, _,			13, 143	1
51.00	05100 RECOVERY ROOM	0	673, 075			9, 195	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	361, 959			0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	59, 204 3, 222, 207	1	0 519	0 10, 860	
60.00	06000 LABORATORY	0	2, 764, 050			3, 530	1
65. 00	06500 RESPI RATORY THERAPY	Ö	1, 540, 021			4, 115	1
66.00	06600 PHYSI CAL THERAPY	0	1, 080, 949	3, 538	85	2, 315	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	346, 235			0	1
68. 00	06800 SPEECH PATHOLOGY	0	119, 079			0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1		0	
72.00	07300 DRUGS CHARGED TO PATIENTS	0	784, 277 0			0	
70.00	OUTPATIENT SERVICE COST CENTERS				<u> </u>	0	70.00
91.00	09100 EMERGENCY	0	2, 480, 840	6, 557	608	12, 440	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 00	04950 WOODLAWN MEDICAL PROFESSIONALS	0	_, -,,			7, 830	1
93. 01	04951 SHAFER MEDICAL CENTER SPECIAL PURPOSE COST CENTERS	0	1, 764, 288	0	0	9, 355	93. 01
113.00	11300 I NTEREST EXPENSE			I			113. 00
118.00	l l	-6, 943, 775	35, 782, 315	88, 197	2, 952	111, 828	1
	NONREI MBURSABLE COST CENTERS			,			
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0					190.00
	19200 PHYSICIANS PRIVATE OFFICES 19201 FCMC	0					192. 00 192. 01
	19202 ARGOS MEDICAL CENTER	0					192. 01
	19203 AKRON MEDICAL CENTER	Ö	948, 663				192. 03
	19300 NONPAI D WORKERS	0	0	Ō			193. 00
	07950 ADVERTI SI NG	0	337, 619	297	0	101	194. 00
200.00							200. 00
201.00			/ 042 775	2 022 1/2	102 702	0.40, 000	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)		6, 943, 775	3, 832, 162	183, 782	848, 989	202.00
203.00			0. 163707	43. 019814	62. 256775	7. 565129	203. 00
204.00			247, 679				204. 00
	Part II)						
205.00			0. 005839	3. 059015	2. 764905	0. 280920	205. 00
206.00							206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00

	ncial Systems	WOODLAWN HO		CN: 15 1212 D		Workshoot R 1	
COST ALLOCA	NTION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2019 o 12/31/2019	Worksheet B-1 Date/Time Pre 5/13/2020 4:3	pared:
	Cost Center Description	DIETARY (PATIENT DA YS)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI ON	SUPPLY	PHARMACY (COSTED REQUIS.)	
				(DI RECT NRS I NG HR)	(COSTED REQUIS.)		
		10.00	11. 00	13. 00	14. 00	15. 00	
	RAL SERVICE COST CENTERS	T					
	O CAP REL COSTS-BLDG & FIXT 2 AKRON BUILDING						1. 00 1. 02
	3 ARGOS BUILDING						1. 02
	1 CLAYS BUILDING						1. 04
	O EMPLOYEE BENEFITS DEPARTMENT						4. 00
	O ADMINISTRATIVE & GENERAL						5. 00
	O OPERATION OF PLANT O LAUNDRY & LINEN SERVICE						7. 00 8. 00
	O HOUSEKEEPI NG						9. 00
	O DI ETARY	3, 173					10. 00
	O CAFETERI A	0	22, 949				11.00
	O NURSING ADMINISTRATION O CENTRAL SERVICES & SUPPLY		961 0		3, 059, 798		13. 00 14. 00
	O PHARMACY	0	698	′I "I	2, 696	100	1
	O MEDICAL RECORDS & LIBRARY	0	1, 660	1, 095	3, 379	0	16. 00
	TIENT ROUTINE SERVICE COST CENTERS	0 (05	2 42/	20 (00	00.450	_	
	O ADULTS & PEDIATRICS O INTENSIVE CARE UNIT	2, 625 548	3, 436 1, 291		90, 158 28, 688	0	
	O NURSERY	0	216		20, 000	Ö	
	LLARY SERVICE COST CENTERS						1
	O OPERATING ROOM	0	2, 231	1	840, 848	0	
	O RECOVERY ROOM O DELIVERY ROOM & LABOR ROOM	0	656 298		54, 162 0	0	
	O ANESTHESI OLOGY		0		25, 356	0	1
	O RADI OLOGY-DI AGNOSTI C	0	2, 970	o	164, 112	0	54.00
	O LABORATORY	0	1, 896	1	0	0	60.00
	O RESPI RATORY THERAPY O PHYSI CAL THERAPY	0	1, 471 952		23, 836 8, 192	0	65. 00 66. 00
	O OCCUPATIONAL THERAPY		309	1	113	0	1
68. 00 0680	O SPEECH PATHOLOGY	0	94	1	14	0	68. 00
	O MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
	O IMPL. DEV. CHARGED TO PATIENTS O DRUGS CHARGED TO PATIENTS	0	0	1	784, 277 0	0 100	
	ATIENT SERVICE COST CENTERS	٥		<i>γ</i> Ο	0	100	73.00
91. 00 0910	O EMERGENCY	0	1, 597	5, 980	80, 655	0	
	O OBSERVATION BEDS (NON-DISTINCT PART		0.400		440.440		92.00
	O WOODLAWN MEDICAL PROFESSIONALS 1 SHAFER MEDICAL CENTER	0	2, 130 0		448, 169 104, 818	0	
	TAL PURPOSE COST CENTERS	٩		ή σ	104, 010		75.01
	O I NTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 173	22, 866	52, 561	2, 659, 473	100	118. 00
	EIMBURSABLE COST CENTERS OGIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	O PHYSICIANS PRIVATE OFFICES	Ö	0	o	0		192. 00
192. 01 1920		0	0	0	243, 044		192. 01
	2 ARGOS MEDICAL CENTER	0	0	0	116, 761		192. 02
	3 AKRON MEDICAL CENTER 0 NONPAID WORKERS		0		40, 178 0		192. 03 193. 00
	O ADVERTI SI NG	o	83	1	342		194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	466, 485	684, 289	1, 029, 075	0	5, 613, 340	201. 00
202.00	Part I)	400, 465	004, 209	1,029,075	O	5, 013, 340	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	147. 017019	29. 817813	19. 578680	0. 000000	56, 133. 400000	203. 00
204. 00	Cost to be allocated (per Wkst. B,	46, 361	75, 977	67, 252	0	61, 638	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	14. 611094	3. 310689	1. 279504	0. 000000	616. 380000	205 00
200.00	II)	11.011074	5. 510007	1.277304	3. 000000	515. 300000	
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	profes ili anu iv)	ı		1		I	I

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1313 Period: From 01/01/2019 Worksheet B-1

MEDICAL INCOME	COST A	LLUCATION - STATISTICAL BASIS		Provider CCN: 15-1313	From 01/01/2019 To 12/31/2019	Date/Time Prepared:
0.00 001000 CAP REL COSTS - BLDG & FIXT		Cost Center Description	RECORDS & LI BRARY (GROSS CHARGES)			5/13/2020 4:35 pm
1.02 00102 ARRON BUILDING						
1.03 00103 ARGOS BULLDING 1.04 1.0						1.00
1.04						1. 02
4.00 00400 IMPLOYEE BENEFITS DEPARTMENT						1. 03
0.000 0.000 D.O. D.O. D.O.	1.04	00101 CLAYS BUILDING				1. 04
7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 CAUNDRY & LINES SERVICE 8.00 00800 DISERCEPTING 9.00 11.00						4. 00
8.00 00800 LAINDRY & LINEN SERVICE 9.00 9.00 00900 DISTARY 11.00 01.00						
9.00 000000						
10.00 10000 DETARY						
11.00 0100 CAFETRIA						
13.00 01300 MURSINK ADMINISTRATION 11.00 11.		l				
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 15.00 15.00 16.00 MEDICAL RECORDS & LIBRARY 129, 338, 610 16.00 MEDICAL RECORDS & LIBRARY 129, 338, 610 16.00 MEDICAL RECORDS & LIBRARY 129, 338, 610 30.00 30.00 3000 3000 MURSIS VE CASE UNIT 1, 482, 108 31.00 31						
15.0 0 1500 PHARMACY 129, 338, 610 16.00 1600 MPATE ENT RECORDS & LIBRARY 129, 338, 610 30.00 30.00 30.00 ADULTS & PEDIATRICS 30.00 31.00 30.00 ADULTS & PEDIATRICS 31.00						
16. 00						
INPATI ENT ROUTINE SERVICE COST CENTERS 33.008 33.00 31.00 03100 ADULTS & PEDIATRICS 6,233,408 31.00 31.00 03100 INTERSI VE CARE UNIT 1,482,108 31.00 31.00 03100 INTERSI VE CARE UNIT 1,482,108 31.00 31.00 30.00 INSERY 234,591 34.501 31.00 30.00 INTERSI VE CARE UNIT 1,482,591 34.501 31.00 30.00 0500 OPERATI ING ROOM 1,45.64,706 51.00 5		l e e e e e e e e e e e e e e e e e e e	129 338 610			
30.00 3000 ADULTS & PEDIATRICS 6, 233, 408 31.00 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 30.00 31.00 3	10.00		127, 330, 010			10.00
31.00 03100 INTERSIVE CARE UNIT	30.00		6, 233, 408			30.00
ANCILLARY SERVICE COST CENTERS 50.00						
50.00 GSGOOQ OPERATING ROOM	43.00	04300 NURSERY	234, 591			43. 00
51.00 05100 RECOVERY ROOM		ANCILLARY SERVICE COST CENTERS				
S2 00 OS200 OS200 OS200 OS200 OS200 SELVERY ROOM & LABOR ROOM 255, 091 52, 00 54, 00 05400 RADIO LOCY-DI ACNOSTIC 29, 418, 946 54, 00 60.00 60.00 06.000 LABORATORY 24, 506, 356 60.00 66.00		l	14, 564, 706			
53.00 05300 ANESTHESI OLOGY 1,904,402 53.00 60.00 ADDIOLOGY—DIACNOSTIC 29,418,946 54.00 60.00 60.00 ADDIOLOGY—DIACNOSTIC 24,506,356 60.00 60.00 60.00 RESPIRATORY THERAPY 2,515,689 66.00 60.00 60.00 RESPIRATORY THERAPY 2,515,689 66.00 60.00 60.00 60.00 RESPIRATORY THERAPY 2,515,689 66.00 60.00 60.00 60.00 RESPIRATORY THERAPY 1,098,461 67.00 67.00 60.00 60.00 RESPIRATORY THERAPY 2,515,689 67.00 60.00 60.00 60.00 RESPIRATORY THERAPY 1,098,461 68.00 60.00 60.00 FRECH PATHOLOGY 457,191 68.00 60.00 60.00 RESPIRATORY CHARGED TO PATIENT 68.00 60.00 60.00 RESPIRATORY CHARGED TO PATIENTS 1,958,722 72.00 73.00		l				
54. 00 05400 RADIOLOGY-DIAGNOSTIC 29, 418, 946 60. 00 0600 LABORATORY 24, 506, 356 60. 00 06500 RESPIRATORY THERAPY 8, 319, 244 65. 00 06600 PHYSI CAL THERAPY 2, 515, 689 66. 00 06700 DRUST CHARGED TO PATIENT 0, 99, 461 67. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0, 99, 461 67. 00 07200 MEDICAL SUPPLIES CHARGED TO PATIENT 0, 971. 00 07200 MEDICAL SUPPLIES CHARGED TO PATIENT 0, 98, 461 71. 00 71. 00 07200 MEDICAL SUPPLIES CHARGED TO PATIENT 0, 98, 722 72. 00 07200 MEDICAL SUPPLIES CHARGED TO PATIENT 0, 98, 722 72. 00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 24, 641, 409 73. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 73. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 73. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 0000 0000 PRUSS CHARGED TO PATIENTS 24, 641, 409 91. 00 00000 0000 0000 0000 0000 00000 00000 00000 0000 0000 00000 00000 00000 00000 00000 00000 00000 00						
60. 00 0.0000 LABORATORY 24,506,356 65. 00 0.00 0.000 CASPIRATORY THERAPY 8,319,264 65. 00 0.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000						
65. 00 0.6500 RESPIRATORY THERAPY 8. 319			· · · · · · · · · · · · · · · · · · ·			
66.00 06600 PHYSI CAL THERAPY 2,515,689 66.00 067.00 06700 0CCUPATIONAL THERAPY 1,098,461 67.00 68.00 06800 SPECH PATHOLOGY 457,191 0 71.00 07100 MID CAL SUPPLIES CHARGED TO PATIENTS 0,98,472 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,958,722 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 24,641,409 73.00 07300 DRUGS CHARGED TO PATIENTS 24,641,409 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 07300						
67.00 0670		<u> </u>				
68. 00 06800 SPECH PATHOLOGY 457,191 0 71.00 71.		<u> </u>	· · · · · · · · · · · · · · · · · · ·			
72. 00 07300 IMPL DEV CHARGED TO PATIENTS 1,958,722 24,641,409 73. 00 07300 DRUGS CHARGED TO PATIENTS 24,641,409 73. 00 07300 DRUGS CHARGED TO PATIENTS 24,641,409 73. 00 07300 DRUGS CHARGED TO PATIENTS 24,641,409 73. 00 07300						
73.00 07300 DRUGS CHARGED TO PATIENTS 24, 641, 409 00TPATIENT SERVICE COST CENTERS 91.00 09000 EMERGENCY 92.00 09200 095ERVATI ON BEDS (NON-DISTINCT PART 93.00 04950 WODLAWN MEDICAL PROFESSIONALS 1,772,777 93.00 04951 SHAFER MEDICAL CENTER 2,017,075 93.01 04951 SHAFER MEDICAL CENTER 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 118.00 NONREI MEURSABLE COST CENTERS 118.00 NONREI MEURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 192.01	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71. 00
OUTPATIENT SERVICE COST CENTERS 91.00			1, 958, 722			
91.00 09100 EMERGENCY 6, 315, 152 91.00 92.00 092000 092			24, 641, 409			73. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 93. 00 04950 000DLAWN MEDI CAL PROFESSI ONALS 1,772,777 93. 00 04951 SHAFER MEDI CAL CENTER 2,017,075 93. 01 04951 SHAFER MEDI CAL CENTER 2,017,075 93. 01 04951 SHAFER MEDI CAL CENTER 2,017,075 93. 01 04951 SHAFER MEDI CAL CENTER 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 O 01000 O O 01000 O O 01000 O O O 01000 O O O O O O O O O						
93. 01 04950 MODDLAWN MEDICAL PROFESSIONALS 1,772,777 93. 01			6, 315, 152			
93. 01			1 772 777			
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 129,338,610 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 19201 FCMC 0 192.01						
113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 129,338,610 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 192.00 192.00 192.01 192.01 FCMC 0 192.01 192.01 FCMC 0 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.01 192.02 192.02 ARGOS MEDICAL CENTER 0 192.02 192.03 192.03 AKRON MEDICAL CENTER 0 192.03 193.00 193.00 NONPAI D WORKERS 0 193.00 193.00 NONPAI D WORKERS 0 193.00 193.00 193.00 193.00 Nonpai D Workers 0 194.00 190.00			2/01//010			76. 51
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 192.00 19200						113. 00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 192. 00 19200 PHYSI CI ANS PRI VATE OFFICES 0 192. 00 19201 19201 FCMC 0 192. 01 19201 PCMC PCMC 0 192. 01 192. 01 19201 PCMC PCMC 0 192. 01	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	129, 338, 610			118. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.01 19201 FCMC 0 192.01 19201 19202 19202 ARGOS MEDICAL CENTER 0 192.02 19203 ARRON MEDICAL CENTER 0 192.03 19203 ARRON MEDICAL CENTER 0 192.03 19300 NONPAID WORKERS 0 193.00 19300 ADVERTISING 0 193.00 200.00 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 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00						
192.01 19201 FCMC 0 19202 19202 19202 19202 ARGOS MEDICAL CENTER 0 192.02 19203 19203 AKRON MEDICAL CENTER 0 192.03 19203 AKRON MEDICAL CENTER 0 192.03 192.03 NONPAID WORKERS 0 193.00 193.00 NONPAID WORKERS 0 194.00 07950 ADVERTISING 0 194.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) 0.011604 203.00 Cost to be allocated (per Wkst. B, Part II) 0.011604 203.00 Unit cost multiplier (Wkst. B, Part II) 0.000651 11) NAHE adjustment amount to be allocated (per Wkst. B, Part II) 0.000651 205.00 NAHE unit cost multiplier (Wkst. B, Part II) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part III) 0.000651 207.00 NAHE unit cost multiplier (Wkst. B, Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII						
192. 02 192.02 19202 ARGOS MEDICAL CENTER 0 192.03 19203 AKRON MEDICAL CENTER 0 192.03 193.00 19300 NONPAI D WORKERS 0 193.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		l				
192.03 19203 AKRON MEDICAL CENTER 193.00 193.00 19300 NONPAID WORKERS 0 194.00 1950 ADVERTISING 0 194.00 200.00 201.00 202.00 203.00 204.00 205.00 205.00 206.00 207.00 207.00 207.00 208.00 209.00		<u> </u>	0			
193.00 19300 NONPAID WORKERS 194.00 07950 ADVERTISING 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) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		<u> </u>	0			
194. 00 07950 ADVERTISING 0 194. 00 200. 00 Cross Foot Adjustments 200. 00 Negative Cost Centers 201. 00 Cost to be allocated (per Wkst. B, Part I) 0. 011604 203. 00 Unit cost multiplier (Wkst. B, Part II) 205. 00 Unit cost multiplier (Wkst. B, Part II) 0. 000651 II) 206. 00 NAHE adjustment amount to be allocated (per Wkst. B, 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 NAHE unit cost multiplier (Wkst. D, 207. 00 September 20 Sept			0			
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 200.00 201.00 201.00 202.00 202.00 203.00 0.011604 203.00 204.00 204.00 205.00 0.000651			Ö			
201.00 202.00 Negative Cost Centers 201.00		<u> </u>				
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 III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	201.00					
203.00 Unit cost multiplier (Wkst. B, Part I) 0.011604 204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	202.00		1, 500, 865			202. 00
204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.0						
Part II) Unit cost multiplier (Wkst. B, Part 0.000651 11) 205.00			l .			
205.00 Unit cost multiplier (Wkst. B, Part 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	204. 00		84, 240			204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00	205 00	,	0 000651			205 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	∠∪3. ∪∪		0. 000001			203.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00	206. 00					206. 00
		(per Wkst. B-2)				
Parts III and IV)	207. 00					207. 00
		Parts III and IV)				

Health Financial Systems	WOODLAWN HOSPITA	AL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Pro	ovider CCN: 15-1313	Peri od:	Worksheet C

From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 5/13/2020 4:35 pm Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 2.00 3.00 4. 00 5. 00 1.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 5, 750, 804 5, 750, 804 30 00 0 Ω 31.00 03100 INTENSIVE CARE UNIT 1, 261, 552 1, 261, 552 0 0 31.00 04300 NURSERY 298, 586 o 43.00 43.00 298, 586 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 3, 440, 132 3, 440, 132 0 0 51.00 05100 RECOVERY ROOM 1, 128, 203 1, 128, 203 0 0 0 0 0 0 0 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 508, 947 508, 947 52.00 97, 018 97, 018 53.00 05300 ANESTHESI OLOGY Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 821, 166 4, 821, 166 0 54.00 60.00 06000 LABORATORY 3, 698, 933 3, 698, 933 60.00 65.00 06500 RESPIRATORY THERAPY 2, 145, 144 2, 145, 144 0 65.00 1, 490, 496 06600 PHYSI CAL THERAPY 0 1, 490, 496 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 424, 877 424, 877 0 67.00 06800 SPEECH PATHOLOGY 68.00 146, 681 146, 681 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 935, 398 935, 398 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 899, 279 5, 899, 279 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 3, 538, 995 3, 538, 995 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 1, 547, 573 1, 547, 573 0 92.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.00 93.00 3, 863, 192 3, 863, 192 0 0 93 01 04951 SHAFER MEDICAL CENTER 2, 147, 292 2, 147, 292 0 Ω 93.01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 0 200. 00 200.00 Subtotal (see instructions) 43, 144, 268 0 43, 144, 268 ol 1, 547, 573 201.00 Less Observation Beds 1, 547, 573 0 201. 00 202.00 Total (see instructions) 41, 596, 695 0 41, 596, 695 0 0 202. 00

Health Financial Systems

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

			Title	: XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	•	+ col. 7)	Ratio	I npati ent	
				,		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 101, 836		3, 101, 836			30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 482, 108		1, 482, 108			31.00
43.00	04300 NURSERY	234, 591		234, 591			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 258, 671	10, 306, 035	14, 564, 706	0. 236196	0.000000	50.00
51.00	05100 RECOVERY ROOM	415, 566	1, 227, 696	1, 643, 262	0. 686563	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	177, 805	77, 286	255, 091	1. 995159	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	309, 287	1, 595, 115	1, 904, 402	0. 050944	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 231, 401	28, 187, 545	29, 418, 946	0. 163880	0.000000	54.00
60.00	06000 LABORATORY	2, 818, 943	21, 687, 413	24, 506, 356	0. 150938	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	2, 026, 471	6, 292, 793	8, 319, 264	0. 257853	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	415, 821	2, 099, 868	2, 515, 689	0. 592480	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	167, 001	931, 460	1, 098, 461	0. 386793	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	22, 691	434, 500	457, 191	0. 320831	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 416, 081	542, 641	1, 958, 722	0. 477555	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 349, 867	21, 291, 542	24, 641, 409	0. 239405	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	223, 621	6, 091, 531	6, 315, 152	0. 560397	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	421, 764	2, 709, 808	3, 131, 572	0. 494184	0.000000	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	0	1, 772, 777	1, 772, 777	2. 179175	0.000000	93.00
93. 01	04951 SHAFER MEDICAL CENTER	500	2, 016, 575	2, 017, 075	1. 064557	0.000000	93. 01
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	22, 074, 025	107, 264, 585	129, 338, 610			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	22, 074, 025	107, 264, 585	129, 338, 610			202. 00

Health Financial Systems	WOODLAWN HO	OSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1313	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 5/13/2020 4:3	pared: 5 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
I NPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30. 00

		II LI C XVIII	nospi tai	0031
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	0. 000000			93. 00
93. 01 04951 SHAFER MEDICAL CENTER	0. 000000			93. 01
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	WOODLAWN HOSP	PLTAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1313	Peri od:	Worksheet C

From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared: 5/13/2020 4:35 pm Title XIX Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 2.00 3.00 4. 00 5. 00 1.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 5, 750, 804 5, 750, 804 30 00 5, 750, 804 31.00 03100 INTENSIVE CARE UNIT 1, 261, 552 1, 261, 552 0 1, 261, 552 31.00 04300 NURSERY o 43.00 298, 586 298, 586 298, 586 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 440, 132 3, 440, 132 3, 440, 132 50.00 51.00 05100 RECOVERY ROOM 1, 128, 203 1, 128, 203 0 1, 128, 203 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 508, 947 508, 947 508, 947 52.00 97, 018 53.00 05300 ANESTHESI OLOGY 97,018 97, 018 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 821, 166 4, 821, 166 4, 821, 166 54.00 60.00 06000 LABORATORY 3, 698, 933 3, 698, 933 0 0 0 3, 698, 933 60.00 65.00 06500 RESPIRATORY THERAPY 2, 145, 144 2, 145, 144 2, 145, 144 65.00 1, 490, 496 06600 PHYSI CAL THERAPY 0 1, 490, 496 1, 490, 496 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 424, 877 424, 877 424, 877 67.00 06800 SPEECH PATHOLOGY 68.00 146, 681 146, 681 0 146, 681 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 71 00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 935, 398 935, 398 935, 398 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 899, 279 5, 899, 279 5, 899, 279 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 3, 538, 995 3, 538, 995 3, 538, 995 91 00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 547, 573 1, 547, 573 1, 547, 573 92.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.00 3, 863, 192 3, 863, 192 0 3, 863, 192 93.00 <u>2, 147,</u> 292 93 01 04951 SHAFER MEDICAL CENTER 2, 147, 292 2, 147, 292 93.01 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 43, 144, 268 0 43, 144, 268 ol 43, 144, 268 200. 00 1, 547, 573 201. 00 201.00 Less Observation Beds 1, 547, 573 1, 547, 573 202.00 Total (see instructions) 41, 596, 695 0 41, 596, 695 0 41, 596, 695 202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1313 Title XIX Hospi tal Cost

		_		CAIA	nospi tai	0031	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 101, 836		3, 101, 836			30. 00
31. 00	03100 INTENSIVE CARE UNIT	1, 482, 108		1, 482, 108			31. 00
43.00	04300 NURSERY	234, 591		234, 591			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 258, 671	10, 306, 035	14, 564, 706	0. 236196	0.000000	50. 00
51.00	05100 RECOVERY ROOM	415, 566	1, 227, 696	1, 643, 262	0. 686563	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	177, 805	77, 286	255, 091	1. 995159	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	309, 287	1, 595, 115	1, 904, 402	0. 050944	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 231, 401	28, 187, 545	29, 418, 946	0. 163880	0.000000	54.00
60.00	06000 LABORATORY	2, 818, 943	21, 687, 413	24, 506, 356	0. 150938	0.000000	60. 00
65.00	06500 RESPI RATORY THERAPY	2, 026, 471	6, 292, 793	8, 319, 264	0. 257853	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	415, 821	2, 099, 868	2, 515, 689	0. 592480	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	167, 001	931, 460	1, 098, 461	0. 386793	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	22, 691	434, 500	457, 191	0. 320831	0.000000	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	0. 000000	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 416, 081	542, 641	1, 958, 722	0. 477555	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 349, 867	21, 291, 542	24, 641, 409	0. 239405	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	223, 621	6, 091, 531	6, 315, 152	0. 560397	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	421, 764	2, 709, 808	3, 131, 572	0. 494184	0.000000	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	O	1, 772, 777	1, 772, 777	2. 179175	0.000000	93. 00
93. 01	04951 SHAFER MEDICAL CENTER	500	2, 016, 575	2, 017, 075	1. 064557	0.000000	93. 01
	SPECIAL PURPOSE COST CENTERS	,					
113.00	11300 I NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	22, 074, 025	107, 264, 585	129, 338, 610			200. 00
201.00							201. 00
202.00	Total (see instructions)	22, 074, 025	107, 264, 585	129, 338, 610			202. 00

Heal th	Financial Systems	WOODLAWN HO	OSPI TAL	In Lie	u of Form CMS-	2552-10
	TATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1313	Peri od: From 01/01/2019	Worksheet C	pared:
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31. 00	03100 INTENSIVE CARE UNIT					31.00
43.00	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50. 00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
60.00	06000 LABORATORY	0. 000000				60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000				65. 00

52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	54.00
60.00	06000 LABORATORY	0. 000000	60.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS		
91.00	09100 EMERGENCY	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	92. 00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	0. 000000	93. 00
93. 01	04951 SHAFER MEDICAL CENTER	0. 000000	93. 01
	SPECIAL PURPOSE COST CENTERS		
113.00	11300 I NTEREST EXPENSE		113. 00
200.00	Subtotal (see instructions)		200. 00
201.00	Less Observation Beds		201. 00
202.00	Total (see instructions)		202. 00

Health Financial Systems		WOODLAWN HOSE	PITAL		In Lieu of Form CMS-2552-10	
ADDODTIONMENT OF INDATIENT ANCILLARY	SEDVICE CADITAL	CUSTS	Provider CCN: 15-1313	Pari ad:	Workshoot D	

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider Co		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 5/13/2020 4:3	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	1,	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		T	T			
50. 00 05000 OPERATING ROOM	221, 071		l .		19, 469	
51. 00 05100 RECOVERY ROOM	125, 666		l .		8, 637	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	42, 226		l .			52. 00
53. 00 05300 ANESTHESI OLOGY	4, 678				210	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	322, 899		l .		5, 135	
60. 00 06000 LABORATORY	98, 287				4, 155	60.00
65. 00 06500 RESPI RATORY THERAPY	108, 711				11, 641	
66. 00 06600 PHYSI CAL THERAPY	90, 128	2, 515, 689	0. 03582	26 126, 078	4, 517	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 760	1, 098, 461	0.00342	43, 293	148	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 304	457, 191			31	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.00000	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 854	1, 958, 722	0. 00298	500, 590	1, 496	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	77, 680	24, 641, 409	0. 00315	1, 079, 045	3, 401	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	181, 528	6, 315, 152	0. 02874	5 21, 126	607	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	124, 646	3, 131, 572	0. 03980	48, 644	1, 936	92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	360, 204	1, 772, 777	0. 20318	86 0	0	93. 00
93. 01 04951 SHAFER MEDICAL CENTER	73, 350	2, 017, 075	0. 03636	5 207	8	93. 01
200.00 Total (lines 50 through 199)	1, 841, 992	124, 520, 075		5, 707, 061	61, 637	200.00

Health Financial Systems	WOODLAWN HOS	PITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1313	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2019	Part IV

THROUGH COSTS 12/31/2019 Date/Time Prepared: To 5/13/2020 4:35 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Post-Stepdown Anesthetist Post-Stepdown Cost Adjustments Adjustments 1.00 2.00 3. 00 2A 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 53. 00 | 05300 | ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 54.00 0 06000 LABORATORY 0 60.00 60.00 0 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS 0 73.00 0 0 73.00 91.00 09100 EMERGENCY 0 0 91.00 0 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 92.00 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 93. 00 0 0 0 93. 01 04951 SHAFER MEDICAL CENTER 0 0 93.01

0

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	WOODLAWN HOSP	PLTAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN	LLARY SERVICE OTHER PASS	Provider CCN: 15-1313	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2019	Part IV

TTIKOOO				-	Го 12/31/2019	Date/Time Prep 5/13/2020 4:3	
			Title	e XVIII	Hospi tal	Cost	о ріп
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(14, 564, 706	1	
	05100 RECOVERY ROOM	0	0		1, 643, 262		
	05200 DELIVERY ROOM & LABOR ROOM	0	0		255, 091		1
	05300 ANESTHESI OLOGY	0	0		1, 904, 402	1	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		29, 418, 946	1	
	06000 LABORATORY	0	0		24, 506, 356	1	•
	06500 RESPI RATORY THERAPY	0	0		8, 319, 264		1
	06600 PHYSI CAL THERAPY	0	0		2, 515, 689		l
	06700 OCCUPATI ONAL THERAPY	0	0		1, 098, 461	1	
	06800 SPEECH PATHOLOGY	0	0		o 457, 191		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		1, 958, 722	1	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(24, 641, 409	0.000000	73. 00
	OUTPAȚIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0) (6, 315, 152	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0) (3, 131, 572	0.000000	92. 00
	04950 WOODLAWN MEDICAL PROFESSIONALS	0	0	(1, 772, 777	0.000000	
	04951 SHAFER MEDICAL CENTER	0	0	(2, 017, 075		
200.00	Total (lines 50 through 199)	0	0) (124, 520, 075		200. 00

Health Financial Systems	WOODLAWN H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		!	Period: From 01/01/2019 Fo 12/31/2019	Worksheet D Part IV Date/Time Pre 5/13/2020 4:3	pared:
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpati ent Program	Outpatient Program Pass-Through	
	to Charges (col. 6 ÷ col.	Charges	Pass-Through Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10. 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
50. 00 05000 OPERATING ROOM	0. 000000	1, 282, 627		0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	112, 937		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	1, 488		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	85, 522		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	467, 797		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	1, 035, 971		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	890, 893		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	126, 078		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	43, 293		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	10, 843		0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	500, 590		0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 079, 045		0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	21, 126		0	_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	48, 644	(0	0	92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	0. 000000	0	(0	0	93. 00
93. 01 04951 SHAFER MEDICAL CENTER	0. 000000	207	9	9	0	93. 01
200.00 Total (lines 50 through 199)	1	5, 707, 061	1	0	1 0	200. 00

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 From 01/01/2019 Part V 12/31/2019 Date/Time Prepared: 5/13/2020 4:35 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 236196 1, 707, 968 0 50.00 51.00 05100 RECOVERY ROOM 0.686563 189, 097 0 0 0 51.00 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 1. 995159 1, 072 0 52 00 0 05300 ANESTHESI OLOGY 53.00 0.050944 0 310, 646 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.163880 8, 089, 779 0 54.00 60.00 06000 LABORATORY 0.150938 0 5, 641, 277 0 0 60.00 06500 RESPIRATORY THERAPY 1, 959, 278 0. 257853 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.592480 625, 906 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.386793 0 255, 267 0 67.00 06800 SPEECH PATHOLOGY 68.00 0.320831 0 68 00 27, 455 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 477555 0 91, 177 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 19, 746 73.00 0. 239405 0 6, 741, 974 0 73.00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.560397 0 1, 259, 865 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 494184 0 494, 282 0 0 92.00 92.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.00 2. 179175 0 33, 378 0 93.00 0 93.01 04951 SHAFER MEDICAL CENTER 93.01 1.064557 0 182, 182 3, 119 0 200.00 Subtotal (see instructions) 27, 610, 603 22, 865 0 200. 00 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges 27, 610, 603 202.00 Net Charges (line 200 - line 201) 0 22, 865 0 202.00

Health Financial Systems	WOODLAWN HOS	PITAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1313	Peri od: From 01/01/2019	Worksheet D

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider CC	JN: 15-1313	From 01/01/2019 To 12/31/2019	Part V Date/Time Pre 5/13/2020 4:3	
			XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM	403, 415	0				50.00
51. 00 05100 RECOVERY ROOM	129, 827	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 139	0				52.00
53. 00 05300 ANESTHESI OLOGY	15, 826	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 325, 753	0				54.00
60. 00 06000 LABORATORY	851, 483					60.00
65. 00 06500 RESPIRATORY THERAPY	505, 206	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	370, 837	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	98, 735	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	8, 808	0				68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	43, 542	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 614, 062	4, 727				73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	706, 025	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	244, 266	0				92. 00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	72, 737	0				93. 00
93. 01 04951 SHAFER MEDICAL CENTER	193, 943	3, 320				93. 01
200.00 Subtotal (see instructions)	6, 586, 604	8, 047				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	6, 586, 604	8, 047				202. 00

 Heal th Financial
 Systems
 WOODLAWN

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 WOODLAWN HOSPITAL Provider CCN: 15-1313 Component CCN: 15-Z313

	L		Charges		Costs	
Cost Center Description Cost	to Charge F	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	sheet C,	inst.)	Servi ces	Services Not		
Part	I, col. 9		Subject To	Subject To		
				Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 236196	0	0	0	0	
51. 00 05100 RECOVERY ROOM	0. 686563	0	0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1. 995159	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 050944	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 163880	0	0	0	0	54. 00
60. 00 06000 LABORATORY	0. 150938	0	0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 257853	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 592480	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 386793	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 320831	0	0	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 477555	0	0	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 239405	0	0	0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 560397	0	0	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 494184	0	0	0	0	92. 00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	2. 179175	0	0	0	0	93. 00
93. 01 04951 SHAFER MEDI CAL CENTER	1. 064557	0	0	0	0	93. 01
200.00 Subtotal (see instructions)		0	0	0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			0	0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	0	0	0	202. 00

Health Financial Systems	WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provi der Co	CN: 15-1313	Peri od: From 01/01/2019	Worksheet D Part V	
		Component	CCN: 15-Z313	To 12/31/2019	Date/Time Prep 5/13/2020 4:3	pared: 5 pm
		Title	XVIII	Swing Beds - SNF	Cost	
	Co	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	,	7 00	1			1

Cost Center Description	Cost	Cost	
	Reimbursed	Reimbursed	
	Servi ces	Services Not	
	Subject To	Subject To	
	Ded. & Coins.	Ded. & Coins.	
	(see inst.)	(see inst.)	
	6.00	7. 00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	54.00
60. 00 06000 LABORATORY	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS			
91. 00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	0	0	93.00
93.01 04951 SHAFER MEDICAL CENTER	0	0	93. 01
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program	0		201. 00
Only Charges			
202.00 Net Charges (line 200 - line 201)	0	0	202. 00

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING CO	T Provider CCN: 15-1313	From 01/01/2019	
		10 12/31/2019	Date/Time Prepared: 5/13/2020 4:35 pm
	Title XVIII	Hospi tal	Cost

DRIT 1. All MODIFIER COMPONENTS 1.00 Impatient days (including private room days and sating-bed days, excluding newtorn) 3,400 1.00 Impatient days (including private room days, excluding sating-bed and newtorn days) 3,400 2.00 Impatient days (including private room days, excluding sating-bed and newtorn days) 0,300 2.00 Impatient days (including sating-bed and observation bed days) 1,700 have only private room days, excluding sating-bed and observation bed days) 0,300 2.00 Ordat sating-bed SIF type inpatient days (including private room days) through becember 31 of the cost 0,600 2.00 Total sating-bed SIF type inpatient days (including private room days) after December 31 of the cost 131 2.00 Total sating-bed SIF type inpatient days (including private room days) after December 31 of the cost 131 2.00 Total sating-bed SIF type inpatient days (including private room days) after December 31 of the cost 131 2.00 Total sating-bed SIF type inpatient days (including private room days) after December 31 of the cost 131 2.00 Total sating-bed SIF type inpatient days (including private room days) after December 31 of the cost 131 2.00 Total sating-bed SIF type inpatient days applicable to the Program (excluding private room days) 2.00 Sing-bed SIF type inpatient days applicable to title XVIII only (including private room days) 2.00 Sing-bed SIF type inpatient days applicable to title XVIII only (including private room days) 2.00 Sing-bed SIF type inpatient days applicable to services after December 31 or the cost reporting period (including private room days) 2.01 Sing-bed SIF type inpatient days applicable to services after December 31 or the cost reporting period (including private room days) 2.01 Sing-bed SIF type inpatient days applicable to services after December 31 or the cost reporting period (including private room days) 2.01 Sing-bed SIF type inpatient days applicable to services through December 31 or the cost reporting pe			Title XVIII	Hospi tal	5/13/2020 4:3 Cost	5 pm
HAMITERI IMPS 1.00 Impatient days (Including private room days, excluding baing-bed days, excluding newborn) 3,114 2.00 1.00		Cost Center Description		,	'	
Impattent days (including private room days and seting-bed days, excluding newborn) 3,410 1,00		PART I - ALL PROVIDER COMPONENTS			1.00	
Impatient days (including private room days, excluding seing-bed and newborn days) 3,114 2,00		I NPATI ENT DAYS				
A consideration of single person of single person of the cost complete that is line. A consideration period (if calendary sear, enter 0 on this line). A consideration is line. A consideration is li						
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Provider OCF: 15-033		Financial Systems	WOODLAWN H				eu of Form CMS-2	
Total Program Pays (c) Pro	COMPUT	ATION OF INPATIENT OPERATING COST				From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
1.00 NURSERY (LITLE V & XIX only)		Cost Center Description		Total	Average Per sDiem (col. 1	Program Days	Program Cost (col. 3 x col.	
Intensive Care Type Impatient Hospital Units 1,261,552 548 2,302.10 239 550,002 43.00 CREMARY CARE UNIT 1,261,552 548 2,302.10 239 550,002 44.00 CREMARY CARE UNIT 47.00 CREMARY CARE UNIT 47.			1.00	2. 00		4. 00		
	42. 00		0		0. (00 C	0	42. 00
44.00 ORGONARY CARE UNIT 45.00 A control (Section 1) 46.00 A control (Section 1)	40.00		4 0/4 550		0 000	4.0	550,000	40.00
			1, 261, 552	54	2, 302.	10 239	550, 202	1
1.00								
Cost Center Rescription								1
1.00		OTHER SPECIAL CARE (SPECIFY)						1
Program inpatient and Illary service cost (West: D-3, coll. 3, line 200) 1, 1478, 973 48.00 3, 340, 926 49.00 1014 Program inpatient costs (special instructions) 3, 340, 926 49.00 1014 Program inpatient costs (special instructions) 3, 340, 926 49.00 1014 Program inpatient costs (special instructions) 3, 340, 926 49.00 1014 Program inpatient costs applicable to Program inpatient and Illary services (from West: D, sum of Parts II and 19 on		Cost Center Description						
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50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D., sum of Parts II and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 51.00 Pass through costs applicable to program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 52.00 Pass through costs (sum of lines 50 and 51) 53.00 Total Program excludible cost (sum of lines 50 and 51) 53.00 Pass of the program inpatient operating cost excluding capital related, non-physician anesthetist, and services (sum of lines 52) 54.00 Program of scharges 55.00 Program of scharges 55.00 Program of scharges 56.00 Program of scharges 57.00 Program of scharges 58.00 Program of scharges 59.00 Program of schar		Total Program inpatient costs (sum of lines			ons)			
51.00 Pass through costs applicable to Program inpatient and illary services (from Wkst. D, sum of Parts II and IPOgram excludable cost (sum of lines 50 and 51) 0 51.00 10 10 10 10 10 10 10	50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sur	m of Parts I and	0	50. 00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 52)	51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51. 00
medical education costs (line 49 inios line 52)							1	
54.00 Program discharges 0.6 4.00	53. 00	medical education costs (line 49 minus line	9 1	lated, non-ph	nysician anestl	hetist, and	0	53. 00
55.00 Target amount per discharge 0.00 55.00 55.00 57.00	54 00						0	54 00
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83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Beasonable inpatient routine services (see instructions)				`				1
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 84.00 85.00 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)								1
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,748.67 88.00				<i>J</i>)				1
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,748.67 88.00		, , , , , , , , , , , , , , , , , , , ,		ns)				85. 00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	86. 00			rough 85)				86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,748.67 88.00	87 00						200	87 00
		,		line 2)			1	1
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)	•			1, 547, 573	89. 00

Health Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Prep 5/13/2020 4:3	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	463, 188	5, 750, 804	0. 08054	1, 547, 573	124, 646	90.00
91.00 Nursing School cost	0	5, 750, 804	0.00000	1, 547, 573	0	91.00
92.00 Allied health cost	0	5, 750, 804	0.00000	1, 547, 573	0	92.00
93.00 All other Medical Education	0	5, 750, 804	0. 00000	1, 547, 573	0	93. 00

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1313	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prep 5/13/2020 4:3!	
	Title XIX	Hospi tal	Cost	
0 1 0 1 1 11				

		Title XIX	Hospi tal	5/13/2020 4: 3! Cost	5 pm
	Cost Center Description	II LIE XIX	nospi tai	Cost	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		3, 410	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			3, 114	
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		21 of the cost	2, 229 0	4. 00 5. 00
5.00	Total swing-bed SNF type inpatient days (including private roof reporting period	olii days) trii ougii becellibei	31 OF THE COST	١	5.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	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 roor	m days) through December	31 of the cost	131	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December 2	1 of the cost	o	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter beceiiber s	i or the cost	١	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	90	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	o	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		Join days) arter	١	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			o	14. 00
15. 00	Total nursery days (title V or XIX only)	din (exer during swring bed to	adys)	326	
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost		18. 00
10.00	reporting period	es arter becember 51 or	the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	129. 14	19. 00
	reporting period				
20. 00	Medical drate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	129. 14	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	=)		5, 750, 804	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	0,730,004	
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18) Swing-bed cost applicable to NF type services through December	- 21 of the cost reporti	ag ported (line	16, 917	24.00
24. 00	7 x line 19)	31 of the cost reporting	ig perrou (Trile	10, 917	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00	Total swing-bed cost (see instructions)	(1: 21 -: 1: 2/)		16, 917	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Tine 21 minus Tine 26)		5, 733, 887	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		. 3,	0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3) 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 min	nus lino 22)(soo instruc	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)	, ,	11 0115)	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 a	and private room cost di	fferential (line	5, 733, 887	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 041 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 841. 33 165, 720	
40. 00	Medically necessary private room cost applicable to the Progra	-		105, 720	40.00
	Total Program general inpatient routine service cost (line 39	,		165, 720	
			'		•

	Financial Systems	WOODLAWN H	_	ON 45 45:-		u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1313	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 5/13/2020 4:3	epared:
			Ti tl	e XIX	Hospi tal	Cost	, с р
	Cost Center Description	Total Inpatient Costl	Total npatient Days	col . 2)		Program Cost (col. 3 x col. 4)	
10.00	NUDGEDY (1111 AV 0 MAY	1.00	2.00	3.00	4. 00	5. 00	10.0
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	298, 586	326	915.	91 0		42.00
43. 00	INTENSIVE CARE UNIT	1, 261, 552	548	2, 302.	10 0	О	43.00
44. 00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
+7.00	Cost Center Description						47.00
	,					1. 00	
48. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			nc)		80, 429	1
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	JIIS)		246, 149	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, su	m of Parts I and	C	50.00
-1 00		ationt anaillam	, 00m/1000 (Fr	som Wko+ D	oum of Doute II		. E1 0
51. 00	Pass through costs applicable to Program inpa and IV)	atrent ancillar	services (Tr	OIII WKSt. D,	oum of Parts II	C	51.00
52. 00	Total Program excludable cost (sum of lines					o	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	ysician anest	hetist, and	О	53.00
54. 00	Program di scharges					0	54.00
55. 00	Target amount per discharge					l	55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tai	ract amount (ino 56 minus	lino 52)		
58. 00	Bonus payment (see instructions)	ring cost and tai	get amount (i	THE 30 IIITIUS	111le 33)		1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period o	endi ng 1996, ເ	updated and c	ompounded by the	0.00	59.00
50. 00	market basket Lesser of lines 53/54 or 55 from prior year	act copert up	lated by the m	arkat backat		0.00	60.00
51. 00	If line 53/54 is less than the lower of line					0.00	1
	which operating costs (line 53) are less than	n expected costs					
(2.00	amount (line 56), otherwise enter zero (see	nstructions)				l o	62. 00
52. 00 53. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				1
	PROGRAM INPATIENT ROUTINE SWING BED COST	(-	
54. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	nber 31 of the	e cost report	ing period (See	0	64.00
55. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cosi instructions)(title XVIII only)</pre>	ts after Decembe	er 31 of the d	cost reportin	g period (See	C	65. 00
56. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line d	64 plus line 6	55)(title XVI	II only). For	o	66. 0
57. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing		•		•	l .	67.00
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	· ·					68. 00
	(line 13 x line 20)			•	ortrig perrou		
J4. UU	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					1	69.00
70. 00	Skilled nursing facility/other nursing facil	ty/ICF/IID rou	ine service o	cost (line 37)		70.0
71. 00 72. 00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71.0
72. 00 73. 00	Program routine service cost (line 9 x line medically necessary private room cost applications)		(line 14 x li	ne 35)			72. 0
74. 00	Total Program general inpatient routine servi						74.0
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from V	Vorksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 0
77. 00	Program capital -related costs (line 9 x line						77. 0
78. 00 79. 00	Inpatient routine service cost (line 74 minuse) Aggregate charges to beneficiaries for excess		ovi den inecono	ds)			78. 0
30. 00	Total Program routine service costs for compa				nus line 79)		80. 0
31. 00	Inpatient routine service cost per diem limi						81. 0
32. 00 33. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (:						82. 0 83. 0
34. 00	Program inpatient ancillary services (see in:		•,				84. 0
35. 00	Utilization review - physician compensation	(see instruction					85. 0
36. 00	Total Program inpatient operating costs (sum		ough 85)				86. 0
37. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					885	87. 00
38. 00	Adjusted general inpatient routine cost per		line 2)			1, 841. 33	
	Observation bed cost (line 87 x line 88) (see					1, 629, 577	1 00 0

Health Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	463, 188	5, 750, 804	0. 080543	1, 629, 577	131, 251	90.00
91.00 Nursing School cost	0	5, 750, 804	0.00000	1, 629, 577	0	91.00
92.00 Allied health cost	0	5, 750, 804	0.00000	1, 629, 577	0	92.00
93.00 All other Medical Education	0	5, 750, 804	0. 000000	1, 629, 577	0	93. 00

Health Financial Systems	WOODLAWN HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019		narod:
			10 12/31/2019	5/13/2020 4: 3	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
	-		0.00	2)	
INDATI ENT POUTINE CERVI OF COCT OFNITERS		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			1 000 4/7		20.00
31. 00 03000 ADULTS & PEDIATRICS			1, 092, 467		30. 00 31. 00
43. 00 04300 NURSERY			634, 146		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 23619	6 1, 282, 627	302, 951	50. 00
51. 00 05100 RECOVERY ROOM		0. 68656			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1. 99515	· ·	1	
53. 00 05300 ANESTHESI OLOGY		0. 05094			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16388	· ·		
60. 00 06000 LABORATORY		0. 15093	· ·		60.00
65. 00 06500 RESPIRATORY THERAPY		0. 25785			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 59248	0 126, 078	74, 699	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38679	3 43, 293	16, 745	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 32083	1 10, 843	3, 479	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 00000	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 47755	500, 590	239, 059	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 23940	5 1, 079, 045	258, 329	73. 00
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0. 56039	· ·		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 49418			
02 00 040E0 WOODLAWN MEDICAL DDOEESSIONALS		2 17017	E 0		02 00

1, 478, 973 200. 00

93.00 0

201. 00 202. 00

220 93.01

5, 707, 061

5, 707, 061

2. 179175

1.064557

93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS

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

93. 01 04951 SHAFER MEDICAL CENTER

200.00

201.00 202.00

Health Financial Systems WOODLAWN HOS	PI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1313	Peri od:	Worksheet D-3	
	Component		From 01/01/2019		narad.
	Component	CCN: 15-Z313	To 12/31/2019	Date/Time Prep 5/13/2020 4:3	pareu: 5 nm
	Title	e XVIII	Swing Beds - SNF		o piii
Cost Center Description		Ratio of Cos		Inpati ent	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30. 00
31.00 03100 NTENSIVE CARE UNIT			0		31. 00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 23619		411	
51. 00 05100 RECOVERY ROOM		0. 68656		5	51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		1. 9951		0	52. 00
53. 00 05300 ANESTHESI OLOGY		0.05094	44 0	0	53.00
		1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 16388			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 15093	16, 033	2, 420	60.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY		0. 15093 0. 25785	16, 033 26, 257	2, 420 6, 770	60. 00 65. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 15093	16, 033 53 26, 257 60, 336	2, 420 6, 770 35, 748	60. 00 65. 00 66. 00

0.320831

0.000000

0.477555

0. 239405

0. 560397

0. 494184

2.179175

1.064557

747

209

25, 724

169, 299

169, 299

0

240 68.00

71.00

0 72.00

73.00

91.00

92.00

93.00

1 93. 01 64, 789 200. 00

201. 00

202.00

0

6, 158

103

0

68. 00 06800 SPEECH PATHOLOGY

09100 EMERGENCY

93. 01 04951 SHAFER MEDICAL CENTER

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

04950 WOODLAWN MEDICAL PROFESSIONALS

71.00

72.00

73.00

91.00

93.00

200.00

201.00

202.00

	Financial Systems	WOODLAWN HOSPITAL			eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
				From 01/01/2019 To 12/31/2019		oorod
				10 12/31/2019	Date/Time Prep 5/13/2020 4:3	bareu. 5 nm
		Ti +I	e XIX	Hospi tal	Cost	o piii
	Cost Center Description		Ratio of Cos		Inpati ent	
	coot conton boson per on		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				3	2)	
			1.00	2, 00	3, 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			108, 673		30. 00
31.00	03100 INTENSIVE CARE UNIT			13, 460		31.00
43.00	04300 NURSERY			2, 044		43.00
	ANCILLARY SERVICE COST CENTERS		1	<u>'</u>		
50.00	05000 OPERATING ROOM		0. 23619	6 95, 705	22, 605	50. 00
51.00	05100 RECOVERY ROOM		0. 68656	3 12, 123	8, 323	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1. 99515	9 0	0	52.00
53.00	05300 ANESTHESI OLOGY		0.05094	4 7, 877	401	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 16388	0 18, 223	2, 986	54.00
60.00	06000 LABORATORY		0. 15093	8 52, 121	7, 867	60.00
65.00	06500 RESPI RATORY THERAPY		0. 25785	3 19, 443	5, 013	65.00
66.00	06600 PHYSI CAL THERAPY		0. 59248	0 3, 449	2, 043	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 38679	3 1, 101	426	67.00
68. 00	06800 SPEECH PATHOLOGY		0. 32083	1 0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000	0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 47755	5 17, 221	8, 224	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 23940	5 64, 685	15, 486	73. 00
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY		0. 56039	7 12, 589	7, 055	91.00
			1	.1	1 _ !	

0. 494184

2. 179175

1.064557

304, 537

304, 537

0

0 93. 01

80, 429 200. 00

92.00

93.00 0

201. 00

202. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS

93. 01 04951 SHAFER MEDICAL CENTER

200.00

201.00

202.00

			10 12,01,201,	5/13/2020 4:3	5 pm
		Title XVIII	Hospi tal	Cost	
				4.00	
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			6, 594, 651	1.00
2.00	Medical and other services (see Fristructions) Medical and other services reimbursed under OPPS (see instructions)	tions)		0, 374, 031	2.00
3.00	OPPS payments	11 0113)		Ö	3.00
4. 00	Outlier payment (see instructions)			Ō	4. 00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of Lines 1 and 10) (see instructions)			0 6, 594, 651	10. 00 11. 00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			0, 394, 031	111.00
	Reasonable charges				
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		Ō	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 p			0	15. 00
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
17.00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0.000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00 18. 00
19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	Ly if line 18 exceeds li	ne 11) (see		19.00
17.00	instructions)	Ty IT TITLE TO EXCEEDS IT	116 11) (366		1 7. 00
20. 00	Excess of reasonable cost over customary charges (complete onl	lv if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)	,	, (
21. 00	Lesser of cost or charges (see instructions)			6, 660, 598	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions	6)		84, 520	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•	uctions)	4, 377, 314	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	•		2, 198, 764	
	instructions)			_,,	
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			2, 198, 764	ı
31. 00	Primary payer payments			3, 691	
32. 00	Subtotal (line 30 minus line 31)	250)		2, 195, 073	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	JES)		0	33.00
34. 00	Allowable bad debts (see instructions)			966, 580	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			628, 277	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		966, 580	36.00
37.00	Subtotal (see instructions)	,		2, 823, 350	37.00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 2, 823, 350	39. 99 40. 00
40. 00 40. 01	Sequestration adjustment (see instructions)			2, 623, 350 56, 467	1
40. 01	Demonstration payment adjustment amount after sequestration			0	40.01
41. 00	Interim payments			3, 210, 529	
42. 00	Tentative settlement (for contractors use only)			0, 2, 0, 0	42. 00
43. 00	Balance due provider/program (see instructions)			-443, 646	1
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	l
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00				0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			l	94.00
, 4. 00	1.00a. (Sam of 111105 /1 and /0)				, , 4. 00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1313

				10 12/31/2019	5/13/2020 4: 35	
		Title	XVIII	Hospi tal	Cost	
			t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	I 	1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 665, 45		3, 210, 529	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0	3. 03 3. 04
3. 04				0		3. 04
3.03	Provider to Program			U _I	U	3.00
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				o	l ol	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4 00	3. 50-3. 98)		0 //5 45		0.040.500	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		2, 665, 45	50	3, 210, 529	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Provider to Program			0	0	5. 03
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51	TENTATI VE TO TROGRAM			0		5. 51
5. 52				o	o o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o	o	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		532, 22		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	443, 646	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 197, 67		2, 766, 883 NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor			1		8. 00
				•	. '	

PITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-1313 | Period: | Worksheet E-1
From 01/01/2019 | Part I
To 12/31/2019 | Date/Time Prepared: | 5/13/2020 4: 35 pm Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/13/2020 4:3	5 pm_
		Title	XVIII S	wing Beds - SNF		
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		292, 96		0	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		(0	2.00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER)	0	3. 01
3. 02	ABSOSTMENTS TO TROVIBER				0	
3. 03					0	
3. 04					0	
3. 05					0	
	Provider to Program		<u>'</u>			1
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3.51)	0	3. 51
3.52			()	0	
3. 53			(0	
3.54			(0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		(0	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		292, 96		0	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					-
5. 00	List separately each tentative settlement payment after		I		I	5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider			1	'	1
5.01	TENTATI VE TO PROVI DER		(0	5. 01
5.02					0	5. 02
5.03			()	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(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	
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		47, 324	ļ	0	
6.02	SETTLEMENT TO PROGRAM				0	
7. 00	Total Medicare program liability (see instructions)		340, 285		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00		()	1. 00	2. 00	0.00
8. 00	Name of Contractor				I	8.00

Heal th	Financial Systems WOODLAWN HOS	SPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1313	Peri od:	Worksheet E-1	
			From 01/01/2019 To 12/31/2019		
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
0.00	line 168				0.00
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				4
	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31. 00
22 00	Dalamas dus providor (line 0 (or line 10) minus line 20 and l	ina 21) (aaa ina+mua+iam	ر _م ر		1 22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

				5/13/2020 4:3	5 pm
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		284, 351	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A	and sum of Wkst. D,	65, 437	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru	uctions)			
4.00	Per diem cost for interns and residents not in approved teaching	program (see		0.00	4. 00
	instructions)				
5.00	Program days		161	0	5. 00
6.00	Interns and residents not in approved teaching program (see inst			0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	d only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		349, 788	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		349, 788	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	e to physician	0	0	11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		349, 788	0	12. 00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	2, 558	0	13. 00
	for physician professional services)				
14. 00	80% of Part B costs (line 12 x 80%)			0	
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		347, 230	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstrati	on) payment	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	0	0	18. 00
19. 00	Total (see instructions)		347, 230	0	
19. 01	Sequestration adjustment (see instructions)		6, 945	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
20. 00	Interim payments		292, 961	0	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	•	47, 324	0	
23. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				1
	Rural Community Hospital Demonstration Project (§410A Demonstrati				
200.00	Is this the first year of the current 5-year demonstration period	d under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement	t D 1 Dt 11 1; 50			201 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	t. D-1, Pt. 11, Tine			201. 00
202.00	66 (title XVIII hospital))	est D 2 col 2 lino			202. 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from WI 200 (title XVIII swing-bed SNF))	CST. D-3, COL. 3, TITLE			202.00
202 00	Total (sum of lines 201 and 202)				203. 00
					204.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fir	set wear of the curren	t E voor domonet	ration	204.00
	period)	st year or the current	t 5-year demonst	.1 a t 1 011	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				200.00
207 00	Program reimbursement under the §410A Demonstration (see instruction)				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	•			208. 00
200.00	and 3)	cor. I, sum of filles i			200.00
200 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	one)			209. 00
	Reserved for future use) (Since			210. 00
Z 10. UC	Comparision of PPS versus Cost Reimbursement				اک ، ۱۵. ۵0 ا
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (Line 209	nlus line 210) (soo			215. 00
Z 1J. UC	instructions)	prus rine 210) (see			213.00
	1.100.000.010/		1	l	1

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 5/13/2020 4:35 pm
	T: +1 o V/// / /	Heeni tel	Coot

				5/13/2020 4: 3	5 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			3, 540, 026	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
3.00	Organ acqui si ti on	,		0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			3, 540, 026	
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 575, 426	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			0,0,0,120	0.00
	Reasonable charges				
7.00	Routi ne servi ce charges			0	7. 00
8. 00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	
10.00	Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for	nayment for services on	a chargo basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for	. 3	9	0	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	1 3	ii a ciiai ye basi s	U	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000))		0. 000000	12 00
14. 00	Total customary charges (see instructions)			0.000000	14. 00
15. 00		ly if lime 14 eyeeede li	no () (ooo	0	15. 00
15.00	Excess of customary charges over reasonable cost (complete on instructions)	Ty IT TITLE 14 exceeds IT	ne o) (see	U	15.00
16. 00		Ly if line 4 eyecods lin	0 14) (600	0	16. 00
10.00	Excess of reasonable cost over customary charges (complete on instructions)	Ty IT TITLE 6 exceeds ITH	e 14) (See	U	10.00
17 00		ructions)		0	17. 00
17.00	\mathbf{J}				
10 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet E-	4 1: 22 40)		0	18. 00
18. 00 19. 00	Cost of covered services (sum of lines 6, 17 and 18)	4, TINE 49)		- 1	
				3, 575, 426	
20.00	Deductibles (exclude professional component)			340, 928	
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 234, 498	
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (line 22 minus line 23)			3, 234, 498	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		43, 746	
26. 00	Adjusted reimbursable bad debts (see instructions)			28, 435	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		43, 746	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			3, 262, 933	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30. 00	Subtotal (see instructions)			3, 262, 933	
30. 01	01 Sequestration adjustment (see instructions)			65, 259	
30. 02	02 Demonstration payment adjustment amount after sequestration			0 2, 665, 450	30. 02
31.00	00 Interim payments				31.00
32.00				0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0)	2, 31, and 32)		532, 224	33.00
34.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2				

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1313	Peri od:	Worksheet E-3

From 01/01/2019 | Part VII | To 12/31/2019 | Date/Time Prepared: 5/13/2020 4:35 pm

			5/13/2020 4:3	o piii	
	Title XIX	Hospi tal	Cost		
		Inpatient	Outpati ent		
		1. 00	2. 00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OF	R XIX SERVICES	•		
	COMPUTATION OF NET COST OF COVERED SERVICES			1	
1.00	Inpatient hospital/SNF/NF services	246, 149		1.00	
2.00	Medical and other services		0	2. 00	
3.00	Organ acquisition (certified transplant centers only)	0	_	3. 00	
4. 00	Subtotal (sum of lines 1, 2 and 3)	246, 149	0	4. 00	
5. 00	Inpatient primary payer payments	210,117	Ĭ	5. 00	
6. 00	Outpatient primary payer payments		0		
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	246, 149	-		
7.00	COMPUTATION OF LESSER OF COST OR CHARGES	240, 147		7.00	
	Reasonable Charges				
0.00	J	104 177	I	0 00	
8.00	Routi ne servi ce charges	124, 177		8.00	
9.00	Ancillary service charges	304, 537	0		
10.00	Organ acquisition charges, net of revenue	0		10.00	
11. 00	Incentive from target amount computation		_	11. 00	
12. 00	Total reasonable charges (sum of lines 8 through 11)	428, 714	0	12. 00	
	CUSTOMARY CHARGES		1		
13. 00	Amount actually collected from patients liable for payment for services on a charge	e 0	0	13. 00	
	basis				
14. 00	Amounts that would have been realized from patients liable for payment for services	s on 0	0	14. 00	
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000			
16. 00	Total customary charges (see instructions)	428, 714		16. 00	
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	182, 565	0	17. 00	
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds I	ine 0	0	18. 00	
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)	0	0		
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0		
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	246, 149	0	21. 00	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS pro	ovi ders.			
22. 00	Other than outlier payments	0			
23.00	Outlier payments	0	0	23. 00	
24.00		0		24. 00	
25.00	Capital exception payments (see instructions)	0		25. 00	
26.00	Routine and Ancillary service other pass through costs	0	0	26. 00	
27.00	Subtotal (sum of lines 22 through 26)	0	0	27. 00	
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00	
29. 00	Titles V or XIX (sum of lines 21 and 27)	246, 149	0	29. 00	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	· · · · · · · · · · · · · · · · · · ·		1	
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)	246, 149			
32. 00	Deducti bl es		0		
33. 00	Coinsurance		l o		
34. 00			0		
35. 00	Utilization review		Ĭ	35. 00	
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	246, 149	0		
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	240, 147	0		
38. 00		246, 149			
39. 00	Direct graduate medical education payments (from Wkst. E-4)	240, 147	٥	39. 00	
40. 00	Total amount payable to the provider (sum of lines 38 and 39)	246, 149	0		
		·			
41. 00	Interim payments	217, 976			
42.00	Balance due provider/program (line 40 minus line 41)	28, 173			
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43. 00	
	chapter 1, §115.2		I	I	

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

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

/2019 Worksheet G /2019 Date/Time Prepared: 5/13/2020 4:35 pm

		General Fund	Speci fi c	Endowment Fund	<u>5/13/2020_4: 3</u> Plant Fund	5 piii
			Purpose Fund			
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	7, 573, 158	С	0	0	1.00
2.00	Temporary investments	0	C	o	0	
3.00	Notes receivable	0	C	0	0	1
4.00	Accounts receivable	20, 780, 674	C	0	0	
5. 00 6. 00	Other receivable	1, 211, 675			0	
7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-13, 629, 140 892, 293			0	6. 00 7. 00
8. 00	Prepaid expenses	182, 965		ol ol	0	8. 00
9.00	Other current assets	0	C	o	0	9. 00
10. 00	Due from other funds	0	C	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	17, 011, 625	C) 0	0	11. 00
12. 00	FI XED ASSETS Land	596, 216		ol	0	12. 00
13. 00	Land improvements	510, 775		1	0	13. 00
14. 00	Accumulated depreciation	-397, 388	ĺ		0	14. 00
15.00	Bui I di ngs	27, 302, 119	C	o	0	15. 00
16. 00	Accumulated depreciation	-13, 679, 818	C	0	0	16. 00
17. 00	Leasehold improvements	0	C	0	0	17. 00
18. 00 19. 00	Accumulated depreciation Fixed equipment	0			0	18. 00 19. 00
20. 00	Accumulated depreciation	0			0	20.00
21. 00	Automobiles and trucks	Ö	Ċ	o o	0	21.00
22. 00	Accumulated depreciation	0	C	o	0	22. 00
23. 00	Major movable equipment	10, 521, 060	C	0	0	23. 00
24. 00	Accumulated depreciation	-8, 110, 788	C	0	0	24. 00
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	0			0	25. 00 26. 00
27. 00	HIT desi gnated Assets	0			0	27. 00
28. 00	Accumulated depreciation	0			0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	C	o	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	16, 742, 176	C	0	0	30.00
21 00	OTHER ASSETS	E 201 224		ا	0	21 00
31. 00 32. 00	Investments Deposits on Leases	5, 291, 234			0	31. 00 32. 00
33. 00	Due from owners/officers	0			0	33.00
34. 00	Other assets	617, 210		o	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	5, 908, 444	C	o	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	39, 662, 245	C	0	0	36. 00
27.00	CURRENT LIABILITIES	2 200 442		ol l	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	2, 288, 443 2, 615, 412		1	0	37. 00 38. 00
39. 00	Payroll taxes payable	2,013,412			0	39.00
40. 00	Notes and Loans payable (short term)	2, 302, 549	d	o	0	40.00
41.00	Deferred income	0	C	o	0	41. 00
42. 00	Accel erated payments	0	_	_	_	42. 00
43.00	Due to other funds	0	C		0	
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	7, 206, 404			0	
43.00	LONG TERM LIABILITIES	7,200,404)I OI		1 43.00
46.00	Mortgage payable	0	C	0	0	46. 00
47. 00	Notes payable	9, 154, 894	C	0	0	1
48. 00	Unsecured Loans	0	C	1	0	1
49. 00	Other long term liabilities	0 154 004	C	1	0	
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	9, 154, 894 16, 361, 298		1	0	
31.00	CAPITAL ACCOUNTS	10, 301, 270		,		31.00
52.00	General fund balance	23, 300, 947				52. 00
53.00	Specific purpose fund		C			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
55. 55	replacement, and expansion				O	55.55
59. 00	Total fund balances (sum of lines 52 thru 58)	23, 300, 947		o	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	39, 662, 245	C	이	0	60.00
	[59]	I	I	ı I		I

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

Provider CCN: 15-1313

					То	12/31/2019	Date/Time Prep 5/13/2020 4:3	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	Э рііі
		1.00	2. 00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	22, 403, 396			4.00		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		897, 551			O		2. 00
3.00	Total (sum of line 1 and line 2)		23, 300, 947			0		3. 00
4. 00	Additions (credit adjustments) (specify)	o			0	_	o	4. 00
5.00	, , , , , , , , , , , , , , , , , , , ,	0			0		0	5. 00
6.00		O			0		0	6. 00
7.00		0			0		0	7. 00
8.00		0			0		0	8. 00
9.00		0			0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0			0		10. 00
11. 00	Subtotal (line 3 plus line 10)		23, 300, 947			0		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13.00		0			0		0	13.00
14.00		0			0		0	
15. 00 16. 00					0		0	15. 00 16. 00
17. 00					0			17. 00
18. 00	Total deductions (sum of lines 12-17)		0		U	0	U	18. 00
19. 00	Fund balance at end of period per balance		23, 300, 947			0		19. 00
.,. 00	sheet (line 11 minus line 18)		20,000,7			· ·		. , , , ,
		Endowment Fund	PI ant	Fund				
		/ 00	7.00	0.00				
1. 00	Fund balances at beginning of period	6.00	7. 00	8. 00	0			1, 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				U			2.00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4. 00	Additions (credit adjustments) (specify)		0		J			4. 00
5. 00	That trons (or car trady as timents) (specify)		0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14.00			0					14. 00
15.00			0					15. 00
16. 00 17. 00			0					16. 00 17. 00
17.00	Total deductions (sum of lines 12-17)		U		0			17.00
19. 00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)				Ĭ			17.00
	1 ('				

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

			To 12/31/2019	Date/Time Pre 5/13/2020 4:3	
	Cost Center Description	Inpati ent	Outpati ent	Total	o piii
	oust defited beschiption	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	3, 101, 836	5	3, 101, 836	1.00
2.00	SUBPROVI DER - I PF	2, ,		2,,	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)	3, 101, 836		3, 101, 836	10.00
10.00	Intensive Care Type Inpatient Hospital Services	0, 101, 000	4	0, 101, 000	10.00
11. 00	INTENSIVE CARE UNIT	1, 485, 332		1, 485, 332	11.00
12. 00	CORONARY CARE UNIT	1, 100, 002		1, 100, 002	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	1, 485, 332		1, 485, 332	16.00
10.00	11-15)	1, 400, 002		1, 400, 332	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 587, 168	3	4, 587, 168	17. 00
18. 00	Ancillary services	16, 609, 60!		111, 283, 499	18.00
19. 00	Outpatient services	645, 88!		11, 924, 487	19.00
20. 00	RURAL HEALTH CLINIC	043, 00.		11, 724, 407	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21.00
22. 00	HOME HEALTH AGENCY	`		U	22.00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPICE				26. 00
27. 00	FCMC CLINIC	,	3, 118, 253	3, 118, 253	27.00
27. 00	ARGOS CLINIC		2, 924, 706	2, 924, 706	27. 00
27. 01	AKRON CLINIC			2, 924, 706 828, 972	27. 01
27. 02	PROFESSIONAL FEES			13, 089, 857	27. 02
27. 03	DIETARY	211, 672		13, 069, 637	27. 03
27. 04	NURSERY	234, 59		234, 591	27. 04
					28.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	22, 288, 92	125, 716, 504	148, 005, 425	28.00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		60, 968, 548		29. 00
30. 00	ADD (SPECIFY)	,	00, 900, 540		30.00
31. 00	ADD (SPECIFI)				31.00
31.00		•)		
)		32.00
33.00)		33. 00 34. 00
34. 00)		
35. 00	Total additions (sum of Lines 20.25)	') 0		35. 00
36.00	Total additions (sum of lines 30-35)				36.00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00					39. 00
40. 00					40.00
41. 00	7				41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	60, 968, 548		43. 00
	to Wkst. G-3, line 4)	1			l

Heal th	Financial Systems WOODLAWN	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1313	Peri od:	Worksheet G-3	
			From 01/01/2019		
			To 12/31/2019	Date/Time Prep 5/13/2020 4:3	
				37 137 2020 4. 3	J pili
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		148, 005, 425	1. 00
2.00	Less contractual allowances and discounts on patients' acc			90, 039, 930	
3.00	Net patient revenues (line 1 minus line 2)			57, 965, 495	•
4.00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		60, 968, 548	4.00
5.00	Net income from service to patients (line 3 minus line 4)	,		-3, 003, 053	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			180, 061	7. 00
8.00	Revenues from telephone and other miscellaneous communicat	ion 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
	Parking Lot receipts			0	12. 00
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests			153, 946	1
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to othe	er than patients		0	
	Revenue from sale of drugs to other than patients			0	1
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
	Rental of vending machines			37	21. 00
	Rental of hospital space			8, 629	•
	Governmental appropriations			0	23. 00
	OTHER REVENUE			940, 108	
	EQUITY REVENUE			2, 621, 263	
	GAIN/LOSS DISP ASSET-MISC			0	

3, 904, 044 900, 991

25.00 26.00 3, 440 27. 00 3, 440 28. 00 897, 551 29. 00

24.02 GAIN/LOSS DISP ASSET-MISC
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 GAIN/LOSS DISP ASSET-MISC
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)