This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1313 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 7: 26 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2024 Ti me: 7:26 am] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WOODLAWN HOSPITAL (15-1313) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	189, 603	-501, 563	0	-15, 178	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	56, 131	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		2, 549		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		-53, 815		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		-37, 198		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		-27, 151		0	10.03
10.04	RURAL HEALTH CLINIC V	0		-39, 144		0	10.04
10.05	RURAL HEALTH CLINIC VI	0		-40, 635		0	10.05
200.00	TOTAL	0	245, 734	-696, 957	0	-15, 178	200.00
Tho ab	nove amounts represent "due to" or "due from"	the applicable	program for t	ho alamont of	the above compl	lov indicated	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1313 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 7:26 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1400 EAST 9TH STREET 1.00 PO Box: 1.00 2.00 City: ROCHESTER State: IN Zip Code: 46975 County: FULTON 2.00 Component Name Payment System (P, CCN CBSA Provi der Date T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal WOODLAWN HOSPITAL 151313 99915 01/01/1966 Ν 0 0 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 WOODLAWN HOSPITAL 15Z313 99915 10/23/2001 N 0 N 7 00 SWI NGBED 8.00 Swing Beds - NF 8.00 9.00 Hospital-Based SNF 9.00 10.00 Hospital -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC SHAFER MEDICAL CENTER 158551 99915 15 00 04/13/2020 N Λ 0 15 00 Hospital -Based Health Clinic - RHC WOODLAWN MEDICAL 158552 99915 04/13/2020 15.01 0 15.01 PROFESSI ONALS Hospital -Based Health Clinic - RHC FULTON COUNTY MEDICAL 158550 99915 0 0 15.02 15.02 04/13/2020 N 1111 CENTER - MAIN FULTON COUNTY MEDICAL 15.03 Hospital -Based Health Clinic - RHC 158549 99915 04/13/2020 Ν 0 0 15.03 CENTER - DUNN ١V 158547 99915 15.04 Hospital-Based Health Clinic - RHC WAKRON MEDICAL CLINIC 04/13/2020 Ν 0 0 15.04 Hospital -Based Health Clinic - RHC 15.05 ARGOS MEDICAL CLINIC 158548 99915 04/13/2020 Ν 0 15.05 0 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 8 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 Ν Ν 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Health Financial			OSPI TAL	ON 4E 4040		eu of Form CMS-	
OSPITAL AND HOS	PITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der CC		Peri od: From 01/01/2023 To 12/31/2023	B Date/Time Pre 5/29/2024 7:2	epared
					1. (+
is this that this faresi dents "N" for no complete Woeginning which mont	reporting periods beginning prior to December first cost reporting period during which acility? Enter "Y" for yes or "N" for no is start training in the first month of this or in column 2. If column 2 is "Y", completowards. D. Parts III & IV and D-2, Pt. II, if on or after December 27, 2020, under 42 CFt. (s) of the cost report the residents were enter "Y" for yes in column 1, do not completents.	reside n colum cost re e Works applic R 413.7 on dut ete col	nts in approve n 1. If column porting period heet E-4. If c able. For cost 7(e)(1)(iv) a y, if the resp umn 2, and com	d GME program 1 is "Y", di 1? Enter "Y" olumn 2 is "N reporting pend (v), regan onse to line uplete Workshe	is yes, ms trained d for yes or w", eriods rdless of 56 is "Y" eet E-4.		57.
defined in	is yes, did this facility elect cost reim n CMS Pub. 15-1, chapter 21, §2148? If yes, claimed on line 100 of Worksheet A? If ye	comple	te Wkst. D-5.		s as N		58. 59.
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2. 00	3. 00	
any progra i nstructi d i s "Y", ar	aiming nursing and allied health education ams that meet the criteria under 42 CFR 413 ons) Enter "Y" for yes or "N" for no in come you impacted by CR 11642 (or subsequent of E? Enter "Y" for yes or "N" for no in colu	.85? (lumn 1. CR) NAH	see If column 1	N			60.
auj ustilieni	.: Litter i for yes of in for he in coru	Y/N	I ME	Direct GME	I ME	Direct GME	
1 00 0: -!	populatel magging FTF elata warden ACA	1. 00	2. 00	3. 00	4. 00	5.00	0 (1
section 55 column 1. 1.01 Enter the	nospital receive FTE slots under ACA 503? Enter "Y" for yes or "N" for no in (see instructions) average number of unweighted primary care the hospital's 3 most recent cost reports				O. C	0.00	61.
ending and instruction 0.02 Enter the FTE count	d submitted before March 23, 2010. (see ons) current year total unweighted primary care (excluding OB/GYN, general surgery FTEs,						61.
ACA). (see .03 Enter the and/or ger	ry care FTEs added under section 5503 of einstructions) base line FTE count for primary care neeral surgery residents, which is used for g compliance with the 75% test. (see						61.
instruction 0.04 Enter the surgery al	ons) number of unweighted primary care/or lopathic and/or osteopathic FTEs in the						61.
1.05 Enter the and/or ger primary ca	ost reporting period. (see instructions). difference between the baseline primary neral surgery FTEs and the current year's are and/or general surgery FTE counts (line us line 61.03). (see instructions)						61.
1.06 Enter the used for a	amount of ACA §5503 award that is being cap relief and/or FTEs that are nonprimary eneral surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	IME FTE Count	FTE Count	
1.10 Of the FTF	Es in line 61.05, specify each new program		1. 00	2. 00	3. 00	4. 00 0 0. 00	61.
specialty, for each r column 1, program co unweighte FTE unweig 1.20 Of the FTE program sp residents instruction Enter in c 3, the IME	if any, and the number of FTE residents new program. (see instructions) Enter in the program name. Enter in column 2, the ode. Enter in column 3, the IME FTE d count. Enter in column 4, the direct GME other of the count. Enter in column 4, the direct GME of the count. It is in line 61.05, specify each expanded opecialty, if any, and the number of FTE for each expanded program. (see ons) Enter in column 1, the program name. Column 2, the program code. Enter in column 5 FTE unweighted count. Enter in column 4, the GME FTE unweighted count.				0.0		61.

40SPLT	Financial Systems		DLAWN HOSPITAL	011 45 45 4		u of Form CMS-2	
	TAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Pre 5/29/2024 7:2	pared
						1.00	
2. 00	ACA Provisions Affecting the Hea Enter the number of FTE resident	s that your hospital	trained in this cost		riod for which		62.0
2. 01	your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe	s that rotated from	a Teaching Health Cer		o your hospital	0.00	62.
. 00	Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col	esidents in Nonprovid ents in nonprovider s	er Settings ettings during this (cost reporting		N	63.
	T TOT YES OF IN TOT HE THE CON	ann 1. 11 yes, compri	ste filles 64 till odgir	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2. 00	3. 00	1
	Section 5504 of the ACA Base Yea				_		
1. 00	period that begins on or after. Enter in column 1, if line 63 is in the base year period, the numeresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column	s yes, or your facili aber of unweighted no otations occurring in a number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2. 00	Si te 3.00	4.00	5. 00	1
	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwai ghtad	Unwei ghted	Patio (cal	
				Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settin	1.00 gsEffective	2.00 for cost report	3.00 ing periods	
. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations of	010 unweighted non-prima occurring in all nonp	ry care resident rovider settings.	0.0			66.
	Enter in column 2 the number of FTEs that trained in your hospil (column 1 divided by (column 1 +	al. Enter in column	3 the ratio of				
	FTEs that trained in your hospit	al. Enter in column	3 the ratio of	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	

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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 7:26 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4. 00 5.00 67.00 Enter in column 1, the program 0.000000 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 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 68.00 68.00 (August 10, 2022)? 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 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 subprovider? Enter "Y" for yes and "N" for no. Ν 75 00 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80 00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 'Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85 00 N 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Permanent Adjustment (Y/N) Adjustments 1.00 2.00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target 0 88.00 Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.

HUSPITAL AND HUSPITAL HEALT	H CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-1313	Peri od: From 01/01/2023 To 12/31/2023		epared:
			Wkst. A Lir No.	ne Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2. 00	3. 00	
on which the per disc Column 2: Enter the e beginning date) for t per discharge.	column 1 is Y, enter the Worksheet Asharge permanent adjustment approval weffective date (i.e., the cost reportishe permanent adjustment to the TEFRA amount of the approved permanent adjuster discharge.	was based. ing period target amount	0.	00 V	XIX	0 89.0
				1.00	2.00	+
Title V and XIX Servi						
	nve title V and/or XIX inpatient hospi the applicable column.	ital services? E	nter "Y" for	N	Y	90.0
91.00 Ís this hospital reim	nbursed for title V and/or XIX through			N	Y	91.0
92.00 Are title XIX NF pati	er "Y" for yes or "N" for no in the ap ents occupying title XVIII SNF beds (Y" for yes or "N" for no in the appli	(dual certificat			N	92.0
93.00 Does this facility op	perate an ICF/IID facility for purpose		d XIX? Enter	N	N	93.0
94.00 Does title V or XIX r	or no in the applicable column. Teduce capital cost? Enter "Y" for yes	s, and "N" for n	o in the	N	N	94.0
applicable column.	nter the reduction percentage in the a	annlicable colum	ın.	0.00	0.00	95. 0
96.00 Does title V or XIX r	reduce operating cost? Enter "Y" for y			N N	N N	96.0
98.00 Does title V or XIX f	nter the reduction percentage in the afollow Medicare (title XVIII) for the	interns and res	idents post	0. 00 Y	0. 00 Y	97. 0 98. 0
column 1 for title V, Does title V or XIX f	on Wkst. B, Pt. I, col. 25? Enter "Y' and in column 2 for title XIX. Follow Medicare (title XVIII) for the For yes or "N" for no in column 1 for	reporting of ch	arges on Wks		Y	98. 0
	ollow Medicare (title XVIII) for the 1, Pt. IV, line 89? Enter "Y" for yes			Y	Υ	98. 0
8.03 Does title V or XIX freimbursed 101% of in	column 2 for title XIX. Follow Medicare (title XVIII) for a cr apatient services cost? Enter "Y" for				N	98.0
8.04 Does title V or XIX foutpatient services of	column 2 for title XIX. Follow Medicare (title XVIII) for a CA Cost? Enter "Y" for yes or "N" for no			N d	N	98.0
Wkst. C, Pt. I, col.	follow Medicare (title XVIII) and add 4? Enter "Y" for yes or "N" for no ir				Y	98.0
	follow Medicare (title XVIII) when cos nter "Y" for yes or "N" for no in colu			Y	Y	98.0
Rural Providers	valify as a CAU2			V		105 0
	ifies as a CAH, has it elected the al	II-inclusive met	hod of payme	nt N		105. 0 106. 0
	es? (see instructions) is is Y, is this facility eligible for	cost reimbursem	ent for I&R	N		107.0
training programs? Er Column 2: If column	ter "Y" for yes or "N" for no in colu 1 is Y and line 70 or line 75 is Y, cation program in the CAH's excluded	umn 1. (see ins do you train I&R	tructions) s in an			
07.01 If this facility is a reimbursement for L&R	"N" for no in column 2. (see instruct REH (line 3, column 4, is "12"), is R training programs? Enter "Y" for yes	it eligible for				107.0
	tal qualifying for an exception to the	he CRNA fee sche	dul e? See 4	2 N		108.0
CFR Section §412.113((c). Enter "Y" for yes or "N" for no.	Physi cal	Occupation	al Speech	Respi ratory	
		FILIYST Cal	2. 00	3. 00	4. 00	

	Physi cal	Occupational	Speech	Respi ratory	
	1. 00	2. 00	3. 00	4.00	
109.00 of this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	N	N	N	N	109. 00
for yes or "N" for no for each therapy.		I			l

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO		eriod: com 01/01/2023	of Form CMS Worksheet S Part I Date/Time P 5/29/2024 7	-2 repared:
			1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.	"N" for no. I	f yes,	N	110.00
		1. 00	2. 00	\dashv
111.00 If this facility qualifies as a CAH, did it participate in the Frontier CO Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N		111.00
	1.00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0115.00
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116. 00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1	1		118.00
	Premiums	Losses	Insurance	
		0.00		
118.01 List amounts of malpractice premiums and paid losses:	1. 00 276, 624	2. 00	3.00	0118.01
118.01 List amounts of malpractice premiums and paid losses:		0		0118.01
	276, 624 than the		3.00	
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118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prospective spatial and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated organization a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certific column 1 and termination date, if applicable, in column 2.	than the cost centers ovision in ACA "for yes or the Outpatient cructions) es charged to B(w) (3) of the er in column 2 sional and/or 1, enter "Y" 1 50% of total ganizations Y" for yes or "Y" for yes or "Y" for yes cification date fication date	N N N N N		118. 02 119. 00 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00 127. 00
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	X IDENTIFICATION DATA	Provi der CCI	N: 15-1313		/01/2023 2/31/2023	J of Form CMS Worksheet S- Part I Date/Time Pr 5/29/2024 7:	2 epared:
					1. 00	2. 00	-
31.00 If this is a Medicare-certified in			erti fi cati d				131.00
date in column 1 and termination of 32.00 If this is a Medicare-certified is in column 1 and termination date,	slet transplant program,	enter the certif	ication da	te			132. 00
33.00 Removed and reserved							133.00
34.00 If this is a hospital-based organ in column 1 and termination date, All Providers			ne OPO numbe	er			134.00
40.00 Are there any related organization chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the	'N" for no in column 1. I e home office chain numbe	f yes, and home er. (see instruct	office cost	ts	N		140. 00
1.00 If this facility is part of a chai		00	ugh 142 +bo	nomo on	3. 00	of the home	
office and enter the home office of	contractor name and contr	ractor number.	ugn 143 the	паше ап	address	or the nome	
41. 00 Name:	Contractor's Name:		Contrac	tor's Nur	mber:		141.00
42.00 Street: 43.00 Ci ty:	PO Box: State:		7in Cod				142.00
43. 00 C Ty.	state.		Zi p Cod	∃.			143.00
						1. 00	
44.00 Are provider based physicians' cos	sts included in Worksheet	t A?				Y	144.00
					1. 00	2. 00	_
45.00 If costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N"	for yes or "N" for no i	n column 1. If o	column 1 is		00	2.00	145.00
46.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	column 1. (See CMS Pub.			f	N		146. 00
47 00W	and the dead of the second of	HAUL C				1. 00	1.17.00
47.00 Was there a change in the statisti 48.00 Was there a change in the order of						N N	147. 00 148. 00
49.00 Was there a change to the simplifi				or no.		N	149.00
		Part A	Part B	Ti	tle V		
Doos this facility contain a provi						Title XIX	117.0
pues tills raciff ty contain a brown	don that qualifies for a	1.00	2. 00		3. 00	4.00	-
or charges? Enter "Y" for yes or '	der that qualifies for a 'N" for no for each compo	an exemption from	2.00 m the appli	cation o	3.00 f the low	4.00 er of costs	
or charges? Enter "Y" for yes or '55.00 Hospital		an exemption from onent for Part A N	2.00 n the appliand Part B N	cation o	3.00 f the lowe 2 CFR §41: N	4.00 er of costs 3.13) N	155. 00
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Health Financial Systems	WOODLAWN HOS	PI TAL		In Lieu	of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-1313	Perio		Worksheet S-	2
			To 12/31/2023 Date/Time P 5/29/2024 7			epareu: 2 <u>6 am</u>
				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						0 171. 00
"Y" for yes and "N" for no in column 1876 Medicare days in column 2. (see	1. If column 1 is yes, e		on			

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1313 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 7:26 am Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 05/07/2024 Υ 05/07/2024 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 17.00 N N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems WOODLAWN H	HOSPI TAL		In Lie	u of Form CM:	S-2552-10
	FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-1313	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P 5/29/2024 7	repared:
			i pti on	Y/N 1,00	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
	Report data for Other? Describe the other adjustments:	Y/N	Data	Y/N	Date	
		1.00	2.00	3.00	4. 00	
21. 00	Was the cost report prepared only using the provider's	N 1.00	2.00	3.00 N	4.00	21. 00
21.00	records? If yes, see instructions.	IV.		, N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ring the cost	N	23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases enter	ed into during	this cost r	eporting period?	N	24. 00
25 00	If yes, see instructions	46		. 16	N.	25.00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	orting period	? IT yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	ha cast rapart	ing ported?	f voc. coo	N	26. 00
20.00	instructions.	ne cost report	ing perrou?	i yes, see	IN	20.00
27. 00	Has the provider's capitalization policy changed during the	e cost renorti	na period? I	f ves submit	N	27. 00
27.00	copy.	o 0001 . opo. t.	ng pontour i	, Joo, Gabiii. c		27.00
	Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cos	t reporting	Υ	28. 00
	period? If yes, see instructions.		3	1 3		
29.00	Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service I	Reserve Fund)	N	29. 00
	treated as a funded depreciation account? If yes, see inst	ructi ons				
30.00	Has existing debt been replaced prior to its scheduled mate	urity with new	debt? If ye	s, see	N	30.00
	i nstructi ons.					
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	ı debt? If ye:	s, see	N	31.00
	i nstructi ons.					
22.00	Purchased Services				N1	
32. 00	Have changes or new agreements occurred in patient care searrangements with suppliers of services? If yes, see instru		ied trirough co	ontractual	N	32.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		na to compet	tive hidding? If	N	33.00
33.00	no, see instructions.	pri ca per tarii	ng to compet	tive brading: 11		33.00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-	pased physicians?	Υ	34.00
	If yes, see instructions.	g		py		
35.00	If line 34 is yes, were there new agreements or amended ex	isting agreeme	ents with the	provi der-based	N	35.00
	physicians during the cost reporting period? If yes, see in	nstructi ons.		•		
				Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36.00	· ·			N		36.00
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	nome office	·		37. 00
20.00	If yes, see instructions.	eloo diee	from that	-		20.00
38. UU	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end					38. 00
30 00	If line 36 is yes, did the provider render services to other					39. 00
37.00	see instructions.	ci charif compo	monta: II ye:	ا, د		37.00
40.00	If line 36 is yes, did the provider render services to the	home office?	If ves see			40.00
	instructions.		. ,			
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41. 00		KYLE		SMI TH		41. 00
	held by the cost report preparer in columns 1, 2, and 3,					
40	respecti vel y.	D. 115 a 22	_			
42. 00		BLUE & CO. LLO	خ ا			42.00
43. 00	preparer.	 317-713-7957		VCCMI TUADI UE AN		42.00
43.00		31/-/13-/95/		KCSMI TH@BLUEAN	DCO. COM	43. 00
	report preparer in columns 1 and 2, respectively.	I		1		II

Health Financial Sy	stems	WOODLAWN H	IOSPI TAL			In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPIT	AL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-1313	Peri From To	01/01/2023	Worksheet S-2 Part II Date/Time Pre 5/29/2024 7:2	pared:	
			3	3. 00					
Cost Report	Preparer Contact Information								
41.00 Enter the fi	rst name, last name and the	title/position	DI RECTOR					41.00	
held by the	cost report preparer in colu	mns 1, 2, and 3,							
respecti vel y									
42.00 Enter the em	ployer/company name of the c	ost report						42.00	
preparer.									
43.00 Enter the te	Lephone number and email add	ress of the cost						43.00	
report prepa	rer in columns 1 and 2, resp	ecti vel y.							

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial SystemsWOODHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1313

				Ť	o 12/31/2023	Date/Time Pre 5/29/2024 7:2	
						1/P Days /	o alli
						0/P Visits /	
						Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days	CAH/REH Hours	Title V	
		1. 00	2. 00	Available 3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	35, 424. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7. 00	Total Adults and Peds. (exclude observation		25	9, 125	35, 424. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00	0	l o	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	31.00			0.00	O	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		0.405	05 404 00	0	13.00
14. 00 15. 00	Total (see instructions) CAH visits		25	9, 125	35, 424. 00	0	14. 00 15. 00
15. 00	REH hours and visits				0.00	0	15. 00
16. 00	SUBPROVI DER - I PF				0.00	O	16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21. 00 22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26. 01 26. 02	RURAL HEALTH CLINIC III	88. 01 88. 02				0	26. 01 26. 02
26. 02	RURAL HEALTH CLINIC III RURAL HEALTH CLINIC IV	88. 02 88. 03				0	26. 02
26. 04	RURAL HEALTH CLINIC V	88. 04				0	26. 04
26. 05	RURAL HEALTH CLINIC VI	88. 05				0	26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		25				27.00
28. 00	Observation Bed Days					0	28. 00
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)						29. 00 30. 00
31.00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)		0	O			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	C		0	33. 01 34. 00
34.00	Tremporary Expansion Covid-19 PRE Acute Care	30.00	1	1	'l I	U	34.00

Provider CCN: 15-1313

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/39/2024 7:26 am

					12/01/2020	5/29/2024 7: 2	6 am
	·	I/P Days	s / O/P Visits	/ Tri ps	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	
	PART I - STATISTICAL DATA			T.	T	Т	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	487	47	1, 476			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	210	400				2 00
2.00	HMO and other (see instructions)	310	402				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4. 00 5. 00	HMO I RF Subprovi der	97	0				4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	97	0	1			6.00
7. 00	Total Adults and Peds. (exclude observation	584	47	1			7.00
7.00	beds) (see instructions)	304	47	1,707			7.00
8. 00	INTENSIVE CARE UNIT	0	0	o			8.00
9. 00	CORONARY CARE UNIT	O	O	1			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	334			13.00
14. 00	Total (see instructions)	584	47	1		238. 52	14.00
15. 00	CAH visits	0	0		0.00	200.02	15.00
15. 10	REH hours and visits	0	0	1			15. 10
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1, 292	789			6. 23	1
26. 01	RURAL HEALTH CLINIC II	456	7, 635			20. 39	1
26. 02	RURAL HEALTH CLINIC III	2, 296	3, 546			15. 25	
26. 03	RURAL HEALTH CLINIC IV	399	581	1		0. 62	
26. 04	RURAL HEALTH CLINIC V	850	1, 007	1		6. 68	1
26. 05	RURAL HEALTH CLINIC VI	2, 363	4, 427	•		l e	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		0.00	1
27. 00	Total (sum of lines 14-26)		_		0. 00	301. 95	1
28. 00	Observation Bed Days		0	976			28.00
29. 00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF		0.2	120			31.00
32.00	Labor & delivery days (see instructions)	0	83	l .			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
33. 00	outpatient days (see instructions)						33.00
33.00	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
	Temporary Expansion COVID-19 PHE Acute Care	0	0	o			34.00
34.00	Tremporary Expansion COVID-19 PRE ACUTE CALE	ا	0	'I '	1	I	J 34. UU

Provider CCN: 15-1313

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/39/2024 7:26 am

						5/29/2024 7: 2	6 am
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	13. 00	14.00	Pati ents 15.00	
	PART I - STATISTICAL DATA	11.00	12.00	13.00	14.00	13.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	142	16	504	1. 00
	8 exclude Swing Bed, Observation Bed and		ŭ			00.	
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			75	167		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions)						8. 00
9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						9. 00 10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	142	16	504	14. 00
15. 00	CAH visits		_				15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23. 00 24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 03	RURAL HEALTH CLINIC IV	0.00					26. 03
26. 04	RURAL HEALTH CLINIC V	0.00					26. 04
26. 05	RURAL HEALTH CLINIC VI	0.00					26. 05
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges	}		0			33. 00 33. 01
	Temporary Expansion COVID-19 PHE Acute Care	}		ا			34.00
34.00	Tremporary Expansion Covid-19 PRE Acute Care			ı l	ļ		34.00

	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	UN: 15-1313	Peri od:	Worksheet	3-0	
			Component	CCN: 15-8551	From 01/01/202 To 12/31/202			
					RHC I	Cos		J GIII
					1	1.00		
	Clinic Address and Identification							
. 00	Street				1430 E 9TH ST			1.
				ty	State	ZIP Code		
. 00	City, State, ZIP Code, County		1. ROCHESTER	. 00	2.00	3. 00 N 46975		2 (
. 00	city, State, ZIP code, county	<u> [</u>	RUCHESTER			11/40975		2.
						1.00		
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - En	ter "R" for rura	al or "U" for				0	3.
					nt Award	Date		
	Source of Federal Funds				1.00	2.00		
. 00	Community Health Center (Section 330(d), PH:	S Act)		T				4.
. 00	Migrant Health Center (Section 329(d), PHS							5.
. 00	Health Services for the Homeless (Section 3							6.
. 00	Appalachian Regional Commission							7.
. 00 . 00	Look-Alikes OTHER (SPECIFY)							8. 9.
. 00	OTHER (SPECIFT)							9.
					1.00	2.00		
0. 00	Does this facility operate as other than a	hospi tal -based R	RHC or FQHC? E	nter "Y" for	N		0	10.
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type hours.)							
	11041 01)	Suno	day	N	londay	Tuesday		
		from		C		E		
		from	to		to	from		
	Facility hours of energtions (1)	1. 00	2. 00	3.00	4. 00	5.00		
1 00	Facility hours of operations (1)			3.00	4. 00	5. 00		11
1. 00	Facility hours of operations (1) CLINIC					_		11.
1. 00				3.00	4. 00	5. 00		11.
2. 00	CLINIC Have you received an approval for an except	1.00	2.00	3. 00 08: 00	4. 00 17: 00 1. 00 Y	5. 00		11. (
2. 00	Have you received an approval for an except Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report	ion to the produ ed in CMS Pub. 1 lumn 1. If yes,	2.00 uctivity stand 100-04, chapte enter in colu	3.00 08:00 lard? er 9, section imn 2 the	4. 00 17: 00 1. 00 Y	5. 00	0	12.
2. 00	Have you received an approval for an except Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in co	ion to the produ ed in CMS Pub. 1 lumn 1. If yes, . List the names ting multiple co	2.00 uctivity stand 100-04, chapte enter in colu s of all provi	3.00 08:00 lard? er 9, section mn 2 the ders and ICS (as define	4. 00 17: 00 1. 00 Y N	5. 00	0	12. 13.
2. 00 3. 00	Have you received an approval for an except Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. If line 13, column 1, is "Y", are you report	ion to the produ ed in CMS Pub. 1 lumn 1. If yes, List the names ting multiple co 2)? Enter "Y" f idated RHC group d RHC grouping. consolidated RHC	2.00 uctivity stance 100-04, chapte enter in colu s of all provi consolidated Refor yes or "N" bings and comp Consolidatec Cs in the grou	3.00 O8:00 Iard? Er 9, section Imm 2 the ders and ICS (as define for no. If I ete a I RHC grouping	4. 00 17: 00 1. 00 Y N	5. 00		12.
2. 00	Have you received an approval for an except Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.3 yes, enter in column 2 the number of consolidate are comprised exclusively of grandfathered or comprised exclusively of grandfathered or consolidate.	ion to the produ ed in CMS Pub. 1 lumn 1. If yes, List the names ting multiple co 2)? Enter "Y" f idated RHC group d RHC grouping. consolidated RHC	2.00 uctivity stance 100-04, chapte enter in colu s of all provi consolidated Refor yes or "N" bings and comp Consolidatec Cs in the grou	3.00 OR: 00 OR:	4.00 17:00 1.00 Y N ed N	5. 00 08: 00 2. 00		12.
2. 00 3. 00 3. 01	Have you received an approval for an except Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.3 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of new consolidated R	ion to the produ ed in CMS Pub. 1 lumn 1. If yes, List the names ting multiple co 2)? Enter "Y" f idated RHC group d RHC grouping. consolidated RHC	2.00 uctivity stance 100-04, chapte enter in colu s of all provi consolidated Refor yes or "N" bings and comp Consolidatec Cs in the grou	3.00 OR: 00 OR:	4.00 17:00 1.00 Y N ed N	5. 00 08: 00 2. 00		12. (
2. 00 3. 00 3. 01	Have you received an approval for an except Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.3 yes, enter in column 2 the number of consolidate are comprised exclusively of grandfathered or comprised exclusively of grandfathered or consolidate.	ion to the produ ed in CMS Pub. 1 lumn 1. If yes, . List the names ting multiple co 2)? Enter "Y" f idated RHC group d RHC grouping. consolidated RHC HCS in the group	2.00 uctivity stance 100-04, chapte enter in colu s of all provi consolidated RHF or yes or "N" consolidated comp Consolidated comp Consolidated	3.00 O8:00 Iard? Er 9, section Imm 2 the ders and ICS (as define for no. If oliete a I RHC grouping provi	4.00 17:00 1.00 Y N ed N gs ider name 1.00	5. 00 08: 00 2. 00	0	12. (
2. 00 3. 00 3. 01	Have you received an approval for an except Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.3 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of new consolidated R	ion to the produced in CMS Pub. 1 lumn 1. If yes, List the names ting multiple co 2)? Enter "Y" fidated RHC group d RHC grouping. consolidated RHC HCS in the group	2.00 uctivity stance 100-04, chapte enter in colu s of all provi consolidated RHFor yes or "N" bings and comp Consolidatec Cs in the grouping.	3.00 O8:00 Iard? Er 9, section Imm 2 the ders and ICS (as define for no. If I ete a I RHC grouping provi	4.00 17:00 1.00 Y N ed N gs ider name 1.00 XIX	08: 00 2. 00 CCN 2. 00	0	12. (
12. 00 13. 00 13. 01	Have you received an approval for an except Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in conumber of providers included in this report numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.3 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of new consolidated R	ion to the produ ed in CMS Pub. 1 lumn 1. If yes, . List the names ting multiple co 2)? Enter "Y" f idated RHC group d RHC grouping. consolidated RHC HCS in the group	2.00 uctivity star 100-04, chapi enter in col s of all prov ponsolidated f for yes or "N pings and cor Consolidate s in the gro	te lu vi RH N" mp	ndard? ter 9, section lumn 2 the viders and RHCs (as define N" for no. If mplete a ed RHC grouping ouping or	3.00 4.00 08:00 17:00	3.00	3.00

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8551	From 01/01/2023 To 12/31/2023		pared.
		ooporrorre			5/29/2024 7: 2	
			RHC I	Cost		
	County					
		4.	00			
2.00 City, State, ZIP Code, County		FULTON				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

	AL-BASED RHC/FQHC STATISTICAL DATA	WOODLAWN		CN: 15-1313	Peri od:	eu of Form CN Worksheet		
	The Bridge time, runs of the bridge bridge				From 01/01/202 To 12/31/202	3		arad
			Component	CCN: 15-8552	10 12/31/202	3 Date/Time 5/29/2024		
					RHC II	Cos		
	Clinic Address and Identification					1. 00		
. 00	Street				1400 E 9TH ST	REET		1.
			Ci	ty	State	ZIP Code		
				00	2. 00	3.00		
. 00	City, State, ZIP Code, County		ROCHESTER			N 46975		2.
						1.00		
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for run	al or "U" for	urban			0	3.
					nt Award	Date		
	Source of Endoral Funds				1.00	2. 00		
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	S Act)				T		4.
. 00	Migrant Health Center (Section 329(d), PHS A							5.
. 00	Health Services for the Homeless (Section 34	10(d), PHS Act)						6.
. 00	Appal achi an Regional Commission							7.
. 00 . 00	Look-Alikes OTHER (SPECIFY)							8. 9.
. 00	OTHER (SI ECT I)							7.
					1.00	2. 00		
0. 00	Does this facility operate as other than a h						0	10.
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type of							
	hours.)	or other operat	ron(s) and the	operating				
		Sur	nday	N	londay	Tuesday		
		from	to	from	to	from		
	5 111 (4)	1. 00	2.00	3.00	4. 00	5. 00		
			2.00					
1 00	Facility hours of operations (1)	1.00	2.00	08: 00				11
1. 00	CLINIC		2.00	08: 00	17: 00	08: 00		11.
	CLINIC				17: 00			
2. 00	Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	17: 00 1. 00 N	08: 00		12.
2. 00	Have you received an approval for an exception is this a consolidated cost report as define	on to the prod	uctivity stand	ard? r 9, section	17: 00 1. 00 N	08: 00	0	12.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	on to the proded in CMS Pub.	uctivity stand 100-04, chapte enter in colu	ard? r 9, section mn 2 the	17: 00 1. 00 N	08: 00	0	12.
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	on to the proded in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	ard? r 9, section mn 2 the ders and	17: 00 1. 00 N N	08: 00		12.
2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report	on to the proded in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	ard? r 9, section mn 2 the ders and Cs (as defin	17: 00 1. 00 N N	08: 00		12. (13. (
2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2	on to the proded in CMS Pub. umn 1. If yes, List the name ting multiple c	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N"	ard? r 9, section mn 2 the ders and Cs (as defin for no. If	17: 00 1. 00 N N	08: 00		12. (13. (
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2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comparison.	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC group d RHC grouping. consolidated RH	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou	ard? r 9, section mn 2 the ders and Cs (as defination for no. If lete a RHC groupin	17: 00 1. 00 N N	08: 00		12. (13. (
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2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comparison.	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC group d RHC grouping. consolidated RH	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou	ard? r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping ping or	17:00 1.00 N N ed N	08: 00 2. 00		12. (13. (
2. 00 3. 00 3. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comparison.	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC group d RHC grouping. consolidated RH	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou	ard? r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping ping or	17: 00 1. 00 N N ed N	2.00		12. (13. (
2. 00 3. 00 3. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH GS in the grou	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou ping.	ard? r 9, section mn 2 the ders and Cs (as definition for no. If lete a RHC grouping ping or Prov	17:00 1.00 N N N ed N gs ider name 1.00	08: 00 2. 00 CCN 2. 00 Total Visi	0	12. (13. (
2. 00 3. 00 3. 01 4. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FQHC name, CCN	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple colly? Enter "Y" dated RHC grouping. consolidated RH CS in the grou	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou ping.	ard? r 9, section mn 2 the ders and Cs (as defin- for no. If lete a RHC grouping ping or Prov	17:00 1.00 N N ed N gs ider name 1.00	08: 00 2. 00 CCN 2. 00	0	12. (13. (13. (14. (14. (14. (14. (14. (14. (14. (14
12.00 13.00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FQHC name, CCN	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH 4Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou ping.	ard? r 9, section mn 2 the ders and Cs (as definition for no. If lete a RHC grouping ping or Prov	17:00 1.00 N N N ed N gs ider name 1.00	08: 00 2. 00 CCN 2. 00 Total Visi	0	12. (13. (13. (13. (13. (13. (13. (13. (13
2. 00 3. 00 3. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH 4Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou ping.	ard? r 9, section mn 2 the ders and Cs (as definition for no. If lete a RHC grouping ping or Prov	17:00 1.00 N N N ed N gs ider name 1.00	08: 00 2. 00 CCN 2. 00 Total Visi	0	12. (13. (13. (14. (14. (14. (14. (14. (14. (14. (14
12. 00 13. 00 13. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FQHC name, CCN	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH 4Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou ping.	ard? r 9, section mn 2 the ders and Cs (as definition for no. If lete a RHC grouping ping or Prov	17:00 1.00 N N N ed N gs ider name 1.00	08: 00 2. 00 CCN 2. 00 Total Visi	0	12. (13. (13. (14. (14. (14. (14. (14. (14. (14. (14
2. 00 3. 00 3. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH 4Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou ping.	ard? r 9, section mn 2 the ders and Cs (as definition for no. If lete a RHC grouping ping or Prov	17:00 1.00 N N N ed N gs ider name 1.00	08: 00 2. 00 CCN 2. 00 Total Visi	0	12. (13. (13. (14. (14. (14. (14. (14. (14. (14. (14
12. 00 13. 00 13. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	on to the proded in CMS Pub. umn 1. If yes, List the name sing multiple c 2)? Enter "Y" dated RHC grouping. consolidated RH 4Cs in the grou Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou ping.	ard? r 9, section mn 2 the ders and Cs (as definition for no. If lete a RHC grouping ping or Prov	17:00 1.00 N N N ed N gs ider name 1.00	08: 00 2. 00 CCN 2. 00 Total Visi	0	12. 13.

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8552	From 01/01/2023 To 12/31/2023		nared.
		Component	OON. 15 0552	10 12/31/2023	5/29/2024 7: 2	
				RHC II	Cost	
		Cou	nty			
		4.	00			
2.00 City, State, ZIP Code, County		FULTON				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

	AL-BASED RHC/FQHC STATISTICAL DATA	WOODLAWN		CN: 15-1313	Peri od:	eu of Form Cl Worksheet		JU2
	The bridge time, rather critically size british			CCN: 15-8550	From 01/01/202 To 12/31/202	3		arad
			Component	CCN. 15-6550	10 12/31/202	5/29/2024		
					RHC III	Cos		
	Clinic Address and Identification					1. 00		
. 00	Street				700 MAIN STRE	ET.	\neg	1.
				ty	State	ZIP Code		
	I			00	2.00	3. 00		
. 00	City, State, ZIP Code, County		ROCHESTER		<u> </u>	N 46975		2.
						1.00		
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban			0	3.
					nt Award	Date		
	Source of Fodoral Funds				1. 00	2. 00		
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)				T		4.
. 00	Migrant Health Center (Section 329(d), PHS A							5.
. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)						6.
. 00	Appalachian Regional Commission							7.
. 00 . 00	Look-Alikes OTHER (SPECIFY)							8. 9.
. 00	OTTER (SECOND)							7.
					1.00	2. 00		
0. 00	Does this facility operate as other than a h						0	10.
	yes or "N" for no in column 1. If yes, indic 2.(Enter in subscripts of line 11 the type of							
	hours.)	or other operat	ron(s) and the	oper a tring				
		Sur	nday	N	londay	Tuesday		
		from	to	from	to	from		
		1. 00	2.00	3.00	4. 00	5. 00		
	Eacility hours of operations (1)		2.00		1.00	0.00		
1 00	Facility hours of operations (1)		2.00					11
1. 00	Facility hours of operations (1) CLINIC		2.00	08: 00	17: 00	08: 00		11.
	CLINIC			08: 00	17: 00			
2. 00	CLINIC Have you received an approval for an excepti	on to the prod	uctivity stand	08: 00 ard?	17: 00 1. 00 N	08: 00	0	12.
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2. 00	CLINIC Have you received an approval for an excepti	on to the proded in CMS Pub.	uctivity stand 100-04, chapte enter in colu	08:00 ard? r 9, section nn 2 the	17: 00 1. 00 N	08: 00	0	12.
2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	on to the proded in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	08:00 ard? r 9, section mn 2 the ders and	17: 00 1. 00 N	08: 00		12.
2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report	on to the proded in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	08:00 ard? r 9, section mn 2 the ders and Cs (as define	17: 00 1. 00 N N	08: 00		12. (13. (
2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2	on to the prod ed in CMS Pub. umn 1. If yes, List the name ing multiple c	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N"	08:00 ard? r 9, section mn 2 the ders and CS (as define for no. If	17: 00 1. 00 N N	08: 00		12. (13. (
11.00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grou	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp	08:00 ard? r 9, section nn 2 the ders and Cs (as define for no. If ete a	17: 00 1. 00 N N	08: 00		12. (13. (13. (
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2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered companies.	on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple compared to the compare	uctivity stand 100-04, chapte enter in colu s of all provi onsolidated RH for yes or "N" pings and comp Consolidated Cs in the grou	o8:00 ard? r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping ping or	17:00 1.00 N N ed N	08: 00 2. 00		12. (13. (
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Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8550	From 01/01/2023 To 12/31/2023		narodi
		Component	CCN. 15-6550	10 12/31/2023	5/29/2024 7: 2	
			RHC III	Cost		
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County		FULTON				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

HOSPI T	Financial Systems FAL-BASED RHC/FQHC STATISTICAL DATA	WOODLAWN		CN: 15-1313	Peri od:	eu of Form CM Worksheet		
	The Bridge William and Chillians British				From 01/01/202	3		
			Component	CCN: 15-8549	To 12/31/202	3 Date/Time 5/29/2024		
					RHC IV	Cos		-
	Clinic Address and Identification				1	1. 00		
. 00	Street				100 EAST DUN	IN STREET	\neg	1.
			Ci	ty	State	ZIP Code		
	Inc. in the second second			00	2. 00	3. 00		
. 00	City, State, ZIP Code, County		FULTON			N 46931		2. (
						1.00		
. 00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban			0	3.
					nt Award	Date		
	Source of Endoral Funds				1. 00	2.00		
. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		I		T		4. (
. 00	Migrant Heal th Center (Section 329(d), PHS A							5. (
. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)						6.
. 00	Appalachian Regional Commission							7.
. 00 . 00	Look-Alikes OTHER (SPECIFY)					+		8. 9.
. 00	TOTHER (OF ESTITI)			1				7.
					1. 00	2.00		
0. 00	Does this facility operate as other than a h						0	10.
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o							
	hours.)	other operat	Tori(3) and the	operatring				
	·							
			nday		Monday	Tuesday		
		from	to	from	to	from		
	Facility hours of operations (1)							
1. 00	Facility hours of operations (1)	from	to	from	to	from		11. (
1. 00		from	to	from 3.00	to 4.00	from 5.00		11. (
	CLINIC	from 1.00	to 2.00	from 3.00	to 4.00	from 5.00		
2. 00	CLINIC Have you received an approval for an excepti	from 1.00 on to the prod	to 2.00	from 3.00 08:00	17: 00 1. 00 N	from 5.00	0	12. (
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2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH	ductivity stand 100-04, chapte enter in colu es of all provi	from 3.00 ard? r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping pring or	17: 00 1. 00 N N N ed N	from 5.00 08:00 2.00		12. (13. (
2. 00 3. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered consolidated are consolid	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC group RHC grouping. onsolidated RH	ductivity stand 100-04, chapte enter in colu es of all provi	from 3.00 ard? r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping ping or	17: 00 1. 00 N N N	from 5.00		11. (12. (13. (
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12.00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH Cs in the grou	to 2.00 Juctivity stand 100-04, chapte enter in colu s of all provi consolidated RH for yes or "N" pings and comp Consolidated Cs in the grouping.	from 3.00 ard? r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping ping or Prov	to 4.00 17:00 1.00 N N N ed N gs ider name 1.00 XIX	608: 00	0	12. (13. (
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12.00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the prod d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH Cs in the grou	to 2.00 Juctivity stand 100-04, chapte enter in colu s of all provi consolidated RH for yes or "N" pings and comp Consolidated Cs in the grouping.	from 3.00 ard? r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping ping or Prov	to 4.00 17:00 1.00 N N N ed N gs ider name 1.00 XIX	608: 00	0	12. (13. (13. (14. (14. (14. (14. (14. (14. (14. (14
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Health Financial Systems	WOODLAWN	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8549	From 01/01/2023 To 12/31/2023		epared: 26 am
				RHC I V	Cost	
		Cou	ınty			
		4.	00			
2.00 City, State, ZIP Code, County		FULTON				2.00
	Tuesday	Wedn	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8.00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLI NI C	08: 00	17: 00				11.00

	Financial Systems	WOODLAWN HO				eu of Form CMS-	
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C Component	CN: 15-1313 CCN: 15-8547	Peri od: From 01/01/2023 To 12/31/2023		epared:
					RHC V	Cost	
					1	00	
	Clinic Address and Identification					. 00	
1. 00	Street				105 SR 14 N		1.00
				ty	State	ZIP Code	
2.00	City, State, ZIP Code, County	Λ.	1. KRON	00	2.00	3. 00 46910	2 00
2. 00	crty, State, ZIP code, county	Ar	KON			140910	2.00
						1. 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rural	or "U" for			C	3.00
					nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	_
4. 00	Community Health Center (Section 330(d), PHS	Act)					4.00
5. 00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6.00
7. 00	Appalachian Regional Commission						7. 00
8.00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ite number of ot	her operatio	ns in column		C	10.00
	1,100,100,100	Sunda	ау	N	Monday	Tuesday	
		from	to	from	to	from	
	Facility hours of energtions (1)	1. 00	2. 00	3. 00	4. 00	5. 00	-
11 00	Facility hours of operations (1)			08: 00	17: 00	08: 00	11.00
11.00	JOET III, O			00.00	17.00	00.00	11.00
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. In numbers below.	d in CMS Pub. 10 umn 1. If yes, e	00-04, chapte enter in colu	r 9, section mn 2 the	Y N	C	12.00 13.00
13. 01	If line 13, column 1, is "Y", are you reporting in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHC	n? Enter "Y" fo dated RHC groupi RHC grouping. onsolidated RHCs	or yes or "N" ngs and comp Consolidated s in the grou	for no. If lete a RHC groupin		C	13. 01
				Prov	ider name	CCN	
	Taua (Faua				1. 00	2. 00	
14. 00	RHC/FQHC name, CCN	V /N	V	V)/I I I	VIV	Total Waite	14.00
		Y/N 1. 00	2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00	0.00		0.00	15.00

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8547	From 01/01/2023 To 12/31/2023		nared.
		Component	0014. 10 0017	10 12,01,2020	5/29/2024 7: 2	
			RHC V	Cost		
	County					
		4.	00			
2.00 City, State, ZIP Code, County		FULTON				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

Financial Systems	WOODLAWN		CN. 1E 1010				55Z-I
AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313			8-8	
		Component	CCN: 15-8548		B Date/Time P		
				RHC VI			alli
				1			
[a.,				1	. 00		
				ESO N MICHICAN	I CTDEET	-	1. 0
Sti ee t		Ci	tv			_	1.0
				2. 00	3. 00	T	
City, State, ZIP Code, County		ARGOS		11	46501		2. 00
					1.00		
HOSPITAL-BASED FOHCS ONLY: Designation - Ent	er "R" for rur	al or "II" for	urhan		1.00	0	3. 0
THOSE THE BROCK FRIENDS ONET. BOST GRACTOR ENG	ici ik roi rui	01 0 101		nt Award	Date		0.0
				1. 00	2. 00		
Source of Federal Funds	S A - 1 S				T		4.0
						ŀ	4. 00 5. 00
						ŀ	6. 0
Appal achi an Regi onal Commissi on	,					İ	7.0
							8.0
OTHER (SPECIFY)						_	9. 0
				1. 00	2.00	_	
Does this facility operate as other than a h	nospi tal -based	RHC or FQHC? E	nter "Y" for		2.00	0	10.0
	of other operat	ion(s) and the	operati ng				
[flour S.]	Sur	ndav	I	londav	Tuesday		
						-	
	from	to	from	to	from		
	1.00	to 2.00	from 3.00	4. 00	from 5.00		
Facility hours of operations (1)			3.00	4. 00	5. 00		11 0
Facility hours of operations (1)							11. 0
			3.00	4. 00	5. 00		11.0
CLINIC Have you received an approval for an excepti	on to the prod	2.00	3.00 08:00 ard?	4. 00 17: 00 1. 00 N	5. 00		12. 0
Have you received an approval for an excepti	1.00 on to the proded in CMS Pub.	2.00 luctivity stand 100-04, chapte	3.00 08:00 ard? r 9, section	4. 00 17: 00 1. 00 N	5. 00	0	12. 0
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	on to the proded in CMS Pub.	2.00 Auctivity stand 100-04, chapte enter in colu	3.00 08:00 ard? r 9, section mn 2 the	4. 00 17: 00 1. 00 N	5. 00	0	12. 0
Have you received an approval for an excepti	on to the proded in CMS Pub.	2.00 Auctivity stand 100-04, chapte enter in colu	3.00 08:00 ard? r 9, section mn 2 the	4. 00 17: 00 1. 00 N	5. 00	0	12. 0
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report	on to the proded in CMS Pub. umn 1. If yes, List the name	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi	3.00 08:00 ard? r 9, section mn 2 the ders and Cs (as defin	4. 00 17: 00 1. 00 N N	5. 00		12. 00 13. 00
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2	on to the proded in CMS Pub. umn 1. If yes, List the name ting multiple c	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N"	3.00 08:00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If	4. 00 17: 00 1. 00 N N	5. 00		12. 00 13. 00
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli	on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple of 2)? Enter "Y" dated RHC grou	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a	4. 00 17: 00 1. 00 N N	5. 00		12. 00 13. 00
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2	on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple of 2)? Enter "Y" dated RHC grouping.	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin	4. 00 17: 00 1. 00 N N	5. 00		12. 00 13. 00
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated	on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple of 2)? Enter "Y" dated RHC group I RHC grouping. consolidated RH	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated Cos in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	4. 00 17: 00 1. 00 N N ed N	5. 00		12. 00 13. 00
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered consolidated.	on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple of 2)? Enter "Y" dated RHC group I RHC grouping. consolidated RH	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated Cos in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	4.00 17:00 1.00 N N ed N	5. 00 08: 00 2. 00		12. 00 13. 00 13. 00
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH	on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple of 2)? Enter "Y" dated RHC group I RHC grouping. consolidated RH	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated ICS in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	4. 00 17: 00 1. 00 N N ed N	5. 00		12. 00 13. 00 13. 0
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered consolidated.	on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple of 2)? Enter "Y" dated RHC group I RHC grouping.	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated ICS in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	4.00 17:00 1.00 N N ed N	5. 00 08: 00 2. 00	0	12. 0 13. 0
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH	on to the proded in CMS Pub. umn 1. If yes, List the name ing multiple of 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the grou	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated Cs in the grou	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	4.00 17:00 1.00 N N N ed N gs ider name 1.00	5. 00 08: 00 2. 00 CCN 2. 00	0	12. 0 13. 0 13. 0
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FQHC name, CCN	on to the proded in CMS Pub. umn 1. If yes, List the name ling multiple of 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the group Y/N 1.00	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated ICs in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	4.00 17:00 1.00 N N N ed N Sider name 1.00 XIX	5. 00 08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 0 13. 0 13. 0
Have you received an approval for an excepti 1s this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	on to the proded in CMS Pub. umn 1. If yes, List the name ling multiple of 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the group Y/N 1.00	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated ICs in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	4.00 17:00 1.00 N N N ed N Sider name 1.00 XIX	5. 00 08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 0 13. 0 13. 0
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH. RHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	on to the proded in CMS Pub. umn 1. If yes, List the name ling multiple of 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the group Y/N 1.00	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated ICs in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	4.00 17:00 1.00 N N N ed N Sider name 1.00 XIX	5. 00 08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 0 13. 0 13. 0
Have you received an approval for an excepti 1s this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	on to the proded in CMS Pub. umn 1. If yes, List the name ling multiple of 2)? Enter "Y" dated RHC grouping. consolidated RH CS in the group Y/N 1.00	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated ICs in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	4.00 17:00 1.00 N N N ed N Sider name 1.00 XIX	5. 00 08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 0 13. 0 13. 0
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	on to the proded in CMS Pub. umn 1. If yes, List the name ling multiple of the Product of the Pr	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated ICs in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	4.00 17:00 1.00 N N N ed N Sider name 1.00 XIX	5. 00 08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 00 13. 00
Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	on to the proded in CMS Pub. umn 1. If yes, List the name ling multiple of the Product of the Pr	2.00 Juctivity stand 100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated ICs in the grou	3.00 ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	4.00 17:00 1.00 N N N ed N Sider name 1.00 XIX	5. 00 08: 00 2. 00 CCN 2. 00 Total Visit	0	12. 00 13. 00 13. 0
	Clinic Address and Identification Street City, State, ZIP Code, County HOSPITAL-BASED FOHCS ONLY: Designation - Ent Source of Federal Funds Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A Appalachian Regional Commission Look-Alikes OTHER (SPECIFY) Does this facility operate as other than a figes or "N" for no in column 1. If yes, indice	Clinic Address and Identification Street City, State, ZIP Code, County HOSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rur Source of Federal Funds Community Health Center (Section 330(d), PHS Act) Migrant Health Center (Section 329(d), PHS Act) Health Services for the Homeless (Section 340(d), PHS Act) Appalachian Regional Commission Look-Alikes OTHER (SPECIFY) Does this facility operate as other than a hospital-based yes or "N" for no in column 1. If yes, indicate number of 2. (Enter in subscripts of line 11 the type of other operat hours.)	Clinic Address and Identification Street Ci City, State, ZIP Code, County HOSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rural or "U" for Source of Federal Funds Community Health Center (Section 330(d), PHS Act) Migrant Health Center (Section 329(d), PHS Act) Health Services for the Homeless (Section 340(d), PHS Act) Appalachian Regional Commission Look-Alikes OTHER (SPECIFY) Does this facility operate as other than a hospital-based RHC or FOHC? E yes or "N" for no in column 1. If yes, indicate number of other operatio 2. (Enter in subscripts of line 11 the type of other operation(s) and the	Clinic Address and Identification Street City 1.00 City, State, ZIP Code, County HOSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rural or "U" for urban Gra Source of Federal Funds Community Health Center (Section 330(d), PHS Act) Migrant Health Center (Section 329(d), PHS Act) Health Services for the Homeless (Section 340(d), PHS Act) Appalachian Regional Commission Look-Alikes OTHER (SPECIFY) Does this facility operate as other than a hospital-based RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column hours.)	AL-BASED RHC/FOHC STATISTICAL DATA Provider CCN: 15-1313 Period: From 01/01/2023 RHC VI Clinic Address and Identification Street 530 N MICHIGAL City State 1.00 2.00 City, State, ZIP Code, County ARGOS IN HOSPITAL-BASED FOHCS ONLY: Designation - Enter "R" for rural or "U" for urban Grant Award 1.00 Source of Federal Funds Source of Federal	AL-BASED RHC/FOHC STATISTICAL DATA Provider CCN: 15-1313	AL-BASED RHC/FQHC STATISTICAL DATA Provider CCN: 15-1313 Period: From 01/01/2023 Date/Time Preport Control Provider CCN: 15-8548 Period: Town 12/31/2023 Date/Time Preport Control Provider CCN: 15-8548 Date/Time Preport CCN: 15-8548 Date/Time Preport CONTROL Provider CCN: 15-8548 Date/Time Preport CCN: 15-854

Health Financial Systems	WOODLAWN I	HOSPI TAL		In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1313	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8548	From 01/01/2023 To 12/31/2023		narodi
		Component	CCN. 15-6546	10 12/31/2023	5/29/2024 7: 2	
				RHC VI	Cost	
		Cou	nty			
		4.	00			
2.00 City, State, ZIP Code, County		MARSHALL				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLI NI C	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

Heal th	Financial Systems WOODLAWN	HOSPI TAI		In lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-1313	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/29/2024 7:2	0 pared:		
					1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA							
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1. 00	Cost to charge ratio (see instructions)				0. 298918	1. 00		
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				129, 519	2.00		
2. 00 3. 00								
4. 00	If line 3 is yes, does line 2 include all DSH and/or suppl		ts from Medic	ai d?	Y Y	3. 00 4. 00		
5. 00	If line 4 is no, then enter DSH and/or supplemental paymen			a. a.	. 0	5. 00		
6.00	Medi cai d charges				29, 589, 653	6. 00		
7.00	Medicaid cost (line 1 times line 6)				8, 844, 880	7. 00		
8.00	Difference between net revenue and costs for Medicaid prog				8, 715, 361	8. 00		
0.00	Children's Health Insurance Program (CHIP) (see instruction	ns for each li	ne)		0	0.00		
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	9. 00 10. 00		
11.00					0	11.00		
12. 00	1	HIP (see instr	uctions)		Ö			
	Other state or local government indigent care program (see)				
13.00	Net revenue from state or local indigent care program (Not	included on li	ines 2, 5 or	9)	0	13.00		
14.00	Charges for patients covered under state or local indigent	care program	(Not included	in lines 6 or	0	14.00		
	10)							
15.00	State or local indigent care program cost (line 1 times li		(- !+	0	15.00		
16. 00	Difference between net revenue and costs for state or loca Grants, donations and total unreimbursed cost for Medicaid				0	16. 00		
	instructions for each line)	, CHIF and Sta	te/Tocal Thui	gent care progra	iiis (see			
17. 00	Private grants, donations, or endowment income restricted	to funding cha	rity care		0	17. 00		
18.00	Government grants, appropriations or transfers for support	of hospital o	perati ons		0	18. 00		
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and 8, 12 and 16)	local indigent	care program	s (sum of lines	8, 715, 361	19. 00		
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
	Uncompensated care cost (see instructions for each line)		1.00	2. 00	3. 00			
20. 00	Charity care charges and uninsured discounts (see instruct	i ons)	278, 7	78 0	278, 778	20.00		
21. 00	Cost of patients approved for charity care and uninsured d		83, 33		83, 332			
	instructions)	()						
22. 00	Payments received from patients for amounts previously wri	tten off as		0	0	22. 00		
	charity care			_				
23. 00	Cost of charity care (see instructions)		83, 33	32 0	83, 332	23. 00		
					1. 00			
24. 00	Does the amount on line 20 col. 2, include charges for pat	i ent davs bevo	nd a Length c	f stav limit	N N	24.00		
	imposed on patients covered by Medicaid or other indigent							
25.00	If line 24 is yes, enter the charges for patient days beyo	nd the indigen	t care progra	m's length of	0	25.00		
	stay limit	_		-	,			
25. 01	Charges for insured patients' liability (see instructions)				0	25. 01		
26.00					2, 016, 007			
27. 00 27. 01	· · · · · · · · · · · · · · · · · · ·				246, 983 379, 973			
28. 00					1, 636, 034			
29.00		t amounts (see	instructions)	622, 030			
30.00				,	705, 362			
	Total unreimbursed and uncompensated care cost (line 19 pl	us line 30)			9, 420, 723			
					. '	-		

10251 1	Financial Systems WOODL FAL UNCOMPENSATED AND INDIGENT CARE DATA	AWN HOSPITAL Provider CO	N. 1E 1212	Period:	u of Form CMS-2 Worksheet S-1	
	AL UNCOMPENSATED AND INDIGENI CARE DATA	Provi der Co		From 01/01/2023 To 12/31/2023	Parts I & II	pared
					1. 00	
	PART II - HOSPITAL DATA					
00	Uncompensated and Indigent Care Cost-to-Charge Ratio					1 .
. 00	Cost to charge ratio (see instructions) Medicaid (see instructions for each line)					1.
00	Net revenue from Medicaid					2.
. 00	Did you receive DSH or supplemental payments from Medi	cai d?				3.
00	If line 3 is yes, does line 2 include all DSH and/or s	upplemental payment	ts from Medio	cai d?		4.
00	If line 4 is no, then enter DSH and/or supplemental pa	yments from Medicai	d			5.
. 00	Medi cai d charges					6.
. 00	Medicaid cost (line 1 times line 6)					7.
. 00	Difference between net revenue and costs for Medicaid Children's Health Insurance Program (CHIP) (see instru					8.
00	Net revenue from stand-alone CHIP	Ctrons for each fir	ie)			9.
0.00	Stand-al one CHIP charges					10.
1. 00	Stand-alone CHIP cost (line 1 times line 10)					11.
2. 00	Difference between net revenue and costs for stand-ald	ne CHIP (see instru	uctions)			12.
	Other state or local government indigent care program					
3. 00	Net revenue from state or local indigent care program	•		•		13.
. 00	Charges for patients covered under state or local indi	gent care program	(Not included	d in lines 6 or		14.
5. 00	10) State or local indigent care program cost (line 1 time	s line 14)				15.
5. 00			e program (se	e instructions)		16.
J. 00	Grants, donations and total unreimbursed cost for Medi				ams (see	10.
7. 00	instructions for each line) Private grants, donations, or endowment income restric	tod to funding char	si ty caro		Г	
	printate grants, donations, or endowners income restrict					1 17
	Government grants appropriations or transfers for sup					1
8. 00		port of hospital op	perati ons	ms (sum of lines		18.
8. 00 9. 00		port of hospital op	perati ons	ns (sum of lines	Total (col. 1	17. 18. 19.
8. 00	Total unreimbursed cost for Medicaid , CHIP and state	port of hospital op	perations care program Uninsured patients	I nsured pati ents	+ col . 2)	18.
3. 00	Total unreimbursed cost for Medicaid , CHIP and state 8, 12 and 16)	port of hospital op and local indigent	perations care program Uninsured	Insured		18.
3. 00 9. 00	Total unreimbursed cost for Medicaid , CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each line)	port of hospital of and local indigent e)	perations care program Uninsured patients	I nsured pati ents	+ col . 2)	18. 19.
3. 00 9. 00 0. 00	Total unreimbursed cost for Medicaid , CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see inst	eport of hospital or and local indigent	perations care program Uninsured patients	I nsured pati ents	+ col . 2)	18. 19.
3. 00 9. 00 0. 00	Total unreimbursed cost for Medicaid, CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see inst Cost of patients approved for charity care and uninsured uninsured uninsured to cost of patients approved for charity care and uninsured u	eport of hospital or and local indigent	perations care program Uninsured patients	I nsured pati ents	+ col . 2)	18. 19.
3. 00 9. 00 0. 00 1. 00	Total unreimbursed cost for Medicaid , CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see inst	e) ructions) red discounts (see	perations care program Uninsured patients	I nsured pati ents	+ col . 2)	18. 19. 20. 21.
3. 00 9. 00 0. 00 1. 00	Total unreimbursed cost for Medicaid, CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see inst Cost of patients approved for charity care and uninsur instructions) Payments received from patients for amounts previously charity care	e) ructions) red discounts (see	perations care program Uninsured patients	I nsured pati ents	+ col . 2)	18. 19. 20. 21. 22.
3. 00 9. 00 9. 00 9. 00 9. 00	Total unreimbursed cost for Medicaid, CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see inst Cost of patients approved for charity care and uninsurinstructions) Payments received from patients for amounts previously charity care	e) ructions) red discounts (see	perations care program Uninsured patients	I nsured pati ents	+ col . 2)	18. 19. 20. 21. 22.
0.00	Total unreimbursed cost for Medicaid, CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see inst Cost of patients approved for charity care and uninsur instructions) Payments received from patients for amounts previously charity care	e) ructions) red discounts (see	perations care program Uninsured patients	I nsured pati ents	+ col. 2) 3.00	18. 19. 20. 21. 22.
0. 00 0. 00 0. 00 0. 00 0. 00	Total unreimbursed cost for Medicaid, CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see inst Cost of patients approved for charity care and uninsurinstructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions)	e) ructions) red discounts (see	perations care program Uninsured patients 1.00	Insured patients 2.00	+ col . 2)	18. 19. 20. 21. 22. 23.
. 00	Total unreimbursed cost for Medicaid, CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) of patients approved for charity care and uninsurinstructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for	e) ructions) red discounts (see	perations care program Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	18. 19. 20. 21. 22. 23.
0. 00 0. 00 0. 00 0. 00 0. 00	Total unreimbursed cost for Medicaid, CHIP and state 8, 12 and 16) Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) of patients approved for charity care and uninsurinstructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for imposed on patients covered by Medicaid or other indig	e) ructions) red discounts (see written off as	Derations Care program Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	18. 19. 20. 21. 22. 23.
0. 00 0. 00 0. 00 0. 00 0. 00	Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for imposed on patients covered by Medicaid or other indig If line 24 is yes, enter the charges for patient days stay limit	e) ructions) red discounts (see written off as	Derations Care program Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20. 21. 22. 23.
3. 00 3. 00 3. 00 3. 00 4. 00 4. 00 5. 00 6. 01	Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for imposed on patients covered by Medicaid or other indiging of the second of the seco	e) ructions) red discounts (see written off as	Derations Care program Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20. 21. 22. 23. 24. 25.
3. 00 3. 00 3. 00 3. 00 4. 00 4. 00 5. 00 6. 01 6. 00	Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for imposed on patients covered by Medicaid or other indig If line 24 is yes, enter the charges for patient days stay limit Charges for insured patients' liability (see instructions)	e) ructions) red discounts (see written off as	Derations Care program Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20. 21. 22. 23. 24. 25. 25. 26.
3.3.00 3.00	Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for imposed on patients covered by Medicaid or other indig If line 24 is yes, enter the charges for patient days stay limit Charges for insured patients' liability (see instructions) Medicare reimbursable bad debts (see instructions)	e) ructions) red discounts (see written off as	Derations Care program Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20. 21. 22. 23. 24. 25. 26. 27.
33. 00 9. 00 1. 00 1. 00 33. 00 44. 00 55. 00 55. 01 56. 00 77. 00	Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for imposed on patients covered by Medicaid or other indig If line 24 is yes, enter the charges for patient days stay limit Charges for insured patients' liability (see instructi Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	e) ructions) red discounts (see written off as	Derations Care program Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20. 21. 22. 23. 24. 25. 26. 27. 27.
3. 00 3. 00 3. 00 4. 00 4. 00 4. 00 7. 01 8. 00	Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Dayments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for imposed on patients covered by Medicaid or other indig If line 24 is yes, enter the charges for patient days stay limit Charges for insured patients' liability (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	e) ructions) red discounts (see written off as patient days beyon tent care program? beyond the indigent	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20. 21. 22. 23. 24. 25. 26. 27. 28.
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 01	Uncompensated care cost (see instructions for each lin Charity care charges and uninsured discounts (see instructions) Payments received from patients for amounts previously charity care Cost of charity care (see instructions) Does the amount on line 20 col. 2, include charges for imposed on patients covered by Medicaid or other indig If line 24 is yes, enter the charges for patient days stay limit Charges for insured patients' liability (see instructi Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad	e) ructions) red discounts (see written off as repatient days beyon tent care program? beyond the indigent ons)	Uninsured patients 1.00	Insured patients 2.00	+ col. 2) 3.00	20. 21. 22. 23. 24. 25. 26. 27. 27.

Health Financial Systems	WOODLAWN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der C	CN: 15-1313 P	eri od:	Worksheet A	
			F	rom 01/01/2023 o 12/31/2023		
			T	o 12/31/2023		
	0.1.1			5	5/29/2024 7: 2	6 am
Cost Center Description	Sal ari es	0ther		Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1. 00 O0100 CAP REL COSTS-BLDG & FLXT		2, 544, 144	2, 544, 144	-133, 980	2, 410, 164	1.00
1. 02 00102 AKRON BUILDING		19, 986			19, 986	1. 02
		· ·				
1. 03 00103 ARGOS BUI LDI NG		80, 898			80, 898	1.03
1. 04 00101 CLAYS BUI LDI NG		49, 856			183, 836	1.04
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 189, 371	1, 189, 371	0	1, 189, 371	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	4, 066, 096	8, 196, 782	12, 262, 878	226, 946	12, 489, 824	5.00
7.00 00700 OPERATION OF PLANT	496, 663	1, 215, 286	1, 711, 949	1, 339, 218	3, 051, 167	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	30, 354	137, 644			167, 998	8.00
9. 00 00900 HOUSEKEEPI NG	391, 400	181, 109			571, 973	9. 00
1 1						
10. 00 01000 DI ETARY	480, 495	355, 816			274, 984	10.00
11. 00 01100 CAFETERI A	0	0	0	,	556, 788	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	202, 233	83, 251	285, 484	354, 804	640, 288	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY	375, 468	3, 346, 656	3, 722, 124	-33, 027	3, 689, 097	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	401, 268	1, 017, 586			1, 373, 617	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	401, 200	1,017,300	1, 410, 004	45, 257	1, 373, 017	10.00
	2 (42 270	949, 669	2 502 047	1 0/5 /0/	2 527 251	20.00
	2, 643, 378	•			2, 527, 351	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0	0	1	0	31.00
43. 00 04300 NURSERY	0	0	C	516, 846	516, 846	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	723, 183	1, 910, 352	2, 633, 535	-235, 866	2, 397, 669	50.00
51.00 05100 RECOVERY ROOM	481, 300	177, 390	658, 690	0	658, 690	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		162, 745	162, 745	52.00
53. 00 05300 ANESTHESI OLOGY	0	1, 017, 843	1, 017, 843		1, 017, 048	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 686, 002	1, 484, 231	3, 170, 233	1	2, 941, 622	54.00
60. 00 06000 LABORATORY	967, 326	2, 062, 643			2, 933, 118	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 127, 610	398, 118			1, 514, 622	65.00
66. 00 06600 PHYSI CAL THERAPY	616, 554	155, 262	771, 816	-205	771, 611	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	169, 934	30, 307	200, 241	0	200, 241	67.00
68. 00 06800 SPEECH PATHOLOGY	82, 233	20, 042	102, 275	ol	102, 275	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	o	804, 113		-	804, 113	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	Ö	004, 113	004, 113		004, 113	73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>			vi Uj		73.00
	348, 944	7/0 /57	1 100 (01	00.000	1 107 (21	00 00
		760, 657	1, 109, 601		1, 197, 631	88.00
88. 01 08801 RURAL HEALTH CLINIC II	2, 646, 822	1, 513, 643			3, 446, 876	88. 01
88.02 08802 RURAL HEALTH CLINIC III	1, 569, 337	938, 342			2, 476, 533	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	188, 403	46, 320	234, 723	19, 018	253, 741	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	705, 687	231, 051	936, 738	-15, 033	921, 705	88. 04
88.05 08805 RURAL HEALTH CLINIC VI	1, 283, 902	1, 244, 649	2, 528, 551	-15, 477	2, 513, 074	88. 05
91. 00 09100 EMERGENCY	1, 359, 215	3, 459, 283			4, 811, 748	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,007,210	0, 107, 200	1,010,170	0,700	1,011,710	92.00
	1 245 (02	112 020	1 250 522	2 420	1 25/ 002	
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	1, 245, 693	113, 829				93.00
93. 01 04951 SHAFER MEDI CAL CENTER	1, 495, 836	484, 356			1, 899, 063	
93. 02 O4040 I NTERNAL MEDICINE	787, 980	55, 938	843, 918	-1, 545	842, 373	93. 02
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE		0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	26, 573, 316	36, 276, 423	62, 849, 739	117, 039	62, 966, 778	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	Ö	0		1		192.00
192. 01 19201 FCMC		0		-		192. 01
	٥	0	0			
192. 02 19202 ARGOS MEDI CAL CENTER	0	0	0	0		192.02
192. 03 19203 AKRON MEDI CAL CENTER	0	0	[C	0		192. 03
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 ADVERTI SI NG	83, 859	167, 569	251, 428	-117, 039	134, 389	194.00
194. 01 07951 LTC/WELLNESS	167, 522	49, 521	217, 043		217, 043	
200.00 TOTAL (SUM OF LINES 118 through 199)	26, 824, 697	36, 493, 513				
, , , , , , , , , , , , , , , , , , ,			,,,	, 91	, ,	

 Health Financial
 Systems
 WOODLAND

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1313

			5/29/2024 7	
Cost Center Description	Adjustments	Net Expenses	9,2,7202.7	20 (3111
	(See A-8)	For		
		Allocation		
OFFICE ALL OFFICE OFFIC	6. 00	7. 00		
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FLXT	15 212	2 204 OF1	I	1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.02 00102 AKRON BUILDING	-15, 313 0	2, 394, 851 19, 986		1. 00 1. 02
1. 03 00103 ARGOS BUILDING	0	80, 898		1.02
1. 04 00101 CLAYS BUILDING	0	183, 836	l control of the cont	1.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 189, 371	1	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-4, 313, 178	8, 176, 646	1	5.00
7. 00 O0700 OPERATION OF PLANT	0,010,170	3, 051, 167	1	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	167, 998		8.00
9. 00 00900 HOUSEKEEPI NG	0	571, 973	l .	9.00
10. 00 01000 DI ETARY	-24, 806	250, 178	1	10.00
11. 00 01100 CAFETERI A	-115, 446	441, 342		11.00
13.00 01300 NURSING ADMINISTRATION	0	640, 288	3	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		14.00
15. 00 01500 PHARMACY	-3, 939	3, 685, 158	3	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	-112	1, 373, 505	5	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	2, 527, 351	l .	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	1	31.00
43. 00 04300 NURSERY	0	516, 846		43.00
ANCILLARY SERVICE COST CENTERS	1	0.007.440	J	
50. 00 05000 OPERATING ROOM	0	2, 397, 669	•	50.00
51. 00 05100 RECOVERY ROOM	0	658, 690		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY	-953, 767	162, 745	•	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	-228, 090	63, 281 2, 713, 532		54.00
60. 00 06000 LABORATORY	-226, 090	2, 713, 332	l control of the cont	60.00
65. 00 06500 RESPIRATORY THERAPY	-180, 733	1, 333, 889		65.00
66. 00 06600 PHYSI CAL THERAPY	-4, 239	767, 372		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	-14, 891	185, 350	1	67.00
68. 00 06800 SPEECH PATHOLOGY	0	102, 275	1	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	804, 113	3	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	-26, 377	1, 171, 254	1	88. 00
88.01 08801 RURAL HEALTH CLINIC II	-139, 799	3, 307, 077	l .	88. 01
88.02 08802 RURAL HEALTH CLINIC III	-77, 587	2, 398, 946	l .	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	0	253, 741	l .	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	-16, 357	905, 348	l .	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI	-30, 921	2, 482, 153	l .	88. 05
91. 00 09100 EMERGENCY	-1, 231, 981	3, 579, 767		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1 124 022	222 070		92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	-1, 134, 022	222, 070	1	93.00
93. 01 04951 SHAFER MEDICAL CENTER 93. 02 04040 INTERNAL MEDICINE	-1, 403, 389 -710, 038	495, 674 132, 335	·	93. 01 93. 02
SPECIAL PURPOSE COST CENTERS	-710,030	132, 333)	- 93.02
113. 00 11300 NTEREST EXPENSE	0	0		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		52, 341, 793		118.00
NONREI MBURSABLE COST CENTERS	10/021/700	02/011/770	'	
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	l control of the cont	192.00
192. 01 19201 FCMC	0	0		192. 01
192.02 19202 ARGOS MEDICAL CENTER	0	0		192. 02
192.03 19203 AKRON MEDICAL CENTER	0	0		192. 03
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194. 00 07950 ADVERTI SI NG	0	134, 389		194. 00
194. 01 07951 LTC/WELLNESS	0	217, 043		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	-10, 624, 985	52, 693, 225	p	200.00

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

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

						5/29/2024 7:26 am
		Increases			<u> </u>	
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3.00	4. 00	5. 00		
1 00	A - CAFETERIA RECLASS	11 00	221 (42	225 145		1 00
1. 00	CAFETERI A	11.00	321, 643	235, 145		1.00
	B - ADVERTISING RECLASS		321, 643	235, 145		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	39, 036	78, 003		1.00
1.00	O O O O O O O O O O O O O O O O O O O		39, 036	78, 003		1.00
	C - DEPRECIATION RECLASS		37, 030	70,003		
1.00	CLAYS BUILDING	1. 04	0	133, 980		1. 00
00	0			133, 980		
	D - NURSERY RECLASS					
1.00	NURSERY	43.00	413, 826	103, 020		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	130, 306	32, 439		2.00
	0		544, 132	135, 459		
	E - NURSING SUPERVISOR RECLAS	SS				
1.00	NURSING ADMINISTRATION	13. 00	358, 029	0		1.00
2.00		0.00		0		2.00
	0		358, 029	0		
	F - MAINTENANCE RECLASS					
1.00	OPERATION OF PLANT	7. 00	0	1, 339, 218		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00		0. 00	0	0		4.00
5. 00		0. 00	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	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	0	0		13.00
14. 00		0.00	0	0		14.00
15. 00		0.00	0	0		15. 00
16. 00		0.00		0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18.00
19. 00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
20.00			 	1, 339, 218		20.00
	G - RENT RECLASS	<u> </u>	-1	.,,		
1.00	RURAL HEALTH CLINIC IV	88. 03	0	12, 730		1.00
				12, 730		
	H - RHC OVERHEAD RECLASS		<u> </u>			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	663, 784		1.00
2.00	RURAL HEALTH CLINIC	88. 00	5, 789	0		2.00
3.00	RURAL HEALTH CLINIC III	88. 02	15, 425	0		3.00
4.00	RURAL HEALTH CLINIC IV	88. 03	2, 203	0		4.00
5.00	RURAL HEALTH CLINIC V	88. 04	6, 100	0		5. 00
6.00	RURAL HEALTH CLINIC VI		2 <u>0, 2</u> 88	0		6.00
	0		49, 805	663, 784		
	J - CLINIC SUPERVISOR					
1.00	RURAL HEALTH CLINIC	88. 00	12, 905	0		1.00
2.00	RURAL HEALTH CLINIC III	88. 02	35, 548	0		2.00
3.00	RURAL HEALTH CLINIC IV	88. 03	4, 085	0		3.00
	0		52, 538	0		
	K - NP RECLASS			Т		
1. 00	RURAL HEALTH CLINIC	8800	6 <u>9, 3</u> 89	0		1.00
F00 07	TOTALS		69, 389			505 5
500.00	Grand Total: Increases		1, 434, 572	2, 598, 319		500.00

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1313

						To 12/	e/Time Prepared: 9/2024 7:26 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref	<u>.</u>	
٨	6. 00 - CAFETERI A RECLASS	7. 00	8. 00	9. 00	10. 00		
	ETARY	10.00	321, 643	235, 145		o	1.00
0 0	LIANI		321, 643	235, 145		4	1.00
В -	- ADVERTISING RECLASS		021, 010	200, 110			
	VERTI SI NG	194. 00	39, 036	78, 003		0	1.00
0			39, 036	78, 003		1	
	- DEPRECIATION RECLASS						
1.00 CAF	P REL COSTS-BLDG & FIXT	1.00	0	13 <u>3, 9</u> 80		9	1.00
0	AUUDOEDVA DEGLAGO		0	133, 980			
	- NURSERY RECLASS	20.00	E44 122	125 450			1 00
1. 00 ADI 2. 00	ULTS & PEDIATRICS	30. 00 0. 00	544, 132	135, 459 0		0	1.00
2.00	+		544, 132	0 135, 459		4	2.00
F -	- NURSING SUPERVISOR RECLAS	S	344, 132	133, 437			
	ULTS & PEDIATRICS	30.00	354, 938	0		0	1.00
	ERATING ROOM	50. 00	3, 091			o	2.00
0			358, 029	0			
	- MAINTENANCE RECLASS						
	MINISTRATIVE & GENERAL	5. 00	0	553, 877		0	1.00
	USEKEEPI NG	9. 00	0	536		0	2.00
	ETARY	10.00	0	4, 539		0	3.00
	RSING ADMINISTRATION	13. 00	0	3, 225		0	4.00
	ARMACY DICAL RECORDS & LIBRARY	15. 00 16. 00	O O	33, 027 45, 237		0	5. 00 6. 00
•	ULTS & PEDIATRICS	30.00	0	31, 167		0	7.00
•	ERATING ROOM	50.00	Ö	232, 775		o	8.00
	ESTHESI OLOGY	53. 00	o	795		o	9. 00
	DI OLOGY-DI AGNOSTI C	54.00	o	228, 611		0	10.00
11.00 LA	BORATORY	60. 00	o	96, 851		0	11.00
12.00 RES	SPI RATORY THERAPY	65. 00	0	11, 106		0	12.00
	YSI CAL THERAPY	66. 00	0	205		0	13.00
	RAL HEALTH CLINIC	88. 00	0	53		0	14.00
•	RAL HEALTH CLINIC V	88. 04	0	21, 133		0	15.00
	RAL HEALTH CLINIC VI	88. 05	0	35, 765		0	16.00
•	ERGENCY	91.00	0	6, 750		0	17.00
I	ODLAWN MEDICAL OFESSIONALS	93. 00	U	3, 430		0	18.00
	AFER MEDICAL CENTER	93. 01	o	28, 591		o	19.00
	TERNAL MEDICINE	93. 02	0	1, 545		0	20.00
0	TEIMWIE MEDI OTNE	70.02	_	1, 339, 218		٩	20.00
G -	- RENT RECLASS		-,	,			
1. 00 RUF	RAL HEALTH CLINIC III	88. 02	0	12, 730		0	1.00
0			0	12, 730			
	- RHC OVERHEAD RECLASS				ı	-1	
	RAL HEALTH CLINIC II	88. 01	49, 805	663, 784		0	1.00
2. 00		0.00	0	0		0	2.00
3. 00		0.00	0	0		0	3.00
1.00		0. 00 0. 00	0	0		0	4.00
5. 00 5. 00		0.00	0	0		0	5. 00 6. 00
0.00	+		49, 805	663, 784		4	0.00
<u>, </u>	- CLINIC SUPERVISOR		77, 000	505, 764			
	AFER MEDICAL CENTER	93. 01	52, 538	0		0	1.00
2. 00	322.	0.00	0	0		o	2. 0
3. 00		0. 00	o	0		0	3.00
0			52, 538				
	- NP RECLASS						
	RAL HEALTH CLINIC III	88. 02	69, 389	0		O	1.00
	TALS		69, 389	0		_	
500. 00 Gra	and Total: Decreases		1, 434, 572	2, 598, 319		1	500.00

| Period: | Worksheet A-7 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS WOODLAWN HOSPITAL Provi der CCN: 15-1313

				To	12/31/2023	Date/Time Pre 5/29/2024 7: 2	
				Acqui si ti ons		3/29/2024 1.2	5 alli
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances	. u. o.i.asso	5011411 011	.ota.	Retirements	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	596, 216	0	0	0	0	1.00
2.00	Land Improvements	513, 782	316, 879	0	316, 879	0	2.00
3.00	Buildings and Fixtures	29, 635, 140	1, 621, 693	0	1, 621, 693	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	16, 309, 970	840, 042	0	840, 042	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47, 055, 108	2, 778, 614	0	2, 778, 614	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	47, 055, 108	2, 778, 614	0	2, 778, 614	0	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
	I	6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	596, 216	0			ļ	1.00
2.00	Land Improvements	830, 661	0			ļ	2.00
3. 00	Buildings and Fixtures	31, 256, 833	0			l	3.00
4.00	Building Improvements	0	0			l	4. 00
5. 00	Fi xed Equi pment	0	0			ļ	5.00
6.00	Movable Equipment	17, 150, 012	0			l	6. 00
7.00	HIT designated Assets	0	0			l	7. 00
8.00	Subtotal (sum of lines 1-7)	49, 833, 722	0			ļ	8.00
9.00	Reconciling Items	0	0			ļ	9.00
10. 00	Total (line 8 minus line 9)	49, 833, 722	0			l	10.00

Health Financial Systems	WOODLAWN H	OSPI TAL		In Lieu of Form CMS-25		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part II Date/Time Pre 5/29/2024 7:2	pared:
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	

						5/29/2024 7: 20	6 am
			SU	IMMARY OF CAPIT	AL		
	October Described	D		1.1		T	
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
		9. 00	10. 00	11.00	instructions) 12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2	12.00	13.00	
1. 00	CAP REL COSTS-BLDG & FIXT			372, 004	619, 941	0	1. 00
1. 00	AKRON BUILDING	1, 512, 774 441	0	372,004	019, 941		1. 00
1. 02	ARGOS BUILDING	1, 353	0	0	45, 131		1. 02
1. 03	CLAYS BUILDING	1, 333	0	0	43, 131		1. 03
3. 00	Total (sum of lines 1-2)	1, 514, 568	0	372, 004	665, 072		3. 00
3.00	Total (suil of Titles 1-2)	SUMMARY O		372,004	005,072	U	3.00
		JUNIMAK I U	I CAFITAL				
	Cost Center Description	0ther	Total (1)				
	000 t 0011to.	Capi tal -Relat					
		ed Costs (see					
		instructions)	g,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	39, 425	2, 544, 144				1.00
1.02	AKRON BUILDING	19, 545	19, 986				1.02
1.03	ARGOS BUILDING	34, 414	80, 898				1.03
1.04	CLAYS BUILDING	49, 856	49, 856				1.04
3.00	Total (sum of lines 1-2)	143, 240	2, 694, 884				3.00
		. '	'	•		'	

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1313 Period: From 01/01/2023 To 12/31/2023 Part III Date/Time Prepared: 5/29/2024 7: 26 am
Cost Center Description Gross Assets Capitalized Leases Gross Assets For Ratio (see instructions)
Leases for Ratio (col. 1 - col. 2)
Col. 1 - col. 2) 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
PART - RECONCILIATION OF CAPITAL COSTS CENTERS
1. 00 CAP REL COSTS-BLDG & FIXT 38, 672, 671 0 38, 672, 671 0. 776034 0 1. 00 1. 02 AKRON BUI LDI NG 1, 243, 551 0 1, 243, 551 0. 024954 0 1. 02 1. 03 ARGOS BUI LDI NG 2, 664, 753 0 2, 664, 753 0. 053473 0 1. 03 1. 04 CLAYS BUI LDI NG 7, 252, 747 0 7, 252, 747 0. 145539 0 1. 04 3. 00 Total (sum of lines 1-2) 49, 833, 722 0 49, 833, 722 1. 000000 0 3. 00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL
1. 03 ARGOS BUILDING 2, 664, 753 0 2, 664, 753 0. 053473 0 1. 03 1. 04 CLAYS BUILDING 7, 252, 747 0 7, 252, 747 0. 145539 0 1. 04 3. 00 Total (sum of lines 1-2) 49, 833, 722 0 49, 833, 722 1. 000000 0 3. 00 ALLOCATION OF OTHER CAPITAL
1. 04 CLAYS BUILDING 7, 252, 747 0 7, 252, 747 0. 145539 0 1. 04 3. 00 Total (sum of lines 1-2) 49, 833, 722 0 49, 833, 722 1. 000000 0 3. 00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL
3.00 Total (sum of lines 1-2)
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL
Cost Center Description Taxes Other Total (sum of Depreciation Lease
Capi tal -Rel at col s. 5
ed Costs through 7)
6.00 7.00 8.00 9.00 10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
1. 00 CAP REL COSTS-BLDG & FIXT 0 0 1, 378, 153 0 1. 00
1. 02 AKRON BUILDING 0 0 441 0 1. 02
1. 03 ARGOS BUILDING 0 0 1, 353 0 1. 03
1. 04 CLAYS BUILDING 0 0 133, 980 0 1. 04
3.00 Total (sum of lines 1-2) 0 0 1,513,927 0 3.00
SUMMARY OF CAPITAL
Cost Center Description Interest Insurance Taxes (see Other Total (2)
(see instructions) Capital - Relat (sum of cols.
i nstructi ons)
11. 00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
1. 00 CAP REL COSTS-BLDG & FIXT 357, 332 619, 941 0 39, 425 2, 394, 851 1. 00
1. 02 AKRON BUI LDI NG 0 0 19, 545 19, 986 1. 02
1. 03 ARGOS BUILDING 0 45, 131 0 34, 414 80, 898 1. 03
1. 04 CLAYS BUILDING 0 0 49,856 183,836 1. 04
3.00 Total (sum of lines 1-2) 357, 332 665, 072 0 143, 240 2, 679, 571 3.00

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

					From 01/01/2023 To 12/31/2023	Date/Time Pre	
				Expense Classification on	Worksheet A	5/29/2024 7: 2	6 am
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
1.00	Investment income - CAP REL	1. 00 B	2. 00 -14, 672	3.00 CAP REL COSTS-BLDG & FLXT	4.00	5. 00 11	1.00
1 00	COSTS-BLDG & FIXT (chapter 2)		0	AKDON BIILLBING	1 02	0	1 00
1. 02	Investment income - AKRON BUILDING (chapter 2)		U	AKRON BUILDING	1. 02	0	1. 02
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
	COSTS-MVBLE EQUIP (chapter 2)		J	oost oontor borotou			
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
4 00	expenses (chapter 8)		0		0.00	0	4 00
6. 00	Rental of provider space by suppliers (chapter 8)		o l		0.00	O	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	
10. 00	Provider-based physician adjustment	A-8-2	-5, 664, 487			0	10.00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12.00
12 00	transactions (chapter 10)		0		0.00	0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-115, 446	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others		0		0. 00	0	15.00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-112	MEDICAL RECORDS & LIBRARY	16. 00	0	18.00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines	В	0	CAFETERI A	11. 00	0	20.00
21. 00		Б	0	ONIETEKTA	0.00	0	•
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
0,	(chapter 21)			OAD DEL 000TO DI DO :			04 ==
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		O	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
26. 02	Depreciation - AKRON BUILDING			AKRON BULLDING	1. 02	0	
26. 03 26. 04				ARGOS BUILDING CLAYS BUILDING	1. 03 1. 04	0	
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		О	*** Cost Center Deleted ***	2. 00	0	27. 00
	COSTS-WVDLL LQUIF		I		l l		<u> </u>

		Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted						
				io so naj astoa				
Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7			
	(2)	0.00	0.00		Ref.			
00.00 New Joseph Comment	1. 00	2. 00	3.00	4.00	5. 00	00.00		
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28.00		
29.00 Physicians' assistant	4 0 0	0	OCCUPATIONAL THERABY	0.00	0			
30.00 Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00		
therapy costs in excess of								
limitation (chapter 14) 30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99		
i nstructions)		0	ADULTS & PEDIATRICS	30.00		30.99		
31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00		
pathology costs in excess of		_						
limitation (chapter 14)								
32.00 CAH HIT Adjustment for	В	-641	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00		
Depreciation and Interest								
33.00 PHYSICIAN RECRUITMENT	A	-4, 688	ADMINISTRATIVE & GENERAL	5. 00	0	33.00		
34.00 PHYSICIAN RECRUITMENT	A	-64, 350	ADMINISTRATIVE & GENERAL	5. 00	0	34.00		
34. 01 HAF EXPENSE	A	-4, 155, 584	ADMINISTRATIVE & GENERAL	5. 00	0	34. 01		
35.00 ADMIN OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	35.00		
36.00 HOME MEAL PROGRAM	В		DI ETARY	10. 00	0	36.00		
37.00 DRUG SALES	В		PHARMACY	15. 00	0	37.00		
38.00 PT - OTHER REVENUE	В		PHYSI CAL THERAPY	66. 00	0	38. 00		
39.00 OCC THER OTH REV	В		OCCUPATI ONAL THERAPY	67. 00	0	39. 00		
40.00 MISC REV -OTH REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	40. 00		
41.00 STAFF RENTAL AGREEMENTS	В		RESPI RATORY THERAPY	65. 00	0	41.00		
42.00 I HA & AHA LOBBYI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	42.00		
43.00 PART B BILLING OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	0	43.00		
44. 00 LTC EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	0	44.00		
45. 00 RHC OFFSETS	Α		RURAL HEALTH CLINIC	88. 00	0	45. 00		
45. 01 RHC OFFSETS	A		RURAL HEALTH CLINIC II	88. 01	0	45. 01		
45. 02 RHC OFFSETS	A		RURAL HEALTH CLINIC III	88. 02	0	45. 02		
45. 03 RHC OFFSETS	A		RURAL HEALTH CLINIC V	88. 04	0	45. 03		
45. 04 RHC OFFSETS	A		RURAL HEALTH CLINIC VI	88. 05	0	45.04		
50.00 TOTAL (sum of lines 1 thru 49)		-10, 624, 985				50.00		
(Transfer to Worksheet A,								
column 6, line 200.)		 	- CMC Dub. 4E 4			L		

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

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

B. Amount Received - if cost cannot be determined.

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

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

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

							5/29/2024 7:2	26 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		l denti fi er	Remuneration	Component	Component		ider Component	
					·		Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	53.00	ANESTHESI OLOGY	965, 767	953, 767	12, 000	C	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	228, 090	228, 090	0	l c	o	2.00
3.00	65. 00	RESPI RATORY THERAPY	33, 658	3, 200	30, 458	l c	o	3.00
4.00	91, 00	EMERGENCY	2, 548, 671	1, 231, 981		l c	o	4.00
5.00	93. 00	WOODLAWN MEDICAL	1, 134, 022	1, 134, 022	. 0	l c	o	5. 00
		PROFESSI ONALS	, , .	,				
6. 00		SHAFER MEDICAL CENTER	1, 403, 389	1, 403, 389	0	l c	o	6.00
7. 00		INTERNAL MEDICINE	710, 038	710, 038		l c	0	7.00
8. 00	0.00		0	0	0		0	8.00
9. 00	0.00		l o	0	0	ĺ	o o	9. 00
10. 00	0.00		l o	0		Ĭ		10.00
200.00	0.00		7, 023, 635	5, 664, 487	1, 359, 148	۲		200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WKSt. A LITTE #	I denti fi er			Memberships &	Component	of Mal practice	
		rdentrirei	LIIIII	Li mi t	Continuing	Share of col.	Insurance	
				LIIIII	Education	12	Trisul ance	
	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		ANESTHESI OLOGY	0.00	7. 00				1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	0	_	1		2.00
3. 00		RESPIRATORY THERAPY	0	0	_			3.00
4. 00		EMERGENCY						4. 00
5. 00		WOODLAWN MEDICAL	0	0	0		0	5.00
5.00		PROFESSI ONALS	0	U	U	١)	5.00
6. 00		SHAFER MEDICAL CENTER		O		_	0	6. 00
7. 00		INTERNAL MEDICAL CENTER	0	0			0	7. 00
7. 00 8. 00	0.00	INTERNAL MEDICINE	0	0	0		0	7. 00 8. 00
			0	U	0		0	
9.00	0.00		0	U			1	9.00
10.00	0. 00		0	U			0	10.00
200.00			0		0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4 00	2.00	14	1/ 00	47.00	10.00		
1 00	1.00	2.00	15. 00	16. 00	17. 00	18. 00		1 00
1.00		ANESTHESI OLOGY	0	0	_	953, 767		1.00
2. 00		RADI OLOGY-DI AGNOSTI C	0	0	_	228, 090		2.00
3. 00		RESPI RATORY THERAPY	0	0	_	3, 200		3.00
4. 00		EMERGENCY	0	0	0	1, 231, 981	1	4. 00
5. 00		WOODLAWN MEDICAL	0	0	0	1, 134, 022	!	5. 00
		PROFESSI ONALS						
6. 00		SHAFER MEDICAL CENTER	0	0	_	.,,		6.00
7.00		INTERNAL MEDICINE	0	O	0	710, 038	3	7.00
8.00	0.00		0	O	0	C)	8.00
9. 00	0.00		0	O	0	[C		9.00
10.00	0.00		0	0	0	[c		10.00
200.00			0	O	0	5, 664, 487	·	200.00
	. '				•			

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared: 5/29/2024 7: 26 am

					10	12/31/2023	5/29/2024 7: 20	
					CAPI TAL REL	ATED COSTS		
		Cost Center Description	Net Expenses	BLDG & FLXT	AKRON	ARGOS	CLAYS	
		cost center bescription	for Cost	DLUG & FIXI	BUI LDI NG	BUI LDI NG	BUI LDI NG	
			Allocation		BOTEBINO	DOTEDINO	DOT EDT NO	
			(from Wkst A					
			col. 7)					
	CENED	AL CEDIUSE COCT CENTEDS	0	1.00	1. 02	1. 03	1. 04	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	2, 394, 851	2, 394, 851				1. 00
1. 00	1	AKRON BUILDING	19, 986		1			1. 00
1. 03		ARGOS BUILDING	80, 898	l e		80, 898		1. 03
1. 04		CLAYS BUILDING	183, 836	ł	0	0	183, 836	1.04
4.00		EMPLOYEE BENEFITS DEPARTMENT	1, 189, 371	2, 828	0	0	0	4.00
5. 00		ADMINISTRATIVE & GENERAL	8, 176, 646		1	6, 472	128	5.00
7.00	1	OPERATION OF PLANT	3, 051, 167	l '	1	7, 378	37, 356	7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	167, 998 571, 973			0	0 345	8. 00 9. 00
10.00	1	DI ETARY	250, 178			0	0	10.00
11. 00		CAFETERI A	441, 342			o	0	11.00
13.00		NURSING ADMINISTRATION	640, 288		1	0	0	13.00
14.00		CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00	1	PHARMACY	3, 685, 158		1	0	0	15.00
16. 00		MEDICAL RECORDS & LIBRARY	1, 373, 505	8, 439	0	0	34, 083	16. 00
30. 00		ADULTS & PEDIATRICS	2, 527, 351	383, 540	O	0	0	30. 00
31. 00		INTENSIVE CARE UNIT	2, 527, 331	0 303, 340	1	0	0	31.00
		NURSERY	516, 846		1	o	Ö	43. 00
	ANCI L	LARY SERVICE COST CENTERS						
		OPERATING ROOM	2, 397, 669			0	0	50.00
51.00	1	RECOVERY ROOM	658, 690			0	0	51.00
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM	162, 745		1	0	0	52. 00 53. 00
54.00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	63, 281 2, 713, 532	3, 075 255, 768		0	0	54.00
60.00		LABORATORY	2, 933, 118	l '		0	0	60.00
65. 00	1	RESPI RATORY THERAPY	1, 333, 889		1	o	0	65. 00
66.00	06600	PHYSI CAL THERAPY	767, 372	70, 720	0	0	0	66.00
67. 00		OCCUPATI ONAL THERAPY	185, 350	ł .	0	0	0	67.00
68. 00	1	SPEECH PATHOLOGY	102, 275	i e	0	0	0	68.00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0 004 113	1	0	O	0	71. 00 72. 00
		DRUGS CHARGED TO PATTENTS	804, 113	i e		0	0	72.00
73.00		TIENT SERVICE COST CENTERS	J			<u> </u>		73.00
88. 00		RURAL HEALTH CLINIC	1, 171, 254	0	0	0	45, 193	88. 00
88. 01		RURAL HEALTH CLINIC II	3, 307, 077	172, 300	0	0	0	88. 01
88. 02		RURAL HEALTH CLINIC III	2, 398, 946	l	1	0	20, 086	
88. 03		RURAL HEALTH CLINIC IV	253, 741	0	_	0	0	88. 03
88. 04 88. 05		RURAL HEALTH CLINIC V RURAL HEALTH CLINIC VI	905, 348 2, 482, 153	l e	16, 332 0	0 67, 048	0	88. 04 88. 05
91. 00		EMERGENCY	3, 579, 767	l e		07, 040	0	91. 00
	1	OBSERVATION BEDS (NON-DISTINCT PART	2,2	1,		1	-	92. 00
		WOODLAWN MEDICAL PROFESSIONALS	222, 070	128, 445	0	0	0	93.00
		SHAFER MEDICAL CENTER	495, 674			0	46, 645	
93. 02		INTERNAL MEDICINE	132, 335	12, 164	0	0	0	93. 02
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE			1	Т		113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52, 341, 793	2, 375, 123	19, 986	80, 898	183, 836	
110.00		IMBURSABLE COST CENTERS	02,011,770	2,070,120	17,700	00,070	100,000	110.00
190.00		GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		PHYSICIANS PRIVATE OFFICES	0	15, 307		0		192. 00
192. 01	1	l e e e e e e e e e e e e e e e e e e e	0	0	0	0		192. 01
		ARGOS MEDICAL CENTER	0	0		0		192. 02 192. 03
		AKRON MEDICAL CENTER NONPALD WORKERS		0		0		192. 03 193. 00
		ADVERTI SI NG	134, 389	4, 421	0	0		194. 00
		LTC/WELLNESS	217, 043		o	o		194. 01
200.00		Cross Foot Adjustments						200. 00
201.00		Negative Cost Centers	F0 ::-	0	0	0		201.00
202. 00)	TOTAL (sum lines 118 through 201)	52, 693, 225	2, 394, 851	19, 986	80, 898	183, 836	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

				10	0 12/31/2023	5/29/2024 7:2	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		4. 00	4A	5. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 02	00102 AKRON BUILDING						1.02
1.03	00103 ARGOS BUILDING						1.03
1. 04 4. 00	OO101 CLAYS BUILDING OO400 EMPLOYEE BENEFITS DEPARTMENT	1, 192, 199					1. 04 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	182, 451	8, 621, 639	8, 621, 639			5.00
7. 00	00700 OPERATION OF PLANT	22, 074	3, 355, 003		4, 011, 336		7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	1, 349	176, 551		11, 578		8.00
9.00	00900 HOUSEKEEPI NG	17, 395	615, 995	120, 506	43, 785	82, 046	9. 00
10.00	01000 DI ETARY	7, 060	344, 140	67, 323	139, 651	5, 728	10.00
11. 00	01100 CAFETERI A	14, 295	488, 450		52, 730	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	24, 900	722, 487		92, 079	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0 722 052	l "	40, 000	0	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	16, 687 17, 834	3, 732, 952 1, 433, 861	730, 270 280, 503	49, 989 166, 810	0	15. 00 16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	17,034	1, 433, 601	200, 503	100, 610	0	10.00
30. 00	03000 ADULTS & PEDIATRICS	77, 524	2, 988, 415	584, 618	616, 349	32, 522	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
43.00	04300 NURSERY	18, 392	539, 435	105, 529	6, 745	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	32, 004	2, 611, 826		292, 720	4, 620	50.00
51.00	05100 RECOVERY ROOM	21, 391	790, 885		178, 063	15, 337	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 791	187, 815		30, 982	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 74, 933	66, 356 3, 044, 233		4, 941 411, 020	0 35, 479	53. 00 54. 00
60.00	06000 LABORATORY	42, 992	3, 034, 980		94, 604	35, 479	60.00
65. 00	06500 RESPI RATORY THERAPY	50, 115	1, 475, 170		146, 504	3, 511	65.00
66. 00	06600 PHYSI CAL THERAPY	27, 402	865, 494		113, 647	1, 663	66.00
67.00	06700 OCCUPATI ONAL THERAPY	7, 553	192, 903		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	3, 655	105, 930	20, 723	0	0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	_	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	804, 113		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	19, 423	1, 235, 870	241, 771	203, 201	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	115, 422	3, 594, 799		276, 886	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	68, 929	2, 487, 961	486, 715	90, 312	Ö	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	8, 653	262, 394		0	0	88. 03
88. 04	08804 RURAL HEALTH CLINIC V	31, 635	953, 315	186, 495	103, 152	3, 326	88. 04
88. 05	08805 RURAL HEALTH CLINIC VI	57, 963	2, 607, 164		224, 192	2, 587	88. 05
91.00	09100 EMERGENCY	60, 409	3, 780, 628	739, 600	225, 707	35, 848	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0			_	92.00
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	55, 364	405, 879		206, 411	0	93.00
93. 01 93. 02	04951 SHAFER MEDICAL CENTER 04040 I NTERNAL MEDICINE	64, 146	606, 465		209, 730	0 0	93. 01 93. 02
93. 02	SPECIAL PURPOSE COST CENTERS	35, 021	179, 520	35, 119	19, 548	0	93.02
113 00	11300 INTEREST EXPENSE						113.00
118. 00		1, 182, 762	52, 312, 628	8, 547, 184	4, 011, 336	222, 667	
	NONREI MBURSABLE COST CENTERS				., ,	,	
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	15, 307	2, 994	0		192. 00
	1 19201 FCMC	0	0	0	0		192. 01
	2 19202 ARGOS MEDICAL CENTER	0	0	0	0		192.02
	3 19203 AKRON MEDICAL CENTER D 19300 NONPALD WORKERS	0	0		0		192. 03 193. 00
	DO7950 ADVERTI SI NG	1, 992	140, 802	27, 545	0		193.00
	1 07951 LTC/WELLNESS	7, 445	224, 488		0		194.00
200.00		7, 443	224, 400	45, 710	J		200.00
201.00	, ,	o	0	o	0	О	201.00
202.00		1, 192, 199	52, 693, 225	8, 621, 639	4, 011, 336	222, 667	202. 00

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/29/2024 7: 26 am

					5/29/2024 7: 2	6 am
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
				ADMI NI STRATI O	SERVICES &	
				N	SUPPLY	
	9. 00	10. 00	11. 00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 02 00102 AKRON BUILDING						1. 02
1. 03 00103 ARGOS BUI LDI NG						1.03
1. 04 00101 CLAYS BUILDING						1.04
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG	862, 332					9. 00
10. 00 01000 DI ETARY	738	557, 580				10.00
11. 00 01100 CAFETERI A	16, 357	337, 380	653, 091			11.00
		0	•	07/ 050		
13. 00 01300 NURSI NG ADMI NI STRATI ON	640	0	20, 314	976, 859	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	U	0	0	0	14.00
15. 00 01500 PHARMACY	6, 174	0	16, 173		0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	4, 821	0	28, 830	91, 326	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	208, 318	557, 580	80, 084		0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43. 00 04300 NURSERY	0	0	18, 673	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	110, 044	0	36, 604		0	50.00
51.00 05100 RECOVERY ROOM	66, 312	0	22, 072		0	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0	5, 860	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	85, 054	0	86, 099	0	0	54.00
60. 00 06000 LABORATORY	38, 838	0	63, 637	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	33, 771	0	58, 246	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	21, 448	o	30, 158	o	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	O	0	6, 368	o	0	67.00
68. 00 06800 SPEECH PATHOLOGY	o	o	3, 516	l	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	ol	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	ol	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	l ol	o o	0	ol	0	73.00
OUTPATIENT SERVICE COST CENTERS	5	٥,		9		70.00
88. 00 08800 RURAL HEALTH CLINIC	35, 222	O	0	ol	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	57, 777	Ö	79, 615		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0,,,,,	0	, , , 0 10	٥	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	22, 432	o o	0	ام	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	0	0	0	٥	0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI		0	0		0	88. 05
91. 00 09100 EMERGENCY	98, 503	0	58, 910	238, 621	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	70, 303	o o	30, 710	230, 021	U	92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	15, 791	0	17, 189		0	93.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS		0	17, 109	0	0	93.00
	38, 542 0	0	10 157	0	0	
93. 02 04040 I NTERNAL MEDI CI NE SPECI AL PURPOSE COST CENTERS	l U	0	10, 157	0	0	93. 02
		1				112 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	040 700	FE7 F00	(40 EOE	074 050	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	860, 782	557, 580	642, 505	976, 859	0	118. 00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	1, 550	Ol	0	ol	0	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	1, 550	ol	0	=		190.00
192. 00 19200 PHTSICIANS PRIVATE OFFICES		-		_		
192.02 19201 FCMC 192.02 19202 ARGOS MEDICAL CENTER	0	0	0	=		192. 01 192. 02
	0	0	0			
192. 03 19203 AKRON MEDICAL CENTER	0	0	0			192.03
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
194. 00 07950 ADVERTI SI NG	0	0	1, 914			194.00
194. 01 07951 LTC/WELLNESS	이	0	8, 672	이	0	194. 01
200.00 Cross Foot Adjustments			_			200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	862, 332	557, 580	653, 091	976, 859	0	202. 00

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-1313 COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 7:26 am Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Total RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00102 AKRON BULLDING 1.02 1 02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 4, 535, 558 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 2,006,151 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 90, 314 5, 805, 112 5, 805, 112 30.00 0 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 673, 594 04300 NURSERY 0 3, 212 673, 594 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 221, 469 3, 788, 229 0 3, 788, 229 50.00 05100 RECOVERY ROOM 0 51.00 24, 503 1, 251, 891 0 1, 251, 891 51.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 3, 948 265, 347 265, 347 52 00 05300 ANESTHESI OLOGY 53.00 29, 205 113, 483 113, 483 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 489, 544 4, 746, 966 0 4, 746, 966 54.00 06000 LABORATORY 60.00 0 0 397, 496 4, 223, 282 0 0 4, 223, 282 60.00 06500 RESPIRATORY THERAPY 102, 779 65 00 2 108 566 2, 108, 566 65 00 66.00 06600 PHYSI CAL THERAPY 31, 733 1, 233, 458 1, 233, 458 66.00 0 06700 OCCUPATI ONAL THERAPY 12, 418 249, 426 0 249, 426 67.00 67.00 0 133, 517 0 133, 517 68.00 06800 SPEECH PATHOLOGY 3, 348 68.00 o 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 71 00 C 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 21, 501 982, 921 0 982, 921 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 535, 558 4, 769, 067 73.00 233, 509 4, 769, 067 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 1, 728, 633 08800 RURAL HEALTH CLINIC 12, 569 0 1, 728, 633 88 00 0 88.01 08801 RURAL HEALTH CLINIC II 0 58, 917 4, 771, 237 0 4, 771, 237 88.01 88 02 08802 RURAL HEALTH CLINIC III 0 34, 554 3, 099, 542 0 3, 099, 542 88 02 0 08803 RURAL HEALTH CLINIC IV 340, 129 0 3.971 340, 129 88.03 88.03 08804 RURAL HEALTH CLINIC V 1, 259, 120 1, 259, 120 88 04 12,832 88 04 88.05 08805 RURAL HEALTH CLINIC VI 0 44, 244 3, 388, 221 0 3, 388, 221 88.05 0 09100 EMERGENCY 0 5, 286, 733 91.00 108.916 5, 286, 733 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 16, 039 740, 710 0 740, 710 93.00 93. 01 04951 SHAFER MEDICAL CENTER 0 32, 807 1,006,186 0 1,006,186 93.01 04040 INTERNAL MEDICINE 93.02 93.02 16, 323 260, 667 260, 667 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 4, 535, 558 2,006,151 52, 226, 037 118. 00 118.00 52, 226, 037 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 1.550 1, 550 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 18, 301 0 18, 301 192. 00 0 192. 01 19201 FCMC 0 0 0 0 192.01 0 0 192. 02 19202 ARGOS MEDICAL CENTER 0 192. 02 0 0 0 192. 03 19203 AKRON MEDICAL CENTER 0 0 0 192.03 193. 00 19300 NONPALD WORKERS 0 o 0 193.00 0 0 0 0 194. 00 07950 ADVERTI SI NG 0 170, 261 170, 261 194, 00 194. 01 07951 LTC/WELLNESS 0 277, 076 194. 01 C 277, 076 0 200.00 Cross Foot Adjustments 0 0 200.00

4 535 558

2, 006, 151

0

52, 693, 225

0

0 201.00

52, 693, 225 202. 00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201.00

202 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 7:26 am

			CAPI TAL REL	ATED COSTS	5/29/2024 7: 2	6 am
Cost Center Description	Di rectly Assi gned New Capi tal Rel ated Costs	BLDG & FIXT	AKRON BUI LDI NG	ARGOS BUI LDI NG	CLAYS BUI LDI NG	
	0	1.00	1. 02	1. 03	1. 04	
GENERAL SERVICE COST CENTERS						
1. 00						1.00 1.02 1.03
1. 03 00103 ARGOS BUI LDI NG 1. 04 00101 CLAYS BUI LDI NG						1.03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	- о	2, 828	0	0	0	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	0	253, 658		6, 472	128	5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	0	235, 658 7, 204		7, 378	37, 356 0	7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	0	26, 282		0	345	9.00
10. 00 01000 DI ETARY	0	86, 902		0	0	10.00
11. 00 01100 CAFETERI A	0	32, 813		0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	57, 299	0	0	0	13. 00 14. 00
15. 00 01500 PHARMACY		31, 107	-	ol	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0			O	34, 083	16.00
INPATIENT ROUTINE SERVICE COST CE						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	0	383, 540		0	0	30. 00 31. 00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0	4, 197	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS		1, 177	<u> </u>	<u> </u>		10.00
50. 00 05000 OPERATING ROOM	0	182, 153	0	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	110, 804		0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	19, 279 3, 075		O O	0	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	255, 768		0	0	54.00
60. 00 06000 LABORATORY	0	58, 870		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	91, 166		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	70, 720	0	O O	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY		0	0	0	0	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO	PATI ENT 0	Ö	Ö	Ö	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIEN	1	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	O	O	45, 193	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0	172, 300	T .	o	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	0	0	0	20, 086	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	0	0	0	0	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V 88. 05 08805 RURAL HEALTH CLINIC VI	0	0	16, 332	67, 048	0	88. 04 88. 05
91. 00 09100 EMERGENCY	0	140, 452		07,040	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTIN						92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONA	ALS 0	128, 445	0	0	0	93.00
93. 01 04951 SHAFER MEDICAL CENTER 93. 02 04040 NTERNAL MEDICINE	0	12, 164	0	0	46, 645 0	93. 01 93. 02
SPECIAL PURPOSE COST CENTERS		12, 104	0	<u> </u>	<u> </u>	75.02
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 th	nrough 117) 0	2, 375, 123	19, 986	80, 898	183, 836	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP &	CANTEEN O		O	ol		190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFICES	CANTEEN			0		190.00
192. 01 19201 FCMC	0	0	0	O		192. 01
192. 02 19202 ARGOS MEDICAL CENTER	0	0	0	0		192. 02
192. 03 19203 AKRON MEDICAL CENTER	0	0	0	O		192.03
193. 00 19300 NONPALD WORKERS 194. 00 07950 ADVERTI SI NG	0	0 4, 421		0		193. 00 194. 00
194. 01 07951 LTC/WELLNESS		0		ol		194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	201)	0	0	0		201.00
202.00 TOTAL (sum lines 118 through	201) 0	2, 394, 851	19, 986	80, 898	183, 836	J2U2. UU

					5/29/2024 7: 2	6 am
Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	2A	4. 00	5. 00	7. 00	8. 00	
GENERAL SERVICE COST CENTERS	'					
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 02 00102 AKRON BUILDING						1. 02
1. 03 00103 ARGOS BUI LDI NG						1.03
1. 04 00101 CLAYS BUILDING						1.04
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 828	2, 828				4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	262, 542	439				5.00
7.00 00700 OPERATION OF PLANT	281, 762	52	· ·	301, 833		7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	7, 204	3			9, 131	8. 00
9. 00 00900 HOUSEKEEPI NG	26, 627	41			3, 365	9. 00
10. 00 01000 DI ETARY	86, 902	17	· ·		235	10.00
11. 00 01100 CAFETERI A	32, 813	34			0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	57, 299	59		6, 928	0	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	0		0,720	0	14. 00
15. 00 01500 PHARMACY	31, 107	39		3, 761	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	42, 522	42			0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	72, 322	72	0, 330	12, 332		10.00
30. 00 03000 ADULTS & PEDIATRICS	383, 540	183	17, 832	46, 379	1, 334	30. 00
31. 00 03100 NTENSI VE CARE UNI T	0	0		40, 377 O	0	31.00
43. 00 04300 NURSERY	4, 197	43		507	0	43. 00
ANCI LLARY SERVI CE COST CENTERS	4, 177	43	5, 217	307		43.00
50. 00 05000 OPERATING ROOM	182, 153	76	15, 585	22, 026	189	50.00
51. 00 05100 RECOVERY ROOM	110, 804	51			629	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	19, 279	14		2, 331	0	52. 00
53. 00 05300 ANESTHESI OLOGY	3, 075	0		372	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	255, 768	177	•		1, 455	54.00
60. 00 06000 LABORATORY	58, 870	102			1, 433	60.00
65. 00 06500 RESPI RATORY THERAPY	91, 166	118			144	65.00
66. 00 06600 PHYSI CAL THERAPY	70, 720	65			68	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	70, 720	18		0, 551	00	67.00
68. 00 06800 SPEECH PATHOLOGY	0	9		0	0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	_	0	0	71.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
OUTPATIENT SERVICE COST CENTERS	l o	U	0	U	U	73. 00
88. 00 08800 RURAL HEALTH CLINIC	45, 193	46	7, 374	15, 290	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC		273			0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	172, 300				0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	20, 086	163 20			0	
	1					88. 03
88. 04 08804 RURAL HEALTH CLINIC V	16, 332	75			136	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI 91. 00 09100 EMERGENCY	67, 048	137			106	88. 05
	140, 452	143	22, 565	16, 983	1, 470	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	120 445	101	2 422	15 501	0	92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	128, 445	131			0	93.00
93. 01 04951 SHAFER MEDICAL CENTER	46, 645	152	·		0	93. 01
93. 02 04040 I NTERNAL MEDICINE	12, 164	83	1, 071	1, 471	0	93. 02
SPECIAL PURPOSE COST CENTERS						440.00
113. 00 11300 INTEREST EXPENSE	0 (50 040	0.005	0/0 740	204 222	0.404	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 659, 843	2, 805	260, 710	301, 833	9, 131	118. 00
NONREI MBURSABLE COST CENTERS		0		٥	-	100 00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	_	0		190.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	15, 307	0		0		192.00
192. 01 19201 FCMC	0	0	_	0		192. 01
192. 02 19202 ARGOS MEDICAL CENTER	0	0		0		192. 02
192. 03 19203 AKRON MEDICAL CENTER	0	0	_	0		192.03
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
194. 00 07950 ADVERTI SING	4, 421	5		0		194.00
194. 01 07951 LTC/WELLNESS	0	18	1, 340	0		194. 01
200.00 Cross Foot Adjustments	0	_	_	_		200.00
201.00 Negative Cost Centers	0 (70 5-1	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	2, 679, 571	2, 828	262, 981	301, 833	9, 131	202. 00

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

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared:

			Т	o 12/31/2023	Date/Time Pre 5/29/2024 7:2	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	O alli
Sect Senter Besser paren	I I I I I I I I I I I I I I I I I I I	5.2.7	0,11 2 1 2 1 1 1 1 1	ADMI NI STRATI O	SERVICES &	
				N	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 BUILDING 1. 03 00103 ARGOS BUILDING						1. 02 1. 03
1. 04 00101 CLAYS BUILDING						1.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG	37, 004					9. 00
10. 00 01000 DI ETARY	32	99, 747				10.00
11. 00 01100 CAFETERI A	702	0	40, 432	l		11.00
13. 00 O1300 NURSING ADMINISTRATION	27	0	1, 258	69, 882		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY	265	0	1, 001	0	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	207	0	1, 785	6, 533	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.020	99, 747	4 050	44 270	0	20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT	8, 939	99, 747	4, 958 0	46, 279 0	0	30. 00 31. 00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0	ol Ol	1, 156		0	43.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	1, 150	<u> </u>	0	43.00
50. 00 05000 OPERATING ROOM	4, 722	O	2, 266	0	0	50.00
51. 00 05100 RECOVERY ROOM	2, 846	o	1, 366	l	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o	363	l	0	52.00
53. 00 05300 ANESTHESI OLOGY	O	O	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 650	o	5, 329	0	0	54.00
60. 00 06000 LABORATORY	1, 667	0	3, 940	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 449	0	3, 606	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	920	0	1, 867	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	394	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	218	0	0	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	ol Ol	0	0	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u>U</u>	0	U _I	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	1, 511	ol	0	O	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	2, 479	o	4, 929		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	2,	o	0	o	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	963	O	0	0	0	88. 03
88.04 08804 RURAL HEALTH CLINIC V	0	0	0	0	0	88. 04
88.05 08805 RURAL HEALTH CLINIC VI	0	0	0	0	0	88. 05
91. 00 09100 EMERGENCY	4, 227	0	3, 647	17, 070	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	678	0	1, 064	0	0	93.00
93. 01 04951 SHAFER MEDICAL CENTER	1, 654	0	0	0	0	93. 01
93. 02 04040 I NTERNAL MEDI CI NE	0	0	629	U ₁	0	93. 02
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	36, 938	99, 747	39, 776	69, 882	0	118.00
NONREI MBURSABLE COST CENTERS	30, 730	77, 747	37, 770	07, 002	0	1110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	66	O	0	O	0	190. 00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	0	o	0	o		192.00
192. 01 19201 FCMC	O	ō	0	o		192. 01
192.02 19202 ARGOS MEDICAL CENTER	O	o	0	0		192. 02
192.03 19203 AKRON MEDICAL CENTER	0	О	0	o	0	192. 03
193.00 19300 NONPALD WORKERS	0	o	0			193. 00
194. 00 07950 ADVERTI SING	0	0	119	0		194. 00
194. 01 07951 LTC/WELLNESS	0	0	537	0	0	194. 01
200.00 Cross Foot Adjustments		_	=	_	=	200.00
201.00 Negative Cost Centers	0 0 1	00 747	40.400	0		201.00
202.00 TOTAL (sum lines 118 through 201)	37, 004	99, 747	40, 432	69, 882	0	202. 00

Health Financial Systems WOODLAWN HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-1313 ALLOCATION OF CAPITAL RELATED COSTS Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/29/2024 7:26 am Cost Center Description **PHARMACY** MEDI CAL Subtotal Intern & Total RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00102 AKRON BULLDING 1.02 1 02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 58, 448 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 72, 197 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 3, 249 612, 440 0 612, 440 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 0 31.00 9, 238 04300 NURSERY 0 9, 238 43.00 43.00 116 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 7,966 234, 983 0 234, 983 50.00 05100 RECOVERY ROOM 0 51.00 881 134, 694 0 134, 694 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 23, 250 23, 250 52 00 142 05300 ANESTHESI OLOGY 53.00 1,050 4.893 4,893 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 17, 646 333, 117 0 333, 117 54.00 06000 LABORATORY 60.00 0 0 14, 298 104, 105 0 0 104, 105 60.00 06500 RESPIRATORY THERAPY 120, 006 65 00 3, 697 120 006 65 00 06600 PHYSI CAL THERAPY 66.00 1, 141 88, 496 88, 496 66.00 2,010 06700 OCCUPATI ONAL THERAPY 0 447 2,010 0 67.00 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 120 979 979 68.00 o 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71 00 Ω C 0 o 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 773 5, 571 5, 571 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 58, 448 8, 399 66,847 66, 847 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 69, 866 0 69, 866 88 00 0 452 88.01 08801 RURAL HEALTH CLINIC II 0 2, 119 224, 384 0 224, 384 88.01 88 02 08802 RURAL HEALTH CLINIC III 0 1, 243 43, 134 0 43, 134 88 02 0 0 08803 RURAL HEALTH CLINIC IV 2,692 88.03 143 2, 692 88.03 08804 RURAL HEALTH CLINIC V 88 04 462 30, 455 30, 455 88 04 1, 591 88.05 08805 RURAL HEALTH CLINIC VI 0 101, 308 0 101, 308 88.05 0 09100 EMERGENCY 0 91.00 3, 918 210, 475 210, 475 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0 577 148, 848 0 148, 848 93.00 93. 01 04951 SHAFER MEDICAL CENTER 0 1, 180 69, 031 0 69, 031 93.01 04040 INTERNAL MEDICINE 16, 005 587 16, 005 93.02 93.02 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 656, 827 118. 00 118.00 58, 448 72, 197 2, 656, 827 0 NONREI MBURSABLE COST CENTERS 66 190.00 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 15, 398 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 0 0 15, 398 192. 00 0 0 192. 01 19201 FCMC 0 192.01 0 0 0 0 192. 02 19202 ARGOS MEDICAL CENTER 0 192. 02 0 0 0 192. 03 19203 AKRON MEDICAL CENTER 0 0 0 192.03 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 0 0 0 0 0 194. 00 07950 ADVERTI SI NG 0 5.385 5. 385 194. 00 194. 01 07951 LTC/WELLNESS 0 1, 895 194. 01 C 1,895

0

72 197

58 448

0

0

2, 679, 571

0

0 200.00

0 201.00

2, 679, 571 202. 00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1313

				T	o 12/31/2023	Date/Time Pre 5/29/2024 7:2	
			CAPITAL RE	LATED COSTS		0,2,,2021 7.2	- Contraction
	Cost Center Description	BLDG & FIXT	AKRON	ARGOS	CLAYS	EMPLOYEE	
	cost center bescription	(SQUARE FEET)	BUI LDI NG	BUI LDI NG	BUI LDI NG	BENEFI TS	
			(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT	
						(GROSS SALARI ES)	
		1. 00	1. 02	1.03	1. 04	4. 00	
	NERAL SERVICE COST CENTERS	10/ 705	ı	1			1 00
4	100 CAP REL COSTS-BLDG & FLXT 102 AKRON BUILDING	106, 705 0	3, 500				1.00
1.03 001	103 ARGOS BUILDING	0	0	i			1.03
	101 CLAYS BUILDING	0	0	_	, , , , ,	27 024 707	1.04
	400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL	126 11, 302	400	_	_	26, 824, 697 4, 105, 132	4. 00 5. 00
	700 OPERATION OF PLANT	10, 500	240	1		496, 663	1
	BOO LAUNDRY & LINEN SERVICE	321	0	_	=	30, 354	•
	900 HOUSEKEEPI NG DOO DI ETARY	1, 171 3, 872	0	0	43	391, 400 158, 852	1
1	100 CAFETERI A	1, 462		ő	o	321, 643	1
	BOO NURSING ADMINISTRATION	2, 553	0	0	O	560, 262	•
	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY	0 1, 386	0	0		0 375, 468	
	500 MEDICAL RECORDS & LIBRARY	376			_	401, 268	•
I NF	PATIENT ROUTINE SERVICE COST CENTERS						
	DOO ADULTS & PEDIATRICS	17, 089		1		1, 744, 308	
	100 I NTENSI VE CARE UNI T 300 NURSERY	0 187	0	1		0 413, 826	31. 00 43. 00
	CILLARY SERVICE COST CENTERS	107			<u> </u>	110,020	10.00
1	OOO OPERATING ROOM	8, 116				720, 092	1
	100 RECOVERY ROOM 200 DELIVERY ROOM & LABOR ROOM	4, 937 859	0			481, 300 130, 306	1
	BOO ANESTHESI OLOGY	137	Ö	ő		0	1
	400 RADI OLOGY-DI AGNOSTI C	11, 396	0	0	0	1, 686, 002	1
1	DOO LABORATORY 500 RESPI RATORY THERAPY	2, 623 4, 062	0	0	0	967, 326 1, 127, 610	1
1	500 PHYSI CAL THERAPY	3, 151		0	0	616, 554	1
67. 00 067	700 OCCUPATI ONAL THERAPY	0	0	0	0	169, 934	67.00
	BOO SPEECH PATHOLOGY 100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	=	82, 233	1
	200 IMPL. DEV. CHARGED TO PATIENTS			0		0	1
73.00 073	BOO DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	FPATIENT SERVICE COST CENTERS BOO RURAL HEALTH CLINIC	T 0	T 0	0	5, 634	437, 027	88. 00
	BO1 RURAL HEALTH CLINIC II	7, 677				2, 597, 017	•
	BO2 RURAL HEALTH CLINIC III	0	0	0	-,:	1, 550, 921	•
	BO3 RURAL HEALTH CLINIC IV BO4 RURAL HEALTH CLINIC V	0	2, 860	0	0	194, 691 711, 787	•
	BOS RURAL HEALTH CLINIC VI	0	2,800	6, 216		1, 304, 190	•
91.00 091	100 EMERGENCY	6, 258	0	0		1, 359, 215	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	E 700				1 245 (02	92.00
	950 WOODLAWN MEDICAL PROFESSIONALS 951 SHAFER MEDICAL CENTER	5, 723	0			1, 245, 693 1, 443, 298	1
93. 02 040	040 I NTERNAL MEDICINE	542	O			787, 980	1
	ECLAL PURPOSE COST CENTERS BOO INTEREST EXPENSE		I	1			113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	105, 826	3, 500	7, 500	22, 918	26, 612, 352	1
	NREIMBURSABLE COST CENTERS		, , , , , ,	,	,		
4	OOO GIFT FLOWER COFFEE SHOP & CANTEEN	0		-			190.00
192. 00 192	200 PHYSICIANS PRIVATE OFFICES	682	0	0			192. 00 192. 01
192. 02 192	202 ARGOS MEDICAL CENTER	0	0	0	O	0	192. 02
	203 AKRON MEDICAL CENTER	0	0	0	0		192.03
1	300 NONPALD WORKERS 950 ADVERTISING	197		0	0		193. 00 194. 00
	951 LTC/WELLNESS	0		ő	o	167, 522	
200.00	Cross Foot Adjustments						200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B,	2, 394, 851	19, 986	80, 898	183, 836	1, 192, 199	201.00
202.00	Part I)	2, 374, 001	17, 700			1, 172, 199	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22. 443662	5. 710286	10. 786400	8. 021468	0. 044444	•
204. 00	Cost to be allocated (per Wkst. B, Part II)					2, 828	204.00
205. 00	Unit cost multiplier (Wkst. B, Part					0. 000105	205. 00
206. 00	NAME adjustment amount to be allocated						206. 00
200.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						200.00
	· · · · /	•	•	•	, '		<u> </u>

Heal th Financ	ial Systems	WOODLAWN I	HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS			Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/29/2024 7:2	epared: 26 am
		CAPITAL RELATED COSTS					
(Cost Center Description	BLDG & FIXT	AKRON	ARGOS	CLAYS	EMPLOYEE	
		(SQUARE FEET)	BUI LDI NG	BUI LDI NG	BUI LDI NG	BENEFITS	
			(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT	
						(GROSS	
						SALARI ES)	
		1. 00	1. 02	1. 03	1. 04	4. 00	
	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

| Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

			To	12/31/2023	Date/Time Pre 5/29/2024 7:2	
Cost Center Description	Reconciliatio		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	n	E & GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	(POUNDS OF	(HOURS OF S ERVIC)	
		(ACCOM. COST)	(SQUARE FEET)	LAUNDR)	LKVIC)	
	5A	5. 00	7. 00	8. 00	9. 00	
GENERAL SERVICE COST CENTERS						4 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.02 00102 AKRON BUILDING					1	1. 00 1. 02
1. 03 00103 ARGOS BUILDING					1	1.02
1. 04 00101 CLAYS BUILDING					ı	1. 04
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					1	4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-8, 621, 639				1	5.00
7.00 00700 0PERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE	0	3, 355, 003		1 205	1	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	176, 551 615, 995		1, 205 444	175, 297	8. 00 9. 00
10. 00 01000 DI ETARY	0	344, 140		31	173, 277	10.00
11. 00 01100 CAFETERI A	0	488, 450		0	3, 325	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	722, 487		0	130	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	1 204	0	1 255	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	3, 732, 952 1, 433, 861	1, 386 4, 625	0	1, 255 980	15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS		1, 433, 661	4, 023	٥	700	10.00
30. 00 03000 ADULTS & PEDIATRICS	0	2, 988, 415	17, 089	176	42, 348	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	l e	-	0	0	31.00
43. 00 04300 NURSERY	0	539, 435	187	0	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	2, 611, 826	8, 116	25	22, 370	50.00
51. 00 05100 RECOVERY ROOM	0	790, 885		83	13, 480	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	187, 815		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	66, 356		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	3, 044, 233		192	17, 290	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	3, 034, 980 1, 475, 170		0 19	7, 895 6, 865	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	865, 494		9	4, 360	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	192, 903		ó	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	105, 930	0	0	0	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	l 0	U	0	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	1, 235, 870	5, 634	0	7, 160	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	3, 594, 799		0	11, 745	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0	2, 487, 961	2, 504	0	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV 88. 04 08804 RURAL HEALTH CLINIC V	0	262, 394 953, 315		0 ₁ 18	4, 560 0	88. 03 88. 04
88. 05 08805 RURAL HEALTH CLINIC VI	0	2, 607, 164		14	0	88. 05
91. 00 09100 EMERGENCY	Ö	3, 780, 628		194	20, 024	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS	0	405, 879		0	3, 210	93.00
93. 01 04951 SHAFER MEDI CAL CENTER 93. 02 04040 I NTERNAL MEDI CI NE	0	606, 465 179, 520		0	7, 835 0	
SPECIAL PURPOSE COST CENTERS	0	174, 320	542	U	0	93.02
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-8, 621, 639	43, 690, 989	111, 219	1, 205	174, 982	118. 00
NONREI MBURSABLE COST CENTERS					215	100.00
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS PRIVATE OFFICES	0	l .		0		190. 00 192. 00
192. 01 19201 FCMC	0	15, 307	0	0		192. 01
192. 02 19202 ARGOS MEDICAL CENTER	0	Ö	Ō	O		192. 02
192.03 19203 AKRON MEDICAL CENTER	0	0	0	0		192. 03
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
194. 00 07950 ADVERTI SI NG 194. 01 07951 LTC/WELLNESS	0	140, 802 224, 488		0		194. 00 194. 01
200.00 Cross Foot Adjustments	0	224, 400		o _l		200.00
201.00 Negative Cost Centers					1	201.00
202.00 Cost to be allocated (per Wkst. B,		8, 621, 639	4, 011, 336	222, 667	862, 332	202. 00
Part I)		0.405,00	0/ 0/7000	104 705000	4 040070	000 00
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B,		0. 195628 262, 981	36. 067003 301, 833	184. 785892 9, 131	4. 919263 37, 004	
Part II)		202, 901	301,033	7, 131	37,004	204.00
205.00 Unit cost multiplier (Wkst. B, Part		0. 005967	2. 713862	7. 577593	0. 211093	205. 00
					ı	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)					ı	206. 00
207.00 NAHE unit cost multiplier (Wkst. D,					ı	207. 00
Parts III and IV)						

1. 00 GENER/	Cost Center Description	DI ETARY (PATI ENT	Provi der CO			5/29/2024 7: 2	pared:
1.00 00100	Cost Center Description		CAFETERI A	NURSLNG	OFNESS		.o aiii
1.00 00100		DAYS)	(FTES)	ADMINISTRATIO N (DIRECT NRS	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	
1. 00 00100				ING HR)	REQUIS.)		
1.00 00100	AL SERVICE COST CENTERS	10. 00	11. 00	13. 00	14. 00	15. 00	
1. 02 00102	CAP REL COSTS-BLDG & FIXT						1.00
1. 04 00101 4. 00 00400 5. 00 00500	AKRON BUILDING ARGOS BUILDING CLAYS BUILDING EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						1. 02 1. 03 1. 04 4. 00 5. 00
8. 00 00800 9. 00 00900	OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING	1 017					7.00 8.00 9.00
	DI ETARY CAFETERI A	1, 917 0	16, 718				10.00
	NURSI NG ADMI NI STRATI ON	Ö	520	85, 785			13.00
	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
	PHARMACY MEDICAL DECORDS & LIBRARY	0	414	0 020	0	100	1
	MEDICAL RECORDS & LIBRARY ENT ROUTINE SERVICE COST CENTERS	U	738	8, 020	0	0	16.00
	ADULTS & PEDIATRICS	1, 917	2, 050	56, 810	0	0	30.00
	INTENSIVE CARE UNIT	0	0	0	0		
	NURSERY LARY SERVICE COST CENTERS	0	478	0	0	0	43.00
	OPERATING ROOM	ol	937	O	0	0	50.00
	RECOVERY ROOM	o	565		0	0	51.00
1	DELIVERY ROOM & LABOR ROOM	0	150	0	0	0	52.00
	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0 2, 204	0	0	0	
	LABORATORY	ő	1, 629		0	0	60.00
1	RESPI RATORY THERAPY	O	1, 491	0	0	0	65.00
	PHYSI CAL THERAPY	0	772	0	0	0	66.00
	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	163 90	0	0	0	67.00
1	MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	0	Ö	0	0	
	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	0	0	0	0	100	73.00
	RURAL HEALTH CLINIC	ol	0	0	0	0	88. 00
88. 01 08801	RURAL HEALTH CLINIC II	o	2, 038		0	0	88. 01
	RURAL HEALTH CLINIC III	0	0	0	0	0	88. 02
1	RURAL HEALTH CLINIC IV RURAL HEALTH CLINIC V	0	0	0	0	0	88. 03 88. 04
	RURAL HEALTH CLINIC VI	ő	0		0	0	
91.00 09100		O	1, 508	20, 955	0	0	
	OBSERVATION BEDS (NON-DISTINCT PART		440		0	0	92.00
	WOODLAWN MEDICAL PROFESSIONALS SHAFER MEDICAL CENTER	0	440 0	0 0	0	0	
	INTERNAL MEDICINE	Ö	260		0	_	93. 02
	AL PURPOSE COST CENTERS						ļ
113.00 11300	INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 917	16, 447	85, 785	0	100	113. 00 118. 00
NONRE	MBURSABLE COST CENTERS	1, 717	10, 447	03, 703	<u> </u>	100	1110.00
190. 00 19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	-	0		190. 00
192. 00 19200 192. 01 19201	PHYSICIANS PRIVATE OFFICES	0	0	-	0		192. 00 192. 01
	ARGOS MEDICAL CENTER	0	0	0	0		192.01
	AKRON MEDICAL CENTER	o	0	0	0		192. 03
	NONPAI D WORKERS	0	0	0	0		193.00
194. 00 07950 194. 01 07951	LTC/WELLNESS	0	49 222	0	0		194. 00 194. 01
200. 00	Cross Foot Adjustments	١			J		200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	557, 580	653, 091	976, 859	0	4, 535, 558	201. 00 202. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	290. 860720 99, 747	39. 065139 40, 432		0. 000000 0	45, 355. 580000 58, 448	203. 00 204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	52. 032864	2. 418471	0. 814618	0. 000000	584. 480000	205. 00
206. 00	II) 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

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

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 7: 26 am Cost Center Description MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00102 AKRON BULLDING 1.02 1 02 1.03 00103 ARGOS BUILDING 1.03 00101 CLAYS BUILDING 1.04 1.04 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9 00 00900 HOUSEKEEPI NG 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 174, 716, 803 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 865, 690 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 04300 NURSERY 279, 770 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 19, 288, 392 50.00 05100 RECOVERY ROOM 51.00 2, 134, 039 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 343 859 52 00 05300 ANESTHESI OLOGY 53.00 2, 543, 542 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 42, 631, 080 54.00 06000 LABORATORY 60.00 34, 619, 087 60.00 06500 RESPIRATORY THERAPY 65 00 8, 951, 318 65 00 66.00 06600 PHYSI CAL THERAPY 2, 763, 687 66.00 06700 OCCUPATI ONAL THERAPY 1, 081, 526 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 291, 559 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 872, 611 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 20, 336, 967 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 1, 094, 644 88 00 88. 01 08801 RURAL HEALTH CLINIC II 5, 131, 230 88.01 88.02 08802 RURAL HEALTH CLINIC III 3,009,424 88 02 08803 RURAL HEALTH CLINIC IV 345, 860 88.03 88.03 08804 RURAL HEALTH CLINIC V 88.04 1, 117, 564 88 04 88.05 08805 RURAL HEALTH CLINIC VI 3, 853, 339 88.05 09100 EMERGENCY 91.00 9, 485, 839 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92 00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 1, 396, 854 93.00 93. 01 04951 SHAFER MEDICAL CENTER 2, 857, 282 93.01 04040 INTERNAL MEDICINE 93.02 93.02 1, 421, 640 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 174, 716, 803 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 0 192. 01 19201 FCMC 192.01 192. 02 19202 ARGOS MEDICAL CENTER 192.02 0 192. 03 19203 AKRON MEDICAL CENTER 192.03 193. 00 19300 NONPALD WORKERS 0 193.00 0 194. 00 07950 ADVERTI SI NG 194. 00 194. 01 07951 LTC/WELLNESS 194. 01 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 2, 006, 151 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.011482 203.00 204.00 Cost to be allocated (per Wkst. B, 72, 197 204.00 Part II) Unit cost multiplier (Wkst. B, Part 205.00 0.000413 205.00 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu of Form CMS-2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1313	Period: Worksheet C From 01/01/2023 Part I

					From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/29/2024 7:2	
			Title	: XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	5, 805, 112		5, 805, 11		0	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
43.00	04300 NURSERY	673, 594		673, 59	4 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	3, 788, 229		3, 788, 22		0	50.00
51.00	05100 RECOVERY ROOM	1, 251, 891		1, 251, 89		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	265, 347		265, 34		0	52.00
53.00	05300 ANESTHESI OLOGY	113, 483	l e	113, 48		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 746, 966		4, 746, 96		0	54.00
60.00	06000 LABORATORY	4, 223, 282		4, 223, 28		0	60.00
65. 00	06500 RESPI RATORY THERAPY	2, 108, 566	l e	2, .00, 00		0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 233, 458		1, 233, 45		0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	249, 426		249, 42		0	67.00
68. 00	06800 SPEECH PATHOLOGY	133, 517	ŀ	133, 51		0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l		0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	982, 921	l e	982, 92		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 769, 067		4, 769, 06	7 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	1 700 (00	I	1 700 (0	ما ما		
88. 00	08800 RURAL HEALTH CLINIC	1, 728, 633	l e	1, 728, 63		0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	4, 771, 237		4, 771, 23		0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	3, 099, 542 340, 129		3, 099, 54		0	88. 02 88. 03
88. 03 88. 04	O8803 RURAL HEALTH CLINIC IV O8804 RURAL HEALTH CLINIC V		l .	340, 12		0	88. 03
	08805 RURAL HEALTH CLINIC V	1, 259, 120		1, 259, 12		0	88.05
88. 05	l l	3, 388, 221		3, 388, 22		-	
91.00	09100 EMERGENCY	5, 286, 733		5, 286, 73		0	91.00 92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 200, 929	l .	2, 200, 92		-	
93.00	04950 WOODLAWN MEDICAL PROFESSIONALS	740, 710	l .	740, 71		0	93.00
93. 01	04951 SHAFER MEDICAL CENTER	1, 006, 186	l .	1, 006, 18		0	93. 01
93. 02	04040 I NTERNAL MEDI CI NE	260, 667		260, 66	7 0	0	93. 02
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE	1			1		1 113. 00
	1 1	E4 424 044	_	E4 424 04	6 0		200.00
200. 00 201. 00		54, 426, 966 2, 200, 929		54, 426, 96 2, 200, 92			200.00
	· ·		l e				201.00
202.00	p protai (see mistructions)	52, 226, 037	0	52, 226, 03	7 0	U	1202.00

| Peri od: | Worksheet C | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

				'	0 12/31/2023	5/29/2024 7: 2	
			Title	XVIII	Hospi tal	Cost	
			Charges	<u> </u>	· ·		
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•	·	·	+ col. 7)	Rati o	Inpati ent	
						Rati o	
		6. 00	7.00	8. 00	9. 00	10.00	
	TENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	2, 591, 914		2, 591, 914			30.00
	INTENSIVE CARE UNIT	0		C			31.00
	NURSERY	279, 770		279, 770			43.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	2, 588, 164	16, 700, 228				
	RECOVERY ROOM	259, 394	1, 874, 645			0. 000000	
	DELIVERY ROOM & LABOR ROOM	223, 331	120, 528	343, 859	0. 771674	0. 000000	52.00
	ANESTHESI OLOGY	175, 470	2, 368, 072	2, 543, 542		0. 000000	
	RADI OLOGY-DI AGNOSTI C	687, 467	41, 943, 613			0. 000000	
60.00 06000	LABORATORY	1, 591, 108	33, 027, 979	34, 619, 087	0. 121993	0. 000000	60.00
65.00 06500	RESPIRATORY THERAPY	764, 900	8, 186, 418	8, 951, 318	0. 235559	0. 000000	65.00
66.00 06600	PHYSI CAL THERAPY	229, 885	2, 533, 802	2, 763, 687	0. 446309	0.000000	66.00
67.00 06700	OCCUPATIONAL THERAPY	127, 744	953, 782	1, 081, 526	0. 230624	0.000000	67.00
68. 00 06800	SPEECH PATHOLOGY	24, 108	267, 451	291, 559	0. 457942	0.000000	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0.000000	0.000000	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	451, 989	1, 420, 622	1, 872, 611	0. 524893	0.000000	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1, 718, 649	18, 618, 318	20, 336, 967	0. 234502	0.000000	73.00
OUTPA	ATIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0	1, 094, 644	1, 094, 644			88. 00
88. 01 08801	RURAL HEALTH CLINIC II	0	5, 131, 230	5, 131, 230			88. 01
88. 02 08802	RURAL HEALTH CLINIC III	0	3, 009, 424	3, 009, 424			88. 02
88. 03 08803	RURAL HEALTH CLINIC IV	0	345, 860	345, 860			88. 03
88. 04 08804	RURAL HEALTH CLINIC V	0	1, 117, 564	1, 117, 564			88. 04
88. 05 08805	RURAL HEALTH CLINIC VI	0	3, 853, 339	3, 853, 339	1		88. 05
91.00 09100	EMERGENCY	143, 027	9, 342, 812	9, 485, 839	0. 557329	0.000000	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	294, 716	4, 979, 060	5, 273, 776	0. 417335	0.000000	92.00
93. 00 04950	WOODLAWN MEDICAL PROFESSIONALS	0	1, 396, 854	1, 396, 854	0. 530270	0.000000	93.00
93. 01 04951	SHAFER MEDICAL CENTER	0	2, 857, 282			0.000000	93. 01
93. 02 04040	INTERNAL MEDICINE	0	1, 421, 640	1, 421, 640	0. 183357	0.000000	93. 02
SPECI	AL PURPOSE COST CENTERS						
113. 00 11300	INTEREST EXPENSE						113.00
200. 00	Subtotal (see instructions)	12, 151, 636	162, 565, 167	174, 716, 803			200.00
201. 00	Less Observation Beds						201.00
202. 00	Total (see instructions)	12, 151, 636	162, 565, 167	174, 716, 803			202. 00
•		•			· ·		

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1313	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 7:26 am

			10 12/31/2023	5/29/2024 7: 26 a	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					0.00
31.00 03100 INTENSIVE CARE UNIT				31	1.00
43. 00 04300 NURSERY				43	3.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			50	0.00
51.00 05100 RECOVERY ROOM	0. 000000				1.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				2.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53	3.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	4.00
60. 00 06000 LABORATORY	0. 000000			60	0.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65	5.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66	6.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67	7.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68	8.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71	1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72	2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73	3.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC				88	8.00
88.01 08801 RURAL HEALTH CLINIC II				88	8. 01
88.02 08802 RURAL HEALTH CLINIC III				88	8.02
88.03 08803 RURAL HEALTH CLINIC IV				88	8.03
88.04 08804 RURAL HEALTH CLINIC V				88	8.04
88. 05 08805 RURAL HEALTH CLINIC VI				88	8. 05
91. 00 09100 EMERGENCY	0. 000000			91	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92	2.00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	0. 000000			93	3.00
93. 01 04951 SHAFER MEDICAL CENTER	0. 000000			93	3. 01
93. 02 04040 INTERNAL MEDICINE	0. 000000			93	3. 02
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 NTEREST EXPENSE				113	3.00
200.00 Subtotal (see instructions)				200	0.00
201.00 Less Observation Beds				201	1.00
202.00 Total (see instructions)				202	2.00
				·	

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1313	Peri od: From 01/01/2023	

					To 12/31/2023		pared: 6 am
			Ti tl	e XIX	Hospi tal	Cost	
			,		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
	LABORT FAIT POLITIME OFFICE OF COOT OFFITTED	1. 00	2. 00	3. 00	4. 00	5. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F 00F 110		F 00F 11		F 00F 110	20.00
30.00	03000 ADULTS & PEDIATRICS	5, 805, 112		5, 805, 11		5, 805, 112	30. 00 31. 00
31.00	03100 NTENSI VE CARE UNI T 04300 NURSERY	0			0 0	0 473 F04	
43.00	ANCI LLARY SERVI CE COST CENTERS	673, 594		673, 59	4 0	673, 594	43.00
50. 00	05000 OPERATING ROOM	3, 788, 229		3, 788, 22	9 0	3, 788, 229	50.00
51. 00	05100 RECOVERY ROOM	1, 251, 891		1, 251, 89		1, 251, 891	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	265, 347		265, 34		265, 347	1
53. 00	05300 ANESTHESI OLOGY	113, 483		113, 48		113, 483	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 746, 966		4, 746, 96		4, 746, 966	
60.00	06000 LABORATORY	4, 223, 282		4, 223, 28		4, 223, 282	
65. 00	06500 RESPIRATORY THERAPY	2, 108, 566		2, 108, 56		2, 108, 566	
66. 00	06600 PHYSI CAL THERAPY	1, 233, 458		1, 233, 45		1, 233, 458	
67. 00	06700 OCCUPATI ONAL THERAPY	249, 426		249, 42		249, 426	1
68. 00	06800 SPEECH PATHOLOGY	133, 517	0	133, 51		133, 517	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	982, 921		982, 92	1 0	982, 921	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 769, 067		4, 769, 06	7 0	4, 769, 067	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	1, 728, 633		1, 728, 63	3 0	1, 728, 633	
88. 01	08801 RURAL HEALTH CLINIC II	4, 771, 237		4, 771, 23	7 0	4, 771, 237	
88. 02	08802 RURAL HEALTH CLINIC III	3, 099, 542		3, 099, 54		3, 099, 542	
88. 03	08803 RURAL HEALTH CLINIC IV	340, 129		340, 12		340, 129	
88. 04	08804 RURAL HEALTH CLINIC V	1, 259, 120		1, 259, 12		1, 259, 120	
88. 05	08805 RURAL HEALTH CLINIC VI	3, 388, 221		3, 388, 22		3, 388, 221	88. 05
91. 00	09100 EMERGENCY	5, 286, 733		5, 286, 73		5, 286, 733	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 200, 929		2, 200, 92		2, 200, 929	1
93. 00	04950 WOODLAWN MEDICAL PROFESSIONALS	740, 710		740, 71		740, 710	
93. 01	04951 SHAFER MEDICAL CENTER	1, 006, 186		1, 006, 18		1, 006, 186	
93. 02	04040 I NTERNAL MEDI CI NE	260, 667		260, 66	7 0	260, 667	93. 02
110 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE	E4 404 044	_	E4 42(0)		E4 404 044	113.00
200. 00 201. 00		54, 426, 966 2, 200, 929		54, 426, 96 2, 200, 92		54, 426, 966 2, 200, 929	
201.00		52, 226, 037					
202.00	p Total (See Histinctions)	1 52, 220, 037	1	1 52, 220, 03	/ 0	52, 220, 037	1202.00

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 7:26 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 2, 591, 914 30.00 03000 ADULTS & PEDIATRICS 2, 591, 914 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 04300 NURSERY 279, 770 279, 770 43.00 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 16, 700, 228 19, 288, 392 0.196399 50.00 05000 OPERATING ROOM 2, 588, 164 51.00 05100 RECOVERY ROOM 259, 394 1, 874, 645 2, 134, 039 0.586630 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 223, 331 120, 528 343, 859 0.771674 0.000000 52.00 05300 ANESTHESI OLOGY 175.470 2, 368, 072 2, 543, 542 0.044616 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 42, 631, 080 0.000000 54.00 687, 467 41, 943, 613 0.111350 54 00 60.00 06000 LABORATORY 1, 591, 108 33, 027, 979 34, 619, 087 0.121993 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 764, 900 8, 186, 418 8, 951, 318 0. 235559 0.000000 65.00 06600 PHYSI CAL THERAPY 229, 885 66.00 2, 533, 802 2, 763, 687 0.446309 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 127, 744 953, 782 1,081,526 0.230624 0.000000 67.00 06800 SPEECH PATHOLOGY 267, 451 0.457942 68.00 24, 108 291, 559 0.000000 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.000000 0.000000 71.00 0 C 07200 IMPL. DEV. CHARGED TO PATIENTS 451, 989 72 00 1, 420, 622 1, 872, 611 0.524893 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 718, 649 18, 618, 318 20, 336, 967 0.234502 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 1,094,644 1,094,644 1.579174 0.000000 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 5, 131, 230 5, 131, 230 0. 929843 0.000000 88.01 88.02 08802 RURAL HEALTH CLINIC III 0 3,009,424 3,009,424 1.029945 0.000000 88.02 0 08803 RURAL HEALTH CLINIC IV 345, 860 345, 860 0. 983430 0.000000 88.03 88.03 08804 RURAL HEALTH CLINIC V 88 04 0 1, 117, 564 1, 117, 564 1.126665 0.000000 88 04 88.05 08805 RURAL HEALTH CLINIC VI 0 3, 853, 339 3, 853, 339 0.879295 0.000000 88.05 09100 EMERGENCY 143, 027 9, 342, 812 9, 485, 839 0.557329 91.00 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 294, 716 4, 979, 060 5, 273, 776 0.417335 0.000000 92.00 92.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.00 0 1, 396, 854 1, 396, 854 0.530270 0.000000 93.00 93.01 04951 SHAFER MEDICAL CENTER 0 2, 857, 282 2, 857, 282 0. 352148 0.000000 93.01 04040 INTERNAL MEDICINE 93.02 0 1, 421, 640 1, 421, 640 0.183357 0.000000 93.02 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 12, 151, 636 162, 565, 167 174, 716, 803 200.00 201.00 Less Observation Beds 201.00

12, 151, 636

162, 565, 167

174, 716, 803

202.00

202.00

Total (see instructions)

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/29/2024 7:26 am
	Title XIX	Hospi tal	Cost

				5/29/2024 7:26 am
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.0
31.00 03100 INTENSIVE CARE UNIT				31.0
43. 00 04300 NURSERY				43.0
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.0
51.00 05100 RECOVERY ROOM	0. 000000			51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
60. 00 06000 LABORATORY	0. 000000			60.0
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.0
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.0
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.0
88.01 08801 RURAL HEALTH CLINIC II	0. 000000			88.0
88.02 08802 RURAL HEALTH CLINIC III	0. 000000			88.0
88.03 08803 RURAL HEALTH CLINIC IV	0. 000000			88.0
88. 04 08804 RURAL HEALTH CLINIC V	0. 000000			88.0
88. 05 08805 RURAL HEALTH CLINIC VI	0. 000000			88.0
91. 00 09100 EMERGENCY	0. 000000			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.0
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	0. 000000			93.0
93. 01 04951 SHAFER MEDICAL CENTER	0. 000000			93.0
93. 02 04040 I NTERNAL MEDICINE	0. 000000			93. 0
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 0
200.00 Subtotal (see instructions)				200. 0
201.00 Less Observation Beds				201. 0
202.00 Total (see instructions)				202. 0

Health Financial Systems	WOODLAWN H	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-1313	Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narodi
				10 12/31/2023	5/29/2024 7: 2	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	234, 983					
51.00 05100 RECOVERY ROOM	134, 694				3, 379	
52.00 05200 DELIVERY ROOM & LABOR ROOM	23, 250				0	52.00
53. 00 05300 ANESTHESI OLOGY	4, 893		0. 00192			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	333, 117		0. 00781			54.00
60. 00 06000 LABORATORY	104, 105	34, 619, 087	0. 00300	7 410, 744	1, 235	60.00
65. 00 06500 RESPI RATORY THERAPY	120, 006	8, 951, 318	0. 01340	255, 486		65.00
66. 00 06600 PHYSI CAL THERAPY	88, 496	2, 763, 687	0. 03202	21 62, 053	1, 987	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 010	1, 081, 526	0. 00185	22, 845	42	67.00
68. 00 06800 SPEECH PATHOLOGY	979	291, 559	0. 00335	6, 034	20	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, 571	1, 872, 611	0. 00297	75 153, 294	456	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	66, 847	20, 336, 967	0. 00328	397, 328	1, 306	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	69, 866	1, 094, 644	0. 06382	25 0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	224, 384	5, 131, 230	0. 04372	.9	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	43, 134	3, 009, 424	0. 01433	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	2, 692	345, 860	0. 00778	0	0	88. 03
88.04 08804 RURAL HEALTH CLINIC V	30, 455	1, 117, 564	0. 02725	51 0	0	88. 04
88.05 08805 RURAL HEALTH CLINIC VI	101, 308	3, 853, 339	0. 02629	0	0	88. 05
91. 00 09100 EMERGENCY	210, 475	9, 485, 839	0. 02218	29, 439	653	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	232, 198	5, 273, 776	0. 04402	28, 741	1, 265	92.00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	148, 848	1, 396, 854	0. 10655	69 0	0	93.00
93.01 04951 SHAFER MEDICAL CENTER	69, 031	2, 857, 282	0. 02416	0 0	0	93. 01
93. 02 04040 I NTERNAL MEDICINE	16, 005	1, 421, 640	0. 01125	0 8	0	93. 02
200.00 Total (lines 50 through 199)	2, 267, 347	171, 845, 119		2, 202, 735	21, 939	200. 00
					-	-

Health Financial Systems		WOODLAWN HOS	PI TAL	In Lieu	of Form CMS-2552-10
ADDODTI ONMENT OF INDATI ENT/OUTDATIENT	ANCILLADV SEDVICE	UTHED DVCC	Drovi don CCN: 15 1212	Pari od:	Workshoot D

Peri od: Worksheet D From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared: THROUGH COSTS

				10 12/31/2023	5/29/2024 7: 2	6 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0)	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0)	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
60. 00 06000 LABORATORY	0	0)	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0	0)	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0)	0	0	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0)	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0)	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	0)	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	0)	0	0	88. 03
88. 04 08804 RURAL HEALTH CLINIC V	0	0)	0	0	88. 04
88. 05 08805 RURAL HEALTH CLINIC VI	0	0)	0	0	88. 05
91. 00 09100 EMERGENCY	0	0)	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0)	0	92.00
93.00 04950 WOODLAWN MEDICAL PROFESSIONALS	0	0)	0	0	93.00
93. 01 04951 SHAFER MEDICAL CENTER	0	0		0	0	93. 01
93. 02 04040 I NTERNAL MEDI CI NE	0	0		0	0	93. 02
200.00 Total (lines 50 through 199)	0	0)	0	0	200. 00

Health Financial Systems		WOODLAWN HOS	SPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATE	ENT ANCILLARY SERVICE	CE OTHER PASS	Provi der CCN: 15-1313	Peri od:	Worksheet D

From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 7: 26 am THROUGH COSTS

						5/29/2024 7: 2	6 am
				XVIII	Hospi tal	Cost	
Co	ost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	RY SERVICE COST CENTERS						
	PERATING ROOM	0	0	(
	ECOVERY ROOM	0	0	(2, 134, 039	l .	
1 1	ELIVERY ROOM & LABOR ROOM	0	0	(343, 859	l	
	NESTHESI OLOGY	0	0	(2, 543, 542	l	
	ADI OLOGY-DI AGNOSTI C	0	0	(42, 631, 080		
60. 00 06000 LA	ABORATORY	0	0	(34, 619, 087	0.000000	60.00
65. 00 06500 RE	ESPI RATORY THERAPY	0	0	(8, 951, 318	0.000000	65.00
	HYSI CAL THERAPY	0	0	(2, 763, 687		
67.00 06700 00	CCUPATI ONAL THERAPY	0	0	(1, 081, 526	0.000000	67.00
	PEECH PATHOLOGY	0	0	(291, 559	0.000000	68.00
71.00 07100 ME	EDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0.000000	71.00
72.00 07200 I M	MPL. DEV. CHARGED TO PATIENTS	0	0	C	1, 872, 611	0.000000	72.00
73.00 07300 DR	RUGS CHARGED TO PATIENTS	0	0	C	20, 336, 967	0.000000	73.00
	ENT SERVICE COST CENTERS						
88. 00 08800 RU	JRAL HEALTH CLINIC	0	0	(1, 094, 644	0.000000	
88. 01 08801 RU	JRAL HEALTH CLINIC II	0	0	(5, 131, 230	0.000000	88. 01
	JRAL HEALTH CLINIC III	0	0	(3, 009, 424		
88. 03 08803 RU	JRAL HEALTH CLINIC IV	0	0	(345, 860	0.000000	88. 03
88. 04 08804 RU	JRAL HEALTH CLINIC V	0	0	C	1, 117, 564	0.000000	88. 04
88. 05 08805 RU	JRAL HEALTH CLINIC VI	0	0	C	3, 853, 339	0.000000	88. 05
91.00 09100 EM		0	0	C	9, 485, 839	0.000000	91.00
	BSERVATION BEDS (NON-DISTINCT PART	0	0	(5, 273, 776	0.000000	92.00
	OODLAWN MEDICAL PROFESSIONALS	0	0	(1, 396, 854		
	HAFER MEDICAL CENTER	0	0	(2, 857, 282	0.000000	93. 01
93. 02 04040 I N	NTERNAL MEDICINE	0	0	(1, 421, 640	0.000000	93. 02
200. 00 To	otal (lines 50 through 199)	0	0	(171, 845, 119		200. 00

Health Financial Systems		WOODLAWN HOS	PI TAL		In Lieu of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCILLADV SEDVICE	UTHED DVCC	Providor CCN: 15 1212	Pari ad:	Workshoot D

Peri od: From 01/01/2023 To 12/31/2023 Part IV THROUGH COSTS Date/Time Prepared: 5/29/2024 7: 26 am Title XVIII Hospi tal Cost Cost Center Description I npati ent Outpati ent Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Charges Pass-Through Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 517, 934 50 00 0 51.00 05100 RECOVERY ROOM 0.000000 53, 529 0 51.00 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0.000000 0 53.00 36, 160 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 229, 148 54.00 0.000000 0 54.00 60.00 06000 LABORATORY 0.000000 410, 744 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 255, 486 0 0 65.00 06600 PHYSI CAL THERAPY 62, 053 0 66.00 0.000000 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 22, 845 0 67.00 06800 SPEECH PATHOLOGY 0.000000 6,034 0 0 68.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 71.00 C 0 07200 I MPL. DEV. CHARGED TO PATIENTS 153, 294 0.000000 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 397, 328 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 88. 01 08801 RURAL HEALTH CLINIC II 0.000000 0 0 88.01 08802 RURAL HEALTH CLINIC III 0.000000 0 0 88.02 88.02 0 0 0 0 0 0 0 0 08803 RURAL HEALTH CLINIC IV 0.000000 0 88.03 88.03 0 08804 RURAL HEALTH CLINIC V 0 88.04 0.000000 0 0 88.04 88.05 08805 RURAL HEALTH CLINIC VI 0.000000 C 0 88.05 09100 EMERGENCY 0.000000 0 91.00 91.00 29, 439 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 28 741 Ω 92.00 0 93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.000000 93.00 C 0 93. 01 04951 SHAFER MEDICAL CENTER 0.000000 0 93.01 0 93. 02 04040 INTERNAL MEDICINE 0 93.02 0.000000 0

2, 202, 735

0 200.00

200.00

Total (lines 50 through 199)

In Lieu of Form CMS-2552-10 Health Financial Systems WOODLAWN HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1313 Peri od: Worksheet D From 01/01/2023 Part V 12/31/2023 Date/Time Prepared: 5/29/2024 7:26 am Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 365, 130 50.00 0. 196399 05100 RECOVERY ROOM 0. 586630 0 241, 859 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.771674 0 52.00 53.00 05300 ANESTHESI OLOGY 0.044616 410,086 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 111350 7, 703, 328 0 54.00 06000 LABORATORY 0. 121993 6, 096, 579 60.00 0 60.00 06500 RESPIRATORY THERAPY 65.00 0. 235559 1, 712, 342 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.446309 635, 039 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 230624 0 168, 499 0 67.00 06800 SPEECH PATHOLOGY 0.457942 0 68.00 68.00 24, 139 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 524893 0 0 72.00 282, 638 72.00 07300 DRUGS CHARGED TO PATIENTS 6, 110, 904 73.00 73 00 0. 234502 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88.01 08802 RURAL HEALTH CLINIC III 88 02 88 02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 08804 RURAL HEALTH CLINIC V 88.04 88.04 08805 RURAL HEALTH CLINIC VI 88.05 88.05 09100 EMERGENCY 91 00 0.557329 1, 292, 015 0 91.00 0 0 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.417335 820, 700 0 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 0.530270 0 93.00 0 04951 SHAFER MEDICAL CENTER 0. 352148 0 93.01 93.01 0 0 93. 02 | 04040 | INTERNAL MEDICINE 0.183357 0 0 93.02 Ω 200.00 Subtotal (see instructions) 0 27, 863, 258 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00

0

27, 863, 258

0 202.00

Only Charges

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	WOODLAWN HOS	PI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1313		Worksheet D
			From 01/01/2023	Part V

12/31/2023 Date/Time Prepared: 5/29/2024 7:26 am Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 464, 509 05100 RECOVERY ROOM 51.00 0 51.00 141, 882 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 18, 296 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 857, 766 54.00 60.00 06000 LABORATORY 0 743, 740 60.00 06500 RESPIRATORY THERAPY 0 65.00 403, 358 65.00 66.00 06600 PHYSI CAL THERAPY 283, 424 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 38, 860 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 11, 054 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 148, 355 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73 00 1, 433, 019 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88.01 08802 RURAL HEALTH CLINIC III 88. 02 88 02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 88.04 08804 RURAL HEALTH CLINIC V 88.04 08805 RURAL HEALTH CLINIC VI 88.05 88.05 91 00 09100 EMERGENCY 720, 077 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 342, 507 92.00 93.00 04950 WOODLAWN MEDICAL PROFESSIONALS 93.00 93. 01 04951 SHAFER MEDICAL CENTER 0 93.01 0 93. 02 | 04040 | I NTERNAL MEDICI NE 0 93.02 200.00 Subtotal (see instructions) 5, 606, 847 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 5, 606, 847 0 202.00

Financial Systems	WOODLAWN HOSPI	I TAL	In Lie	of Form CMS-2	2552-10
TION OF INPATIENT OPERATING COST		Provider CCN: 15-1313	Peri od: From 01/01/2023	Worksheet D-1	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
NPATI ENT DAYS					
npatient days (including private room days a	and swing-bed days	, excluding newborn)		2, 763	1.00
npatient days (including private room days,	excluding swing-b	ed and newborn days)		2, 452	2.00
	Cost Center Description PART I - ALL PROVIDER COMPONENTS NPATIENT DAYS Inpatient days (including private room days)	TION OF INPATIENT OPERATING COST Cost Center Description PART I - ALL PROVIDER COMPONENTS NPATIENT DAYS Inpatient days (including private room days and swing-bed days)	TION OF INPATIENT OPERATING COST Provider CCN: 15-1313 Title XVIII Cost Center Description PART I - ALL PROVIDER COMPONENTS	TION OF INPATIENT OPERATING COST Provider CCN: 15-1313 Period: From 01/01/2023 To 12/31/2023 Title XVIII Hospital Cost Center Description PART I - ALL PROVIDER COMPONENTS NPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn)	TION OF INPATIENT OPERATING COST Provider CCN: 15-1313 Period: From 01/01/2023 To 12/31/2023 Pate/Time Preiod: From 01/01/2023 Pate/Time Preiod: From 01/01/2

	Cost Center Description	1 00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 763	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 452	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4. 00	Semi-private room days (excluding swing-bed and observation bed days)	1, 476	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	97	5.00
	reporting period	 -	
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)	214	7.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	214	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	· [
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	487	9. 00
10.00	newborn days) (see instructions)	07	40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	97	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	- I	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private 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 XIX only (including private room days)	0	13.00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	 -	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	 -	18. 00
10.00	reporting period	 -	18.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	266. 32	19.00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	266. 32	20.00
21 00	reporting period	5, 805, 112	21.00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		21.00
22.00	5 x 1 in e 17)	١	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	56, 992	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
23.00	In line 20)	·	25.00
26.00	Total swing-bed cost (see instructions)	275, 732	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 529, 380	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	1
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 5, 529, 380	36. 00 37. 00
37.00	27 minus Line 36)	J, JZ7, JOU	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	2, 255. 05	1
39.00	Program general inpatient routine service cost (line 9 x line 38)	1, 098, 209	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 1, 098, 209	40.00
		., 3,0, 207	

7. 00	reporting period (IT calendar year, enter 0 on this line) Total swipp hod NE type inpatient days (including private room days) through December 21 of the cost	214	7. 00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	214	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	487	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	97	10. 00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
18. 00			18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	266. 32	19. 00
	reporting period	244 22	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	266. 32	20. 00
21.00	Total general inpatient routine service cost (see instructions)	5, 805, 112	21. 00
22. 00			22. 00
	5 x line 17)		
23. 00		0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7×1 line 19)	56, 992	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 \times line 20)	0	25. 00
26.00	Total swing-bed cost (see instructions)	275, 732	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 529, 380	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	34.00
	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37. 00
07.00	27 minus line 36)	0,027,000	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	2, 255. 05	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 098, 209	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 098, 209	41.00
		·	

Interest via Care type Inpatrient Inselt tal Units		Financial Systems	WOODLAWN H	OSPI TAL		u of Form CMS-2	2552-10
Doct Centur Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-1313	From 01/01/2023	Date/Time Pre	pared:
Program Inpatient Cell Light Section Program Inpatien				Title XVIII	Hospi tal		.o aiii
MDSERY (LITE V & XIX only)		Cost Center Description	Inpatient Cost	Inpatient Diem (col. Days ÷ col. 2)	1	(col. 3 x col. 4)	
Internet via Carne Type Inpatient Hisspital Units	42 00	NURSERY (title V & XIX only)					42.00
44.00 CORONARY CARE UNIT	.2. 00			5,	50	<u> </u>	1 .2.00
Program inpatient ancillary service cost (Wist. D.3. col. 3, Iline 200) 508,309 48. 100	44. 00 45. 00 46. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0 0. (00 0	0	43. 00 44. 00 45. 00 46. 00 47. 00
Program inpatient cell ular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		·				1. 00	
1.60, 518 47.		Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)		508, 309	1
9.00 Pass through costs applicable to Program inpatient routine services (from Wist. D. sum of Parts I and III) 9.11 Plass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II of III) 9.12 Aug. 1970 Plass through costs applicable to Program inpatient ancillary services (from Wist. D. sum of Parts II of III) 9.13 Aug. 1970 Plass (Strong Mist. D. sum of Parts III) 9.14 Program accludable cost (sum of Fines 50 and 51) 9.15 Cost (Program decludable cost (sum of Fines 50 and 51) 9.15 Cost (Program decludable cost (sum of Fines 50 and 51) 9.16 Cost (Program decludable cost (sum of Fines 50 and 51) 9.16 Cost (Program decludable cost (sum of Fines 50 and 51) 9.17 Cost (Program decludable cost (sum of Fines 52) 9.18 Cost (Program decludable cost (sum of Fines 52) 9.19 Cost (Program decludable cost (sum of Fines 52) 9.10 Program and scharges 9.10 Program an		Total Program inpatient costs (sum of lines), column 1)		
51.00 pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV) 52.00 Total Program excludable cost (sum of Ilnes 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs. (Ilne 49 minus Ilne 52) 54.00 Program discharges 55.00 Program discharges 55.01 Permanent adjustment amount per discharge (contractor use only) 55.01 Permanent adjustment amount per discharge (contractor use only) 55.02 Program discharges scharge 56.00 Difference between adjusted inpatient operating cost and target amount (Ilne 56 minus Ilne 53) 57.00 Difference between adjusted inpatient operating cost and target amount (Ilne 56 minus Ilne 53) 58.00 Bons payment (see Instructions) 58.00 Bons payment (see Instructions) 59.00 Expected costs (lesser of Ilne 53 + Ilne 54, or Ilne 55 from the cost reporting period ending 1996, co. 05 pudated and compounded by the market basket) 60.00 Expected costs (lesser of Ilne 53 + Ilne 54, or Ilne 55 from prior year cost report, updated by the market basket) 61.00 Expected costs (lesser of Ilne 53 + Ilne 54, or Ilne 55 from prior year cost report, updated by the market basket) 61.01 Expected costs (lesser of Ilne 53 + Ilne 54 ilne 54 is less than the lovest of Ilne 55 plus 55, 01, or Ilne 59 or Ilne 50, enter the lesser of 50% or The amount by which operating costs (Ilne 53, 01, or Ilne 59 or Ilne 50, enter the lesser of 50% or The amount by which operating costs (Ilne 53, 01, or Ilne 59 or Ilne 50, enter the lesser of 50% or The amount by which operating period (See instructions) 62.00 Relief payment (see instructions) 63.01 All lowable Inpatient cost plus incentive payment (see instructions) 64.00 Total Exported Costs (Ilne 54 x 60), or 1 % of the cost reporting period (See instructions) (Ille 64) (Ille 64) (Ille 64) (Ille 65) (Ille 65) (Ille 65) (Ille 65) (Ille 65) (Ille 66) (Ille 66) (Ille 67) (50.00	3 11 3 1	atient routine	services (from Wkst. D, su	ım of Parts I and	0	50.00
Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	51. 00	Pass through costs applicable to Program inpand IV)		y services (from Wkst. D,	sum of Parts II	0	51.00
54.00 Program discharges 0.0 55.01 Permanent adjustment amount per discharge 0.00 55.55.01 Permanent adjustment amount per discharge 0.00 55.55.02 Adjustment amount per discharge 0.00 55.55.02 Adjustment amount per discharge 0.00 55.55.02 Adjustment amount per discharge (contractor use only) 0.00 55.55.02 Adjustment amount per discharge (contractor use only) 0.00 55.55.00 Adjustment amount per discharge (contractor use only) 0.00 55.55.00 Permanent adjusted inpatient operating costs and target amount (line 56 minus line 53) 0.57.55.00 Deference between adjusted inpatient operating costs and target amount (line 56 minus line 53) 0.57.55.00 Deference costs (line 53 + line 54, or line 55 from the cost reporting period ending 1996, 0.00 59.00 Deference costs (line 53 + line 54, or line 55 from the cost report, updated by the market basket) 0.00 0.0		Total Program inpatient operating cost exclumedical education costs (line 49 minus line	ding capital re	lated, non-physician anest	hetist, and	_	
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63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Total title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total trice and the cost of the cost reporting period (line 13 x line 20) 60.00 Total trice and the cost reporting period (line 13 x line 69) 60.00 Total Program general inpatient routine service costs (line 67 + line 68) 60.00 Total Program proutine service cost (line 70 + line 2) 60.00 Total Program routine service costs (line 75 + line 2) 60.00 Total Program routine service costs (line 75 + line 2) 60.00 Total Program routine service cost (line 74 minus line 77) 60.01 Inpatient routine service cost (line 74 minus line 77) 60.01 Inpatient routine service cost (line 9 x line 81) 60.01 Inpatient routine service cost (line 11 minus 11) 60.01 I		53) are less than expected costs (lines 54 \times enter zero. (see instructions)					
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65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.01 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Program capital -related costs (line 75 + line 2) 76.00 Program capital -related costs (line 74 minus line 77) 77.00 Program capital -related costs (line 74 minus line 77) 78.00 Total Program proutine service cost (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs (see instructions) 80.01 Inpatient routine service cost (see instructions) 81.02 Reasonable inpatient routine services (see instructions) 82.03 Reasonable inpatient routine service (see instructions) 83.04 Utilization review - physician compensation (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	64. 00		ts through Dece	mber 31 of the cost report	ing period (See	218, 740	64.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total Program facility/other nursing facility/ICF/IID routine service cost (line 37) 70.10 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.01 Program general inpatient routine service costs (line 72 + line 73) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Per diem capital -related costs (line 75 + line 2) 76.00 Program capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 76) 78.00 Inpatient routine service cost (line 76) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 79.00 Inpatient routine service cost per diem limitation 80.01 Inpatient routine service cost (see instructions) 81.00 Inpatient routine service cost (see instructions) 82.01 Program inpatient an	65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the cost reportin	g period (See	0	65. 00
67. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 70 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71. 00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75. 00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital -related costs (line 75 + line 2) 77. 00 Program capital -related costs (line 74 minus line 77) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 01 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 79. 10 Inpatient routine service costs (see instructions) 80. 00 Total Program inpatient routine service costs (see instructions) 81. 01 Inpatient routine service costs (see instructions) 82. 03 Reasonable inpatient routine service (see instructions) 83. 04 Reasonable inpatient routine service (see instructions) 84. 05 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 65)(title XVI	II only); for	218, 740	66. 00
Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	67. 00		e costs through	December 31 of the cost r	reporting period	0	67.00
69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY 70. 00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70. 01 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 71. 02 Program routine service cost (line 9 x line 71) 72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 ÷ line 2) 77. 00 Program capital-related costs (line 78 × line 79) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 01 O Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 01 Inpatient routine service cost per diem limitation 81. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine services (see instructions) 83. 00 Reasonable inpatient ancillary services (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 84. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of the cost rep	orting period	0	68. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.10 Inpatient routine service cost per diem limitation 10 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost limitation (line 9 x line 81) 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) 70.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	69. 00	Total title V or XIX swing-bed NF inpatient				0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.01 Inpatient routine service cost per diem limitation 81.02 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine services (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	70. 00				')		70.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1npatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.10 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.10 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Program inpatient routine service costs (see instructions) 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 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	71. 00	Adjusted general inpatient routine service of	ost per diem (I		•		71.00
Total Program general inpatient routine service costs (line 72 + line 73) 74. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 1 Inpatient routine service cost per diem limitation 1 Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions) 1 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				(line 14 v line 25)			72.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 18.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.01 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Utilization review - physician compensation (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							73.00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 01 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 01 Inpatient routine service cost per diem limitation 81. 02 Inpatient routine service cost limitation (line 9 x line 81) 82. 03 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 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		Capital-related cost allocated to inpatient			Part II, column		75. 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.01 Inpatient routine service cost per diem limitation 81.02 Inpatient routine service cost limitation (line 9 x line 81) 82.03 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		•	,				76.00
79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80. 01 Inpatient routine service cost per diem limitation 81. 02. 00 Inpatient routine service cost limitation (line 9 x line 81) 82. 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		•					77. 00 78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 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 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				rovi der records)			79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				ost limitation (line 78 mi	nus line 79)		80.00
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) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		·)			81. 00 82. 00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		·					83.00
86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	84.00	Program inpatient ancillary services (see in	structions)				84.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		· ·					85.00
	ชo. UU			rougn 85)			86.00
770 071	87. 00	Total observation bed days (see instructions				976	87.00

Health Financial Systems	ealth Financial Systems WOODLAWN HOSPITAL In Lieu				u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			2, 200, 929	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	612, 440	5, 805, 112	0. 10550	0 2, 200, 929	232, 198	90.00
91.00 Nursing Program cost	0	5, 805, 112	0.00000	0 2, 200, 929	0	91.00
92.00 Allied health cost	o	5, 805, 112	0.00000	0 2, 200, 929	0	92.00
93.00 All other Medical Education	o	5, 805, 112	0. 00000	0 2, 200, 929	0	93. 00

	Financial Systems WOODLAWN HOS			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1313	Peri od: From 01/01/2023	Worksheet D-1	
			To 12/31/2023		
		Title XIX	Hospi tal	5/29/2024 7: 2 Cost	6 am
	Cost Center Description	TI LIE XIX	поѕрі таі	COST	
	oost contor boson per on			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			2, 763	
2. 00	Inpatient days (including private room days, excluding swing-			2, 452	
3.00	Private room days (excluding swing-bed and observation bed days	ays). If you have only p	rivate room days,	0	3.00
4 00	do not complete this line.			4 47/	4 00
4.00	Semi-private room days (excluding swing-bed and observation by		or 21 of the cost	1, 476 97	
5. 00	Total swing-bed SNF type inpatient days (including private reporting period	dolli days) through beceilib	er 31 of the cost	97	5.00
6. 00	Total swing-bed SNF type inpatient days (including private ro	nom davs) after December	31 of the cost	0	6.00
0.00	reporting period (if calendar year, enter 0 on this line)	Join days, a. te. Beesinge.	0. 0. 1 0001	· ·	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	214	7.00
	reporting period	3 7			
8.00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	g swing-bed and	47	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12.00
40.00	through December 31 of the cost reporting period	V I C I I I	1	0	40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)	am (exchading swring bea	uays)	334	
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				1
17.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost		17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	os through Dosombor 21 o	f the cost	266. 32	19.00
19.00	reporting period	es through becember 31 0	i the cost	200. 32	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	266. 32	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			5, 805, 112	
22.00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22. 00
	5 x line 17)]	_	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 31 of the cost roport	ing period (lips	56, 992	24.00
∠4.00	7 x line 19)	of the cost report	ing period (Title	50, 792	24.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. 00

	INPATTENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2, 763	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 452	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
	do not complete this line.		
4.00	Semi -pri vate room days (excluding swing-bed and observation bed days)	1, 476	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost		1
5.00	reporting period	7/	3.00
		0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	214	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	47	9.00
7. 00	newborn days) (see instructions)	.,	/. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00		U	10.00
44.00	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	334	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18.00
	reporting period		
19. 00		266. 32	19.00
19.00		200. 32	1 7. 00
	reporting period	0,, 00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	266. 32	20.00
	reporting period		l
21.00	Total general inpatient routine service cost (see instructions)	5, 805, 112	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23.00		0	23.00
23.00	Swing bed east approach to swing period (The East reporting period (The Eas	0	25.00
24 00		E4 000	24.00
24. 00		56, 992	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	275, 732	26.00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 529, 380	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	.,,	1
28 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00		0	29.00
30.00		0	30.00
31.00		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34. 00			34.00
35. 00		0.00	
			1
36.00	· · · · · · · · · · · · · · · · · · ·	0	36.00
37. 00		5, 529, 380	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
38. 00		2, 255. 05	38.00
39. 00		105, 987	
			1
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	105, 987	41.00

<u>Heartn</u>	Financial Systems	WOODLAWN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 1		eriod: rom 01/01/2023	Worksheet D-1	
					o 12/31/2023	Date/Time Pre 5/29/2024 7:2	
			Title XI		Hospi tal	Cost	
	Cost Center Description	Total Inpati ent		erage Per m (col. 1	Program Days	Program Cost (col. 3 x	
		Cost		col. 2)		col . 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	673, 594	334	2, 016. 75	0	0	42.00
43. 00	INTENSIVE CARE UNIT	0	0	0. 00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	. line 200)			1. 00 34, 737	48.00
48. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	eet D-6, Part III,	line 10,	column 1)	0	
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instruction	ıs)		140, 724	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from Wks	st. D. sum	of Parts I and	0	50. 00
	111)		·				
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	y services (from V	lkst. D, sı	um of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu	ding capital re	lated, non-physici	an anesth	etist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor		0. 00 0. 00				
56.00	Target amount (line 54 x sum of lines 55, 55	0.00	1				
57.00	O Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						
58. 00 59. 00							
07.00	updated and compounded by the market basket)						
60.00	0 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les	0	61.00				
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	the target amount	(line 56)	, otherwise		
62. 00	Relief payment (see instructions)	0	62.00				
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the cos	st reportin	na period (See	0	64.00
	instructions)(title XVIII only)	3		'			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the cost	reporti ng	peri od (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 65)(1	itle XVIII	only); for	0	66.00
67. 00	CAH, see instructions					0	/7.00
67.00	(line 12 x line 19)	e costs through	December 31 of th	ie cost rep	orting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68.00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line 68)	ı		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY	AND ICF/IID ONLY	′			1
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of			(IIne 37)			70.00
72. 00	Program routine service cost (line 9 x line		THE 70 : TIME 2)				72.00
73.00	Medically necessary private room cost applic			35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		sheet B. Pa	art II. column		74.00 75.00
	26, line 45)		(,	,		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76.00 77.00
78. 00	Inpatient routine service cost (line 74 minu						78.00
79.00	Aggregate charges to beneficiaries for exces	s costs (from p		76 .			79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation (li	ne 78 minu	ıs IIne 79)		80.00 81.00
82. 00	Inpatient routine service cost per drem from Inpatient routine service cost limitation (I)				82.00
83.00	Reasonable inpatient routine service costs (see instruction					83.00
	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				84. 00 85. 00
84.00			11.37				1 00.00
85.00	Total Program inpatient operating costs (sum						86.00
85.00		of lines 83 th S THROUGH COST				071	86. 00 87. 00

th Financial Systems WOODLAWN HOSPITAL In L				In Lie	eu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC	Provider CCN: 15-1313		Worksheet D-1	
				From 01/01/2023 To 12/31/2023		pared: 6 am
		Ti tl e	Title XIX		Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			2, 200, 929	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	612, 440	5, 805, 112	0. 10550	0 2, 200, 929	232, 198	90.00
91.00 Nursing Program cost	0	5, 805, 112	0.00000	0 2, 200, 929	0	91.00
92.00 Allied health cost	o	5, 805, 112	0.00000	0 2, 200, 929	0	92.00
93.00 All other Medical Education	o	5, 805, 112	0. 00000	0 2, 200, 929	0	93. 00

Health Financial Systems WOOI INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	DLAWN HOSPITAL Provider C		Peri od:	u of Form CMS-2 Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
				col . 2)	
LABATI FAT. BOUTLANE OFFICE OF COOT. OFFITERS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			700 400		
30. 00 03000 ADULTS & PEDI ATRI CS			728, 492		30.00
31. 00 03100 I NTENSI VE CARE UNIT			0		31.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 19639	9 517, 934	101, 722	50.00
51. 00 05100 RECOVERY ROOM		0. 19039		31, 402	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 38003		31, 402	1
53. 00 05300 ANESTHESI OLOGY		0.77167		1, 613	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 04401		25, 516	
60. 00 06000 LABORATORY		0. 11133		50, 108	
65. 00 06500 RESPI RATORY THERAPY		0. 23555		60, 182	
66. 00 06600 PHYSI CAL THERAPY		0. 44630		27, 695	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 23062		5, 269	
68. 00 06800 SPEECH PATHOLOGY		0. 45794		2, 763	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000		0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 52489	3 153, 294	80, 463	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 23450	2 397, 328	93, 174	73.00
OUTPATIENT SERVICE COST CENTERS					1
88. 00 08800 RURAL HEALTH CLI NI C		0.00000	0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	1 00.0.
88. 02 08802 RURAL HEALTH CLINIC III		0.00000		0	
88. 03 08803 RURAL HEALTH CLINIC IV		0.00000		0	
88. 04 08804 RURAL HEALTH CLINIC V		0.00000		0	
88. 05 08805 RURAL HEALTH CLINIC VI		0.00000		0	
91. 00 09100 EMERGENCY		0. 55732		16, 407	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 41733		11, 995	
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS		0. 53027		0	1
93. 01 04951 SHAFER MEDICAL CENTER		0. 35214		0	
93. 02 04040 I NTERNAL MEDI CI NE	1 00)	0. 18335		0	
200.00 Total (sum of lines 50 through 94 and 96 through			2, 202, 735	508, 309	
201.00 Less PBP Clinic Laboratory Services-Program onl	y charges (line 61)		2 202 725		201.00
202.00 Net charges (line 200 minus line 201)		1	2, 202, 735		202.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 01/01/2023	Worksheet D-3	3
	Component		To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
	Title	XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.0
I3. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.0
50. 00 O5000 OPERATI NG ROOM		0. 19639	99 0	0	50.00
51. 00 05100 RECOVERY ROOM		0. 58663		Ö	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 77167		Ō	
53. 00 05300 ANESTHESI OLOGY		0. 04461	6 0	0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11135	5, 855	652	54.0
00. 00 06000 LABORATORY		0. 12199		711	
55. 00 06500 RESPI RATORY THERAPY		0. 23555		942	
66. 00 06600 PHYSI CAL THERAPY		0. 44630		15, 046	1
57. 00 06700 OCCUPATI ONAL THERAPY		0. 23062		5, 401	
8.00 06800 SPEECH PATHOLOGY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 45794	1	1, 383 0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS		0. 00000 0. 52489		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 23450		1, 982	
OUTPATIENT SERVICE COST CENTERS		0. 20 100	0, 101	1, 702	1 , 0. (
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. (
8.01 08801 RURAL HEALTH CLINIC II		0. 00000	00	0	88.0
8.02 08802 RURAL HEALTH CLINIC III		0. 00000		0	1
8.03 08803 RURAL HEALTH CLINIC IV		0. 00000		0	1
8. 04 08804 RURAL HEALTH CLINIC V		0. 00000		0	1
8. 05 08805 RURAL HEALTH CLINIC VI		0.00000		0	1
1. 00 09100 EMERGENCY		0. 55732		3, 870	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 3.00 04950 WOODLAWN MEDICAL PROFESSIONALS		0. 41733 0. 53027		0	
3.01 04950 WOODLAWN MEDICAL PROFESSIONALS 3.01 04951 SHAFER MEDICAL CENTER		0. 35214			
3. 02 04040 I NTERNAL MEDICINE		0. 33214		0	1
200.00 Total (sum of lines 50 through 94 and 96	through 98)	0. 10000	91, 226		
201.00 Less PBP Clinic Laboratory Services-Progra			0	2.,,0,	201. 0
Net charges (line 200 minus line 201)	3 2 3 3 2 7	[91, 226		202.0

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1313	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/29/2024 7:2	pared:
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x	
		1.00	2.00	col . 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			79, 258		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.0
13. 00 04300 NURSERY			0		43.0
ANCILLARY SERVICE COST CENTERS 50.00 OF		0. 19639	99 64, 531	12, 674	50. 0
51. 00 05000 OPERATING ROOM		0. 19639		4, 342	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 30003		0	1
53. 00 05300 ANESTHESI OLOGY		0. 04461		209	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11135	· ·	1, 023	1
50. 00 06000 LABORATORY		0. 12199	34, 236	4, 177	60.0
55. 00 06500 RESPIRATORY THERAPY		0. 23555		1, 614	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 44630		253	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 23062		25	
58. 00 06800 SPEECH PATHOLOGY		0. 45794		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000 0. 52489		0	
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 23450		589 7, 522	
OUTPATIENT SERVICE COST CENTERS		0. 23430	32,070	1, 322	73.0
38. 00 08800 RURAL HEALTH CLINIC		1. 57917	74 0	0	88.0
38.01 08801 RURAL HEALTH CLINIC II		0. 92984		0	88. C
8.02 08802 RURAL HEALTH CLINIC III		1. 02994	15 0	0	88.0
88.03 08803 RURAL HEALTH CLINIC IV		0. 98343	0	0	88.0
88. 04 08804 RURAL HEALTH CLINIC V		1. 12666		0	
38. 05 08805 RURAL HEALTH CLINIC VI		0. 87929		0	
11. 00 09100 EMERGENCY		0. 55732		2, 309	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 23.00 04950 WOODLAWN MEDICAL PROFESSIONALS		0. 41733 0. 53027		0	
93. 00 04950 WOODLAWN MEDICAL PROFESSIONALS 93. 01 04951 SHAFER MEDICAL CENTER		0. 35214		0	
93. 02 04040 I NTERNAL MEDICINE		0. 35214		0	1
200.00 Total (sum of lines 50 through 94 and 96 through	ah 98)	0. 15555	164, 904	34, 737	
201.00 Less PBP Clinic Laboratory Services-Program on			0	3.,707	201.0
Net charges (line 200 minus line 201)	J . J		164, 904		202. C

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

		Ti +l o W/III		Date/Time Pre 5/29/2024 7: 2	
		Title XVIII	Hospi tal	Cost	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			5, 606, 847	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	ctions)		0	
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)				
4. 01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	1
6. 00 7. 00	Line 2 times line 5			0 0. 00	
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)				1
9. 00	Ancillary service other pass through costs including REH dire	ect graduate medical educ	cation costs from	0	1
40.00	Wkst. D, Pt. IV, col. 13, line 200				40.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 5, 606, 847	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 000, 047	11.00
	Reasonabl e charges				
12. 00 13. 00	Ancillary service charges	inc 40)		0	
14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	1116 07)		0	1
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for			0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(1 3	on a chargebasis	0	16.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	()		0. 000000	17.00
18. 00	Total customary charges (see instructions)			0	1
19. 00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds li	ne 11) (see	0	19.00
20. 00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)	,	, ,		
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			5, 662, 915 0	
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	1
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	>		70.740	1 25 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lir	•	ructions)	79, 749 4, 341, 887	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•		1, 241, 279	•
00.00	instructions)	1			00.00
28. 00 28. 50	Direct graduate medical education payments (from Wkst. E-4, I REH facility payment amount (see instructions)	The 50)		0	28. 00 28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			1, 241, 279	1
31.00	Primary payer payments			218	1
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		1, 241, 061	32.00
	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			358, 452 232, 994	
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		295, 393	
37. 00	Subtotal (see instructions)	,		1, 474, 055	
38. 00	MSP-LCC reconciliation amount from PS&R			0	1
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39. 00 39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	,		0	1
39. 97	Demonstration payment adjustment amount before sequestration			0	1
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	nced devices (see instru	ctions)	0	1
40.00	Subtotal (see instructions)			1, 474, 055	
40. 01	Sequestration adjustment (see instructions)			29, 481	
40. 02	Demonstration payment adjustment amount after sequestration			0	1
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			1, 946, 137	40.03
41. 01	Interim payments-PARHM			.,,,	41. 01
42.00	Tentative settlement (for contractors use only)			0	1
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-501, 563	42. 01 43. 00
43. 00	Balance due provider/program-PARHM (see instructions)			-501,565	43.00
44. 00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2 TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	,			0.00	92. 00 93. 00
93.00	Time Value of Money (see instructions)		ļ	0	73.00

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	Peri od:	Worksheet E	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	pared:
			5/29/2024 7: 2	<u>:6 am</u>
	Title XVIII	Hospi tal	Cost	
			1. 00	
94.00 Total (sum of lines 91 and 93)			0	94.00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5//9/2024 7:26 am	Health Financial Systems

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

					5/29/2024 7: 2	6 am
		Title	: XVIII	Hospi tal	Cost	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	1.00	1, 223, 575	0.00	1, 946, 137	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVI DER		0		0	3. 01
3. 02 3. 03 3. 04 3. 05	AUSOSTIMENTS TO TROVIDER		0 0		0 0	3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3. 50 3. 51 3. 52 3. 53 3. 54 3. 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines		0 0 0 0 0		0 0 0 0 0	3. 50 3. 51 3. 52 3. 53 3. 54 3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 223, 575		1, 946, 137	4. 00
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 00
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03	TENTATIVE TO TROVIDER		0		0	5. 02 5. 03
	Provider to Program					
5. 50 5. 51 5. 52 5. 99	TENTATIVE TO PROGRAM Subtotal (sum of lines 5.01-5.49 minus sum of lines		0 0 0 0		0 0	5. 50 5. 51 5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
6. 01 6. 02 7. 00	the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		189, 603 0 1, 413, 178	Contractor	0 501, 563 1, 444, 574 NPR Date	6. 01 6. 02 7. 00
			•	Number	(Mo/Day/Yr)	
0.00		()	1. 00	2. 00	0.5-
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 01/01/2023 | Part I
To 12/31/2023 | Date/Time Prepared: | 5/29/2024 7: 26 am Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		·			5/29/2024 7: 2	.6 am
		Title	XVIII S	wing Beds - SNF	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		189, 47	1	0	1.00
2.00	Interim payments payable on individual bills, either				0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVI DER		(D	0	3. 01
3.02			(0	3. 02
3.03			(0	3. 03
3.04			(0	3.04
3.05			(0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(D	0	3.50
3. 51			(0	3. 51
3. 52			(0	3. 52
3.53			(0	3.53
3.54			(0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		189, 47 ⁻	1	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02			(D	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		(D	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		56, 13°	1	0	
6. 02	SETTLEMENT TO PROGRAM		(0	
7. 00	Total Medicare program liability (see instructions)		245, 602		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8.00

Heal th	Financial Systems WOODLAWN HO	SPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1313 Period: V				
			From 01/01/2023 To 12/31/2023		nared:
			10 12/31/2023	5/29/2024 7: 2	
Title XVIII Hospital					
	TO BE COMPLETED BY CONTRACTOR FOR MONOTANDARD COST REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	NI.			-
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				4 00
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2. 00	Medicare days (see instructions)				2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3. 00
4. 00	Total inpatient days (see instructions)				4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00
			· ·		•

		Component CCN: 15-Z313 T	o 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title XVIII S	wing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		220, 927	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 Par	t A, and sum of Wkst. D,	30, 287	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	ng-bed pass-through, see			
0.01	instructions)				0.04
3. 01 4. 00	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teach	ing program (soc		0. 00	3. 01 4. 00
4.00	instructions)	riig program (see		0.00	4.00
5.00	Program days		97	0	5.00
6.00	Interns and residents not in approved teaching program (see i			0	6.00
7. 00	Utilization review - physician compensation - SNF optional me	thod only	0	_	7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		251, 214	0	
9. 00 10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		251, 214	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	231, 214	0	
	professional services)			_	
12.00	Subtotal (line 10 minus line 11)		251, 214	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	600	0	13. 00
14. 00	for physician professional services) 80% of Part B costs (line 12 x 80%)			0	14.00
15. 00	Subtotal (see instructions)		250, 614	0	
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16. 55
47.00	adjustment (see instructions)				44 00
16. 99 17. 00	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	
17. 00	Adjusted reimbursable bad debts (see instructions)		0	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)	0	0	
19.00	Total (see instructions)	•	250, 614	0	19.00
19. 01	Sequestration adjustment (see instructions)		5, 012	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03 19. 25	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)		0	0	19. 03 19. 25
20.00	Interim payments		189, 471	0	20.00
	Interim payments-PARHM		107, 171	Ŭ	20. 01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	56, 131	0	
22. 01 23. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nco with CMS Dub 15.2	0	0	22. 01 23. 00
23.00	chapter 1, §115.2	nce with cm3 rub. 15-2,	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				-
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from '	Wkst. D-1, Pt. II, line			201.00
201.00	66 (title XVIII hospital))	wkst. D-1, It. II, IIIe			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line			202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the surren	t 5 year demons	tration	204.00
	period)	Trist year or the curren	t 5-year demons	Strati Oii	
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 00
007.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburg				
	Program reimbursement under the §410A Demonstration (see inst	•			207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E- and 3)	z, cor. r, sum or rines r			208. 00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
	Reserved for future use	,			210.00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
	instructions)		[I

Health Financial Systems	WOODLAWN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 7:26 am

				5/29/2024 7:2	6 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		
1.00	Inpatient services		NET INDOTTOEMENT	1, 606, 518	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3. 00	Organ acquisition	013)		0	3.00
				0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			_	
4.00	Subtotal (sum of lines 1 through 3.01)			1, 606, 518	
5. 00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 622, 583	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	11.00
12. 00	Amounts that would have been realized from patients liable for				12.00
.2.00	had such payment been made in accordance with 42 CFR 413.13(e		on a onal go baol a		12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0.000000	14. 00
15. 00	Excess of customary charges over reasonable cost (complete or	alv if line 14 exceeds li	no 6) (soo	0	15.00
13.00	linstructions)	illy II IIIIe 14 exceeds II	ne o) (see	U	13.00
16. 00	Excess of reasonable cost over customary charges (complete or	alvifling 6 avenade lin	20 14) (600	0	16. 00
10.00	linstructions)	if y if fille 6 exceeds iff	le 14) (See	U	10.00
17 00	1	trusti ono)		0	17. 00
17. 00	Cost of physicians' services in a teaching hospital (see inst	tructions)		U	17.00
10.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1 11			10.00
18.00	Direct graduate medical education payments (from Worksheet E-	-4, TINE 49)			18.00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 622, 583	
20.00	Deductibles (exclude professional component)			193, 325	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 429, 258	
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			1, 429, 258	24.00
25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		19, 631	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			12, 760	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		9, 468	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 442, 018	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	29. 50
29. 98	Recovery of accelerated depreciation.	,		0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			Ö	
30.00	Subtotal (see instructions)			1, 442, 018	
30. 01	Sequestration adjustment (see instructions)			28, 840	
30. 01	Demonstration adjustment (see First detrois) Demonstration payment adjustment amount after sequestration			20, 040	30. 01
30. 02				U	30. 02
	Sequestration adjustment-PARHM			1 222 575	
31.00	Interim payments			1, 223, 575	
31. 01	Interim payments-PARHM			_	31. 01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0			189, 603	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m				33. 01
34.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2				

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1313	Peri od:	Worksheet E-3
		From 01/01/2023	

			To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		140, 724		1.00
2. 00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		140, 724	0	4. 00
5. 00	Inpatient primary payer payments		0		5. 00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		140, 724	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges		70.250		0 00
8. 00 9. 00	Routine service charges Ancillary service charges		79, 258 164, 904	0	8. 00 9. 00
10. 00	Organ acquisition charges, net of revenue		104, 904	U	10.00
	Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		244, 162	0	12.00
12.00	CUSTOMARY CHARGES		244, 102		12.00
13.00	Amount actually collected from patients liable for payment for servi	ces on a charge	0	0	13.00
	basis	3.			
14.00	Amounts that would have been realized from patients liable for payme	ent for services or	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	0.000000	15.00
16.00	Total customary charges (see instructions)		244, 162	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if I	ine 16 exceeds	103, 438	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if I	ine 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	10.00
19. 00	Interns and Residents (see instructions)	20)	0	0	19. 00 20. 00
20. 00 21. 00	Cost of physicians' services in a teaching hospital (see instruction Cost of covered services (enter the lesser of line 4 or line 16)	15)	140, 724	0	20.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comple	tod for DDS provid		U	21.00
22. 00	Other than outlier payments	sted for 113 provid	0	0	22.00
	Outlier payments		Ö	0	23.00
	Program capital payments		o	Ü	24.00
	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)		140, 724	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		140, 724	0	31.00
	Deducti bl es		0	0	32.00
	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		140 724	0	35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		140, 724	0	36. 00 37. 00
	Subtotal (line 36 ± line 37)		140, 724	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		140, 724	Ü	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		140, 724	0	40.00
	Interim payments		155, 902	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		-15, 178	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance wit	th CMS Pub 15-2,	0	0	43.00
	chapter 1, §115. 2				
			•		

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

Provi der CCN: 15-1313

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 7: 26 am

——————————————————————————————————————					5/29/2024 7: 2	<u>6 am</u>
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	10, 780, 400	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes recei vabl e	0	0	0	1	3.00
4.00	Accounts receivable	22, 047, 543	0	0	0	4.00
5. 00	Other recei vable	1, 365, 063		0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7.00	Inventory	964, 708		0	0	7.00
8. 00	Prepai d expenses	238, 243	0	0	0	8.00
9. 00 10. 00	Other current assets	0		0	0 0	9.00
11. 00	Due from other funds Total current assets (sum of lines 1-10)	21, 173, 745		0		10.00 11.00
11.00	FIXED ASSETS	21, 173, 743	η <u>σ</u>	0		11.00
12. 00	Land	596, 216	0	0	0	12.00
13. 00	Land improvements	830, 661	Ö	0	-	13.00
14.00	Accumul ated depreciation	-507, 816	0	0	0	14.00
15.00	Bui I di ngs	31, 256, 833	0	0	0	15.00
16.00	Accumulated depreciation	-18, 167, 885	0	0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fixed equipment	0	0	0	0	19.00
20.00	Accumul ated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00	Accumulated depreciation	17 150 013		0	0	22.00
23. 00	Maj or movable equipment	17, 150, 012		0	0 0	24.00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-13, 381, 834		0	0	25.00
26.00	Accumulated depreciation			0	0	26.00
27. 00	HIT designated Assets			0	0	27.00
28. 00	Accumulated depreciation	0		0	Ö	28.00
29. 00	Mi nor equi pment-nondepreci abl e	0	o	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	17, 776, 187	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	11, 765, 439	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	_	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	708, 019		0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	12, 473, 458		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	51, 423, 390	0	0	0	36.00
37. 00	Accounts payable	3, 179, 845	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1, 921, 553		0		38.00
39. 00	Payrol I taxes payable	1, 721, 559		0	Ö	39.00
40. 00	Notes and Loans payable (short term)	531, 422		0	l o	40.00
41. 00	Deferred income	0	o o	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1, 504, 090	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7, 136, 910	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	_	46. 00
47. 00	Notes payable	7, 407, 150		0	_	47.00
48. 00	Unsecured Loans	0	0	0	_	48.00
49. 00	Other long term liabilities	7 407 450	0	0	_	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7, 407, 150		0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	14, 544, 060	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	36, 879, 330	1		I	52. 00
53. 00	Specific purpose fund	30, 679, 330	0			53.00
54.00	Donor created - endowment fund balance - restricted		J	0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			· ·	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				Ö	58.00
	replacement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	36, 879, 330	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	51, 423, 390	0	0	0	60.00
	[59]					

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

Peri od: Worksheet G-1 From 01/01/2023 Provider CCN: 15-1313

					То	12/31/2023	Date/Time P 5/29/2024 7	rep': 26	ared: am
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund		
		1. 00	2. 00	3.00		4. 00	5. 00	+	
1. 00	Fund balances at beginning of period	1.00	33, 962, 539			0	3.00	\top	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2, 916, 791						2.00
3.00	Total (sum of line 1 and line 2)		36, 879, 330			0			3.00
4. 00	Additions (credit adjustments) (specify)	0			0			0	4.00
5.00		0			0			0	5.00
6. 00 7. 00		0			0			0	6.00
7. 00 8. 00		0			0			0	7. 00 8. 00
9. 00		0			0			0	9. 00
10.00	Total additions (sum of line 4-9)		0		Ĭ	ol		- 1	10.00
11.00	Subtotal (line 3 plus line 10)		36, 879, 330			o		ı	11.00
12.00	Deductions (debit adjustments) (specify)	0			0			0	12.00
13.00		0			0				13.00
14.00		0			0				14.00
15.00		0			0				15.00
16.00		0			0				16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)	٥	0		U	o			17. 00 18. 00
19. 00			36, 879, 330			0		- 1	19.00
17.00	sheet (line 11 minus line 18)		00,017,000			Ĭ			17.00
		Endowment	PI ant	Fund					
		Fund							
		6. 00	7. 00	8. 00					
1. 00	Fund balances at beginning of period	0			0				1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)								2.00
3.00	Total (sum of line 1 and line 2)	0			0				3.00
4. 00 5. 00	Additions (credit adjustments) (specify)		0						4. 00 5. 00
6. 00			0						6.00
7. 00			0						7. 00
8. 00			0					ı	8. 00
9.00			0					ı	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					- 1	13.00
14. 00 15. 00			0						14. 00 15. 00
16. 00		}	0						16.00
17. 00			0						17. 00
18. 00			U	I					
	Total deductions (sum of lines 12-17)	ol			0				18.00
19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0				18. 00 19. 00

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

		Т	o 12/31/2023	Date/Time Pre 5/29/2024 7:2	
	Cost Center Description	Inpatient	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	3, 277, 175	i	3, 277, 175	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	53, 750		53, 750	5. 00
6.00	Swing bed - NF	140, 625		140, 625	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, 471, 550		3, 471, 550	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	C		0	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	s C		0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 471, 550		3, 471, 550	17. 00
18. 00	Ancillary services	8, 692, 929		151, 106, 775	18. 00
19. 00	Outpati ent servi ces	C		22, 477	19. 00
20.00	RURAL HEALTH CLINIC	C	,	1, 094, 644	20.00
20. 01	RURAL HEALTH CLINIC II	C		5, 131, 230	20. 01
20. 02	RURAL HEALTH CLINIC III	C		3, 009, 424	20. 02
20. 03	RURAL HEALTH CLINIC IV	C		345, 860	20. 03
20. 04	RURAL HEALTH CLINIC V		., ,	1, 117, 564	20.04
20. 05	RURAL HEALTH CLINIC VI	C	.,	3, 853, 339	20. 05
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	C	0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23. 00	AMBULANCE SERVICES				23.00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26. 00	HOSPI CE				26.00
27. 00	OTHER OUTPATIENT	C		5, 675, 776	27. 00
27. 01	PROFESSI ONAL FEES	. C	4,075,700	4, 095, 908	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to We	kst. 12, 164, 479	166, 760, 068	178, 924, 547	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		(2.210.210		20.00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200)		63, 318, 210		29.00
30.00	ADD (SPECIFY)				30.00
			1		31.00
32.00			1		32.00
33. 00 34. 00		C			33. 00 34. 00
35. 00		C	1		35.00
36. 00	Total additions (sum of Lines 20 25)	١	0		36.00
	Total additions (sum of lines 30-35)				
37.00	DEDUCT (SPECIFY)	_			37.00
38. 00		C			38.00
39.00		C	1		39.00
40.00		C			40.00
41. 00	Total deductions (sum of lines 27 41)	C			41.00
42.00	Total deductions (sum of lines 37-41)	mofor	(2.210.210		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trato Wkst. G-3, line 4)	ansi er	63, 318, 210		43.00
	10 WKSt. 0-3, 11110 4)	I			

	Financial Systems WOODLAWN HO: MENT OF REVENUES AND EXPENSES	SPITAL Provider CCN: 15-1313	Period:	u of Form CMS-2 Worksheet G-3	
SIAIE	IENT OF REVENUES AND EXPENSES	Provider CCN. 15-1313	From 01/01/2023	WOLKSHEET G-3	
			To 12/31/2023	Date/Time Pre	pared:
				5/29/2024 7: 2	6 am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		178, 924, 547	1. 00
2. 00	Less contractual allowances and discounts on patients' accou			120, 267, 912	2.00
3. 00	Net patient revenues (line 1 minus line 2)			58, 656, 635	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		63, 318, 210	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4, 661, 575	5.00		
	OTHER INCOME				
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			671, 517	7. 00
8. 00	Revenues from telephone and other miscellaneous communication	n services		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			140, 252	14.00
15.00	Revenue from rental of living quarters	Harris Harris		0	15.00
16.00		than patients		0	16.00
17.00	3			0	17. 00 18. 00
18.00				0	
19. 00 20. 00				0	19. 00 20. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen Rental of vending machines			0	20.00
22. 00	Rental of hospital space			0	22.00
23. 00	Governmental appropriations			0	23.00
24. 00	OTHER OPERATING INCOME			4, 340, 372	
24. 00				2, 426, 306	
24. 01				-81	24. 01
	COVID-19 PHE Funding			0	24. 50
25. 00				7, 578, 366	
26. 00	,			2, 916, 791	26.00
27. 00				2, 710, 771	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			2, 916, 791	
			'		•

56, 609

56, 609

348, 944

7,066

117, 820

124, 886

760, 657

0

7,066

174, 429

181, 495

1, 109, 601

0

-53

18, 694

18, 641

88, 030

0 28.00

29.00

30.00

31.00

32.00

7, 013

193, 123

200, 136

1, 197, 631

28.00

29.00

30.00

31.00

through 27) FACILITY OVERHEAD

30)

and 31)

Facility Costs

Administrative Costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Heal th	Financial Systems	WOODLAWN	HOSPI TAL		In Lieu	of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1313	Peri od:	Worksheet M-1	
					From 01/01/2023		
			Component	CCN: 15-8551	To 12/31/2023	Date/Time Pre 5/29/2024 7:2	pared:
					RHC I	Cost	<u>o ani</u>
		Adjustments	Net Expenses		•		
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS		T	,			
1. 00	Physi ci an	0	4, 250)			1.00
2. 00	Physician Assistant	0	0)			2.00
3.00	Nurse Practitioner	-26, 377	201, 881				3.00
4.00	Visiting Nurse	0	0)			4. 00
5.00	Other Nurse	0	48, 659)			5.00
6. 00	Clinical Psychologist	0	0)			6. 00

-26, 377

-26, 377

0

0

0 0 0

0 0 0

0

0

-26, 377

0

0

80, 557

335, 347

635, 314

635, 314

457

0

0

0

457

0

0

0

0

7, 013

193, 123

200, 136

1, 171, 254

971, 118

7.00

7.10

7.11

8.00

9.00

10.00

11.00

12.00

13.00

14.00

15.00

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17.00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

29.00

30.00

31.00

32.00

7.00

7.10

7.11

8.00

9.00

10.00

11.00

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13.00

14.00

15.00

16.00

17.00

18.00

19.00

20 00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

29.00

30.00

31.00

Clinical Social Worker

Mental Health Counselor

Laboratory Techni ci an

Medical Supplies

Marriage and Family Therapist

Other Costs Under Agreement

Other Facility Health Care Staff Costs

Physician Supervision Under Agreement

Subtotal (sum of lines 11 through 13)

Subtotal (sum of lines 15 through 20)

COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Subtotal (sum of lines 1 through 9)

Physician Services Under Agreement

Transportation (Health Care Staff)

Depreciation-Medical Equipment

Other Health Care Costs

Allowable GME Costs

lines 10, 14, and 21)

Chronic Care Management

Nonallowable GME costs

through 27) FACILITY OVERHEAD

Administrative Costs

Facility Costs

and 31)

Pharmacy

Optometry

Tel eheal th

Dental

Professional Liability Insurance

	Financial Systems	WOODLAWN F				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	CN: 15-1313	Peri od: From 01/01/2023	Worksheet M-1	
			Component	CCN: 15-8552	To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	EAGULETY WENT THE CARE OTAGE COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1 000 070	10.050	0.000.46		0.000.400	
1.00	Physi ci an	1, 983, 070		2, 002, 42		2, 002, 422	
2.00	Physician Assistant	0	0	007.50	0 0	0	2.00
3.00	Nurse Practitioner	237, 587	0	237, 58	0 0	237, 587	3.00
4.00	Visiting Nurse	215, 954	0	215, 95	0	0 215, 954	1
5.00	Other Nurse	•	0	215, 95	0 0		1
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0	0		0	0	
7. 10	Marriage and Family Therapist	U	U		٥	U	7. 10
7. 10 7. 11	Mental Health Counselor						7. 10
8. 00	Laboratory Techni ci an	0	n			0	1
9. 00	Other Facility Health Care Staff Costs	0	0		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2, 436, 611	19, 352	2, 455, 96	٥	2, 455, 963	
11. 00	Physician Services Under Agreement	2, 430, 011	17, 332	2, 400, 70	0 0	2, 433, 703	1
12. 00	Physician Supervision Under Agreement	0	n			0	1
13. 00	Other Costs Under Agreement	0	0		0 0	Ö	
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	1
15.00	Medical Supplies	0	437, 554	437, 55	54 0	437, 554	15.00
16.00	Transportation (Health Care Staff)	0	0	,	0 0	0	1
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	437, 554	437, 55	0	437, 554	21.00
22.00	Total Cost of Health Care Services (sum of	2, 436, 611	456, 906	2, 893, 51	7 0	2, 893, 517	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0		0	0	
24.00	Dental	0	0		0	0	
25. 00	Optometry	0	0		0	0	25.00
25. 01	Tel eheal th	0	0		0	0	
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	O	0			0	
27. 00 28. 00	Nonallowable GME costs	0	0		0	0	27. 00 28. 00
∠8. ∪0	Total Nonreimbursable Costs (sum of lines 23 through 27)	U				0	28.00
	FACILITY OVERHEAD						1
29 00	Facility Costs	0	663, 792	663, 79	-663, 784	8	29.00
	Administrative Costs	210, 211	392, 945				

0 210, 211 210, 211

2, 646, 822

663, 792 392, 945 1, 056, 737

1, 513, 643

-663, 784 -49, 805 -713, 589

-713, 589

30.00

31.00

32.00

553, 351 553, 359

3, 446, 876

603, 156

1, 266, 948

4, 160, 465

30.00 Administrative Costs

30)

and 31)

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28

Health Financial Systems	WOODLAWN HOSPITAL				In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi	der C	CCN: 15-1313	Peri od From (d: 01/01/2023	Worksheet M-1	
		Compo	nent	CCN: 15-8552			Date/Time Pre 5/29/2024 7:2	pared: 6 am
					R	HC II	Cost	
	Adj ustments	Net Exp for Alloca	ti on					
	4.00	(col.	6)					

		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	-136, 246		•	1.00
2.00	Physician Assistant	0	0	l .	2.00
3.00	Nurse Practitioner	-3, 553	· ·	•	3.00
4. 00	Visiting Nurse	0	0	l .	4.00
5.00	Other Nurse	0	215, 954		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
7. 10	Marriage and Family Therapist				7. 10
7. 11	Mental Health Counselor				7. 11
8.00	Laboratory Techni ci an	0	0		8. 00
9. 00	Other Facility Health Care Staff Costs	0	0		9. 00
10.00	Subtotal (sum of lines 1 through 9)	-139, 799	2, 316, 164		10.00
11. 00	Physician Services Under Agreement	0	0		11. 00
12. 00	Physician Supervision Under Agreement	0	0	l .	12.00
13. 00	Other Costs Under Agreement	0	0	l .	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15. 00	Medical Supplies	0	437, 554		15. 00
16. 00	Transportation (Health Care Staff)	0	0	l .	16. 00
17. 00	Depreciation-Medical Equipment	0	0	l .	17. 00
18. 00	Professional Liability Insurance	0	0	l .	18. 00
19. 00	Other Health Care Costs	0	0		19. 00
20. 00	Allowable GME Costs				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	437, 554	•	21.00
22. 00	Total Cost of Health Care Services (sum of	-139, 799	2, 753, 718		22. 00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICES		_		
23. 00	Pharmacy	0	1	l .	23. 00
24.00	Dental	0	1	I .	24.00
25. 00	Optometry	0	0	l .	25. 00
25. 01	Tel eheal th	0	0	l .	25. 01
25. 02	Chronic Care Management	0	0	l .	25. 02
26. 00	All other nonreimbursable costs	0	0		26.00
27. 00	Nonallowable GME costs				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)				
20.00	FACILITY OVERHEAD	0		I	20.00
29.00	1	0		•	29.00
30.00	Administrative Costs	0	553, 351	•	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	553, 359		31.00
22 00	30)	120 700	2 207 077		22.00
32. 00	Total facility costs (sum of lines 22, 28 and 31)	-139, 799	3, 307, 077		32. 00
	laur 21)		I	I	I

136, 173

136, 173

1, 569, 337

C

198, 989

436, 283

635, 272

938, 342

0

198.989

572, 456

771, 445

2, 507, 679

0

-12, 730

50, 973

38, 243

-31, 146

27.00

29.00

30.00

31.00

32.00

0 28.00

186, 259

623, 429

809, 688

2, 476, 533

27.00

28.00

29.00

30.00

31.00

through 27) FACILITY OVERHEAD

30)

and 31)

Facility Costs

Administrative Costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

ealth Financial Systems	WOODLAWN	HOSPI TAL		In Lieu	u of Form CMS-25	552-10
NALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1313		Worksheet M-1	
				From 01/01/2023		
		Component	CCN: 15-8550	To 12/31/2023	Date/Time Prep 5/29/2024 7:26	ared:
				RHC III	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				
		(col. 5 +				
		col. 6)				
	6, 00	7.00				

		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1. 00	Physi ci an	-68, 034	1, 184, 500		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	-9, 553	147, 519		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	67, 767		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7. 00
7. 10	Marriage and Family Therapist				7. 10
7. 11	Mental Health Counselor				7. 11
8. 00	Laboratory Techni ci an	0	0		8.00
9. 00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-77, 587	1, 399, 786		10.00
11. 00	Physician Services Under Agreement	-77, 507	1, 377, 700		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
		0	_		
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15. 00	Medical Supplies	0	189, 472		15. 00
16. 00	Transportation (Health Care Staff)	0	0		16. 00
17. 00	Depreciation-Medical Equipment	0	0		17. 00
18. 00	Professional Liability Insurance	0	0		18. 00
19. 00	Other Health Care Costs	0	0		19. 00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	189, 472		21.00
22.00	Total Cost of Health Care Services (sum of	-77, 587	1, 589, 258		22.00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25. 01	Tel eheal th	0	0		25. 01
25. 02	Chronic Care Management	0	0		25. 02
26. 00	All other nonreimbursable costs	0	0		26.00
27. 00	Nonallowable GME costs				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
20.00	through 27)	ŭ	Ŭ		20.00
	FACILITY OVERHEAD				
29. 00		0	186, 259		29.00
30.00	Administrative Costs	0	623, 429		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	809, 688		31.00
51.00	30)	U	007,000		31.00
32. 00	Total facility costs (sum of lines 22, 28	-77, 587	2, 398, 946		32.00
JZ. 00	and 31)	- / / , 50 /	2, 370, 740		32.00
	lana ori		ı	I	I

15, 866

15, 866

188, 403

C

6, 473

30, 167

36, 640

46, 320

0

6, 473

46, 033

52, 506

234, 723

0

12, 730

6, 288

19, 018

19, 018

27.00

29.00

30.00

31.00

32.00

0 28.00

19, 203

52, 321

71, 524

253, 741

Nonallowable GME costs

Administrative Costs

through 27) FACILITY OVERHEAD

30)

and 31)

Facility Costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

27.00

28.00

29.00

30.00

31.00

Heal th	Financial Systems	WOODLAWN	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1313	Peri od:	Worksheet M-1	
			Component	CCN: 15-8549	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	pared: 26 am
					RHC I V	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6, 00	col. 6) 7.00	-			
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1. 00	Physi ci an	С	153, 948				1.00
2.00	Physician Assistant	C	0				2.0
3.00	Nurse Practitioner	C	22, 136				3.00
4.00	Visiting Nurse	C	0				4.0
5.00	Other Nurse	C	978				5.00

0

0

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0

0

177, 062

0

C

0

0

0

0

0

0

19, 203

52, 321

71, 524

253, 741

5, 155

182, 217

7.00

7.10

7.11

8.00

9.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

29.00

30.00

31.00

32.00

6.00

7.00

7.10

7.11

8.00

9.00

10.00

11.00

12.00

13.00

14.00

15.00

16. 00 17. 00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

29.00

30.00

31.00

Clinical Psychologist

Clinical Social Worker

Mental Health Counselor

Laboratory Techni ci an

Medical Supplies

Marriage and Family Therapist

Other Costs Under Agreement

Other Facility Health Care Staff Costs

Physician Supervision Under Agreement

Subtotal (sum of lines 11 through 13)

Subtotal (sum of lines 15 through 20)

COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Subtotal (sum of lines 1 through 9)

Physician Services Under Agreement

Transportation (Health Care Staff)

Depreciation-Medical Equipment

Other Health Care Costs

Allowable GME Costs

lines 10, 14, and 21)

Chronic Care Management

Nonallowable GME costs

through 27) FACILITY OVERHEAD

Administrative Costs

Facility Costs

and 31)

Pharmacy

Optometry

Tel eheal th

Dental

Professional Liability Insurance

0

61, 755

61, 755

705, 687

C

C

21, 133

165, 720

186, 853

231, 051

0

0

21, 133

227, 475

248, 608

936, 738

0

-15, 033

-15, 033

-15, 033

0

0 28.00

21, 133

212, 442

233, 575

921, 705

26.00

27.00

29.00

30.00

31.00

32.00

26.00

27.00

28.00

29.00

30.00

31.00

All other nonreimbursable costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Nonallowable GME costs

Administrative Costs

through 27) FACILITY OVERHEAD

30)

and 31)

Facility Costs

Heal th	Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	」of Form CMS-	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS			CCN: 15-1313 CCN: 15-8547	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-1 Date/Time Pre 5/29/2024 7:2	epared:
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6) 7.00	_	RHC V	Cost	
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00	-I			
1.00	Physi ci an	-677	504, 466	5			1.00
2.00	Physician Assistant	0	(2.00
3.00	Nurse Practitioner	-15, 680	136, 356				3.00
4.00	Visiting Nurse	0	(4.00
5.00	Other Nurse	0	(5.00
6.00	Clinical Psychologist	0	(6.00
7. 00 7. 10	Clinical Social Worker Marriage and Family Therapist	0	()			7. 00 7. 10
7. 10 7. 11	Mental Health Counselor						7.10
8. 00	Laboratory Techni ci an	0					8.00
9. 00	Other Facility Health Care Staff Costs	0					9.00
10.00		-16, 357	640, 822				10.00
	Physician Services Under Agreement	0	(11.00
	Physician Supervision Under Agreement	0					12.00
	Other Costs Under Agreement	0					13.00
	Subtotal (sum of lines 11 through 13)	0	(14.00
15.00	Medical Supplies	0	30, 951	1			15.00
16.00		0	()			16.00
	Depreciation-Medical Equipment	0	()			17. 00
	Professional Liability Insurance	0	(O			18. 00
19. 00	Other Heal th Care Costs	0	(P			19.00

-16, 357

0

0

-16, 357

30, 951

671, 773

0

0

0

0

0

21, 133 212, 442

233, 575

905, 348

20.00

21.00

22.00

23.00

24.00

25.00

25.01

25.02

26.00

27.00

28.00

29.00

30.00

31.00

32.00

20.00 Allowable GME Costs

Subtotal (sum of lines 15 through 20)

lines 10, 14, and 21)
COSTS OTHER THAN RHC/FQHC SERVICES

All other nonreimbursable costs

Total Cost of Health Care Services (sum of

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

21.00

22.00

24.00

25.00

25. 01

25.02

26.00

27.00

28.00

31.00

23.00 Pharmacy

Dental

Optometry

29.00 Facility Costs

and 31)

Tel eheal th

Chronic Care Management

Nonallowable GME costs

through 27) FACILITY OVERHEAD

30.00 Administrative Costs

0

249, 291

249, 291

1, 283, 902

C

35, 765

302, 545

338, 310

1, 244, 649

0

0

35, 765

551, 836

587, 601

2, 528, 551

0

-15, 477

-15, 477

-15, 477

0

0 28.00

35, 765

536, 359

572, 124

2, 513, 074

26.00

27.00

29.00

30.00

31.00

32.00

26.00

27.00

28.00

29.00

30.00

31.00

All other nonreimbursable costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Nonallowable GME costs

Administrative Costs

through 27) FACILITY OVERHEAD

30)

and 31)

Facility Costs

WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	Provi der C	CN: 15-1313	Peri od: From 01/01/2023	Worksheet M-1	
	Component	CCN: 15-8548	To 12/31/2023	Date/Time Pre 5/29/2024 7:2	pared: .6 am
			RHC VI	Cost	
Adjustments	Net Expenses				
	for				
	Allocation				
	(col. 5 +				
	col. 6)				
6. 00	7. 00				
	Adjustments	Adjustments Net Expenses for Allocation (col. 5 + col. 6)	Adjustments Net Expenses for Allocation (col. 5 + col. 6)	Provi der CCN: 15-1313	Provider CCN: 15-1313

		Adj do tilicitto	for		
			for		
			Allocation		
			(col. 5 +		
			col . 6)		
	540111TV U541TU 04B5 07455 00070	6. 00	7. 00		_
	FACILITY HEALTH CARE STAFF COSTS	1, 000	754 040		4
1.00	Physi ci an	-16, 032	i .	•	1.00
2. 00	Physician Assistant	0	0	1	2.00
3.00	Nurse Practitioner	-14, 889	207, 487		3. 00
4. 00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	44, 335		5. 00
6.00	Clinical Psychologist	0	0		6. 00
7.00	Clinical Social Worker	0	0		7. 00
7. 10	Marriage and Family Therapist				7. 10
7. 11	Mental Health Counselor				7. 11
8.00	Laboratory Techni ci an	0	0		8. 00
9.00	Other Facility Health Care Staff Costs	0	0		9. 00
10.00	Subtotal (sum of lines 1 through 9)	-30, 921	1, 003, 690		10.00
11.00	Physician Services Under Agreement	0	779, 863		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	779, 863		14.00
15. 00	Medical Supplies	0	126, 476		15. 00
16. 00	Transportation (Health Care Staff)	0	0		16.00
17. 00	Depreciation-Medical Equipment	0	0	l .	17. 00
18. 00	Professional Liability Insurance	0	0	l .	18.00
19. 00	Other Health Care Costs	0	0	l .	19. 00
20.00	Allowable GME Costs	O	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	126, 476		21.00
22. 00	Total Cost of Health Care Services (sum of	-30, 921	1, 910, 029	•	22.00
22.00	lines 10, 14, and 21)	-30, 921	1, 910, 029		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				+
23. 00	Pharmacy	0	0		23. 00
24.00	Dental	0	0	l .	24. 00
25.00	Optometry	0	0	•	25. 00
25. 00	1 '	0	0		25. 00
25. 01	Tel eheal th	0	0		25. 01
	Chronic Care Management	0	ľ	l .	
26.00	All other nonreimbursable costs	U	0		26.00
27. 00	Nonallowable GME costs				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		28. 00
	through 27)				-
00.00	FACILITY OVERHEAD		05 3/5		
29. 00	Facility Costs	0	35, 765		29.00
30.00	Administrative Costs	0	536, 359		30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	572, 124		31.00
	30)				
32. 00	Total facility costs (sum of lines 22, 28	-30, 921	2, 482, 153		32. 00
	and 31)				1

	Financial Systems	WOODLAWN H				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co	CN: 15-1313	Peri od: From 01/01/2023	Worksheet M-2	
			Component	CCN: 15-8551	To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi t	y Minimum	Greater of	
		Personnel		Standard (1	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1					
1.00	Physi ci an	0. 01	17		1 0		1.00
2.00	Physici an Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	1. 07			1 1		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.08			1	1, 345	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	1
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7.04
8.00	Total FTEs and Visits (sum of lines 4	1. 08	1, 345			1, 345	8.00
	through 7)						
9. 00	Physician Services Under Agreements		4, 124			4, 124	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEF	RVICES		1.00	
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			971, 118	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line :	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			971, 118	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. I	M-1, col. 7, li	ne 31)		200, 136	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			557, 379	15.00
16.00	Total overhead (sum of lines 14 and 15)	-				757, 515	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					757, 515	18.00
19.00	Overhead applicable to hospital-based RHC/FC	HC services (I	ine 13 x line 1	18)		757, 515	19.00
20 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 10	and 19)		1, 728, 633	20.00

	Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1313	Peri od:	Worksheet M-2	
			Component	CCN: 15-8552	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00	0.00	2.22	1 x col . 3)	col . 4	
	WALTE AND DESCRIPTION TV	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1 00	Posi ti ons	2.//	14.05/	4.20	15 272		1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	3. 66 0. 00					1.00 2.00
3. 00	Nurse Practitioner	1. 51					3.00
4. 00	Subtotal (sum of lines 1 through 3)	5. 17			18, 543	19, 399	4.00
5. 00	Visiting Nurse	0.00		i e	10, 543	17, 377	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7. 02	Di abetes Self Management Training (FQHC	0.00				0	7. 02
7.02	only)	0.00				· ·	/
7. 03	Marriage and Family Therapist						7.03
7. 04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4	5. 17	19, 399			19, 399	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVICES			
10.00	Total costs of health care services (from Wk					2, 753, 718	
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
12.00	Cost of all services (excluding overhead) (s					2, 753, 718	
13.00	Ratio of hospital -based RHC/FQHC services (I			04)		1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		553, 359	
15.00	Parent provider overhead allocated to facili Total overhead (sum of lines 14 and 15)	ty (see Instru	Ctrons)			1, 464, 160	1
16. 00 17. 00	Allowable GME overhead (see instructions)					2, 017, 519 0	16. 00 17. 00
17.00	Enter the amount from line 16					2, 017, 519	
19. 00	Overhead applicable to hospital-based RHC/FQ	HC services (1	ine 13 v line	18)		2, 017, 519	
	Total allowable cost of hospital-based RHC/F					4, 771, 237	
20.00	1. Sta. a Shabi o oost of Hospi tal based Mio/1	2 301 11 003 (Cu 01 111103 11	a.ia i / /	ļ	1, 7, 1, 207	0.00

	Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1313	Peri od:	Worksheet M-2	
			Component	CCN: 15-8550	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC III	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	•	col. 2 or	
		1.00	0.00	0.00	1 x col . 3)	col . 4	
	VICITE AND DRODUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						
1. 00	Physi ci an	1. 94	12, 405	4, 20	00 8, 148		1.00
2. 00	Physician Assistant	0.00					2.00
3. 00	Nurse Practitioner	0.59					3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 53			9, 387	14, 573	4.00
5. 00	Visiting Nurse	0.00			,,,,,,,	0	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7.03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4	2. 53	14, 573			14, 573	8. 00
0.00	through 7)						0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASI	FD_RHC/FOHC_SE	RVLCES		1.00	
10.00	Total costs of health care services (from Wk			020		1, 589, 258	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
12.00	Cost of all services (excluding overhead) (s					1, 589, 258	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, li	ine 31)		809, 688	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			700, 596	15.00
16.00	Total overhead (sum of lines 14 and 15)					1, 510, 284	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18. 00	Enter the amount from line 16					1, 510, 284	1
19. 00	Overhead applicable to hospital-based RHC/FQ					1, 510, 284	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 10	o and 19)		3, 099, 542	20.00

	Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1313	Peri od:	Worksheet M-2	
			Component	CCN: 15-8549	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC I V	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	•	col. 2 or	
		1.00	0.00	0.00	1 x col . 3)	col . 4	
	VICITE AND DRODUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY Positions						1
1. 00	Physi ci an	0. 26	1, 384	4, 20	00 1, 092		1.00
2. 00	Physician Assistant	0. 20					2.00
3. 00	Nurse Practitioner	0.33		2, 10			3.00
4. 00	Subtotal (sum of lines 1 through 3)	0. 59		2, 10	1, 785	2, 081	4.00
5. 00	Visiting Nurse	0.00			1,700	0	5.00
6. 00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00	0			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7.03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7. 04
8.00	Total FTEs and Visits (sum of lines 4	0. 59	2, 081			2, 081	8. 00
0.00	through 7)						0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASI	ED RHC/EOHC SEL	RVICES		1.00	
10.00	Total costs of health care services (from Wk			(11020		182, 217	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	1
12. 00	Cost of all services (excluding overhead) (s					182, 217	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		71, 524	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			86, 388	15.00
16.00	Total overhead (sum of lines 14 and 15)					157, 912	16.00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					157, 912	
19.00	Overhead applicable to hospital-based RHC/FQ					157, 912	
20. 00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 10	0 and 19)		340, 129	20.00

	Financial Systems	WOODLAWN H				u of Form CMS-	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Peri od: From 01/01/2023	Worksheet M-2	
			Component	CCN: 15-8547	To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC V	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1			_1		
1.00	Physi ci an	0. 90			1 1		1.00
2. 00	Physician Assistant	0.00			1 0		2.00
3. 00	Nurse Practitioner	1. 39			1 1		3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 29			2	5, 763	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7. 03	Marriage and Family Therapist						7.03
7. 04	Mental Health Counselor					- 7/0	7.04
8. 00	Total FTEs and Visits (sum of lines 4	2. 29	5, 763			5, 763	8. 00
0.00	through 7)						0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE 7	TO HOSPI TAL-BASE	ED RHC/FQHC SEF	RVICES		11.00	
10.00	Total costs of health care services (from WI	kst. M-1, col.	7, line 22)			671, 773	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line :	28)			0	11.00
12.00	Cost of all services (excluding overhead) (671, 773	12.00
13.00	Ratio of hospital-based RHC/FQHC services (1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fi			ne 31)		233, 575	14.00
15.00	Parent provider overhead allocated to facili			•		353, 772	
16.00	Total overhead (sum of lines 14 and 15)	• •	•			587, 347	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18. 00	Enter the amount from line 16					587, 347	18.00
19.00	Overhead applicable to hospital-based RHC/FG	QHC services (I	ne 13 x line	18)		587, 347	19.00
	Total allowable cost of hospital-based RHC/I					1, 259, 120	1 20 00

	Financial Systems	WOODLAWN I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1313	Peri od:	Worksheet M-2	
			Component	CCN: 15-8548	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
					RHC VI	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	•	col. 2 or	
		1.00	0.00		1 x col . 3)	col . 4	
	WICHTO AND DEODUCTIVIETY	1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
1. 00	Posi ti ons Physi ci an	0. 53	4, 585	4, 20	2, 226		1.00
2. 00	Physician Assistant	0. 53					2.00
3. 00	Nurse Practitioner	1. 56					3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 09			5, 502		4.00
5. 00	Visiting Nurse	0.00			0,002	0	5.00
6. 00	Clinical Psychologist	0.00				0	6. 00
7. 00	Clinical Social Worker	0.00				0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	only)						
7.03	Marriage and Family Therapist						7. 03
7.04	Mental Health Counselor						7. 04
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	2. 09	12, 500			12, 500	8. 00
9. 00	Physician Services Under Agreements		6, 667			6, 667	9.00
	<u>, , , , , , , , , , , , , , , , , , , </u>						
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
10.00	Total costs of health care services (from Wk					1, 910, 029	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
12.00	Cost of all services (excluding overhead) (s					1, 910, 029	
13.00	Ratio of hospital -based RHC/FQHC services (I			243		1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		572, 124	
15.00	Parent provider overhead allocated to facili Total overhead (sum of lines 14 and 15)	ty (see instru	ctions)			906, 068	
16. 00 17. 00	Allowable GME overhead (see instructions)					1, 478, 192 0	17.00
18. 00	Enter the amount from line 16					1, 478, 192	
19. 00	Overhead applicable to hospital-based RHC/FC	OHC services (ine 13 x line	18)		1, 478, 192	
	Total allowable cost of hospital-based RHC/F					3, 388, 221	
	1	(-,,	

ealth Financial Systems WOODLAWN HOS		In_Lie	u of Form CMS-2	<u> 2552-</u> 1
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1313	Peri od:	Worksheet M-3	
SERVI CES	Component CCN: 15-8551	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			5/29/2024 7:2	
	Title XVIII	RHC I	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 728, 633	
2.00 Cost of injections/infusions and their administration (from W			4, 700	
B.OO Total allowable cost excluding injections/infusions (line 1 m H.OO Total Visits (from Wkst. M-2, column 5, line 8)	ninus iine 2)		1, 723, 933 1, 345	3.00 4.00
5.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		4, 124	5.00
5.00 Total adjusted visits (line 4 plus line 5)			5, 469	6.00
7.00 Adjusted cost per visit (line 3 divided by line 6)			315. 22	7.00
		Cal cul ati on	of Limit (1)	
			Rate Period 1	
		N/A	(01/01/2023	
			through 12/31/2023)	
		1. 00	2. 00	
3.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20).6 or your contractor)	0.00	279. 94	8.00
Rate for Program covered visits (see instructions)		0. 00	279. 94	9.00
CALCULATION OF SETTLEMENT	contractor records)	0	1 202	10.00
<pre>10.00 Program covered visits excluding mental health services (from 11.00 Program cost excluding costs for mental health services (line</pre>		0	1, 292 361, 682	
12.00 Program covered visits for mental health services (from contr	*	0	0	1
13.00 Program covered cost from mental health services (line 9 x li	•	0	0	13.00
14.00 Limit adjustment for mental health services (see instructions	*	0	0	14.00
15.00 Graduate Medical Education Pass Through Cost (see instruction			2/1 /02	15.00
16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 16.01 Total program charges (see instructions) (from contractor's re		0	361, 682 217, 044	
16.02 Total program preventive charges (see instructions)(from prov			2, 831	
16.03 Total program preventive costs ((line 16.02/line 16.01) times			4, 717	
16.04 Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		265, 712	16. 04
(Titles V and XIX see instructions.)		0	270 420	14 0
<pre>16.05 Total program cost (see instructions) 17.00 Primary payer amounts</pre>		0	270, 429 0	16. 05 17. 00
18.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		24, 825	
records)	•		•	
19.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		37, 854	19.00
20.00 Net program cost excluding injections/infusions (see instruct	i ons)		270, 429	20.00
21.00 Program cost of vaccines and their administration (from Wkst.	•		1, 967	21.00
21.50 Total program IOP OPPS payments (see instructions)				21.50
21.55 Total program IOP Costs (see instructions) 21.60 Program IOP deductible and coinsurance (see instructions)				21. 55 21. 60
21.60 Program IOP deductible and coinsurance (see instructions) 22.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21 60)		272, 396	
23.00 Allowable bad debts (see instructions)	rids 11116 21. 66)			23.00
23.01 Adjusted reimbursable bad debts (see instructions)			303	
24.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	20)		0	
25.50 Pioneer ACO demonstration payment adjustment (see instruction 25.99 Demonstration payment adjustment amount before sequestration	13)		0	25. 50 25. 99
26.00 Net reimbursable amount (see instructions)			272, 699	
26.01 Sequestration adjustment (see instructions)			5, 454	26. 0°
26.02 Demonstration payment adjustment amount after sequestration			0	26. 02
27.00 Interim payments			264, 696	
28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		0 2, 549	28. 00 29. 00
80.00 Protested amounts (nonallowable cost report items) in accorda	· · · · · · · · · · · · · · · · · · ·	,	2, 549	1
chapter I, §115. 2		. [J	1

ealth Financial Systems WOODLAWN HOS		In Lie	u of Form CMS-2	<u> 2552-</u> 1
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1313	Peri od: From 01/01/2023	Worksheet M-3	
ERVI CES	Component CCN: 15-8552	To 12/31/2023	Date/Time Pre	pared
	·		5/29/2024 7: 2	6 am
<u> </u>	Title XVIII	RHC II	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro			4, 771, 237	
.00 Cost of injections/infusions and their administration (from W			104, 200	
.00 Total allowable cost excluding injections/infusions (line 1 m .00 Total Visits (from Wkst. M-2, column 5, line 8)	inus iine 2)		4, 667, 037 19, 399	
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		17, 377	5.0
.00 Total adjusted visits (line 4 plus line 5)	,		19, 399	6.0
.00 Adjusted cost per visit (line 3 divided by line 6)			240. 58	7. C
		Cal cul ati on	of Limit (1)	
			Rate Period 1	
		N/A	(01/01/2023 through	
			12/31/2023)	
		1. 00	2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	299. 90	1
.00 Rate for Program covered visits (see instructions)		0.00	240. 58	9.0
CALCULATION OF SETTLEMENT 0.00 Program covered visits excluding mental health services (from	contractor records)	0	456	10. C
1.00 Program cost excluding costs for mental health services (line		0	109, 704	
2.00 Program covered visits for mental health services (from contr	,	0	0	1
3.00 Program covered cost from mental health services (line 9 x li	•	0	0	
4.00 Limit adjustment for mental health services (see instructions	•	0	0	
5.00 Graduate Medical Education Pass Through Cost (see instruction 6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		o	109, 704	15. C
6.01 Total program charges (see instructions)(from contractor's re			70, 099	
6.02 Total program preventive charges (see instructions) (from prov			2, 548	
6.03 Total program preventive costs ((line 16.02/line 16.01) times	•		3, 988	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		77, 908	16.0
(Titles V and XIX see instructions.) 6.05 Total program cost (see instructions)		0	81, 896	16.0
7.00 Primary payer amounts			01, 070	17.0
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		8, 331	18.0
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		11, 821	19.0
records) 0.00 Net program cost excluding injections/infusions (see instruct	i ons)		81, 896	20.0
1.00 Program cost of vaccines and their administration (from Wkst.	*		500	1
1.50 Total program IOP OPPS payments (see instructions)				21.5
1.55 Total program IOP Costs (see instructions)				21.5
1.60 Program IOP deductible and coinsurance (see instructions) 2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus Line 21 40)		82, 396	21.6
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, 3.00 Allowable bad debts (see instructions)	minus ithe 21.60)		82, 390	1
3.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
5.50 Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 5
5.99 Demonstration payment adjustment amount before sequestration 6.00 Net reimbursable amount (see instructions)			0 82, 396	1
6.01 Sequestration adjustment (see instructions)			1, 648	
6.02 Demonstration payment adjustment amount after sequestration			0	1
7.00 Interim payments			134, 563	27. (
8.00 Tentative settlement (for contractor use only)	00 07 1		0	
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	•		-53, 815	
0.00 Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-11		0	30.0

lealth Financial Systems WOODLAWN HOS		In Lie	u of Form CMS-2	<u> 2552-</u> 1
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1313	Peri od:	Worksheet M-3	
SERVI CES	Component CCN: 15-8550	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
	·		5/29/2024 7: 2	
	Title XVIII	RHC III	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro			3, 099, 542	1.00
2.00 Cost of injections/infusions and their administration (from V			85, 092	2.00
3.00 Total allowable cost excluding injections/infusions (line 1 m 4.00 Total Visits (from Wkst. M-2, column 5, line 8)	minus line 2)		3, 014, 450 14, 573	3.00 4.00
5.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		14, 5/3	5.00
5.00 Total adjusted visits (line 4 plus line 5)			14, 573	6.00
7.00 Adjusted cost per visit (line 3 divided by line 6)			206. 85	7.00
		Cal cul ati on	of Limit (1)	
			Rate Period 1	
		N/A	(01/01/2023	
			through 12/31/2023)	
		1.00	2. 00	
3.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	0.00	221. 05	8.00
P.00 Rate for Program covered visits (see instructions)		0.00	206. 85	9.00
CALCULATION OF SETTLEMENT	n contractor records)	0	2, 296	10.00
10.00 Program covered visits excluding mental health services (from 11.00 Program cost excluding costs for mental health services (line		0	2, 296 474, 928	
12.00 Program covered visits for mental health services (from contr	,	0	0	12.00
13.00 Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.00
14.00 Limit adjustment for mental health services (see instructions	•	0	0	14.00
15.00 Graduate Medical Education Pass Through Cost (see instruction			474 000	15.00
16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 16.01 Total program charges (see instructions)(from contractor's re		0	474, 928 345, 772	
16.02 Total program preventive charges (see instructions)(from prov			5, 242	
16.03 Total program preventive costs ((line 16.02/line 16.01) times			7, 200	
16.04 Total Program non-preventive costs ((line 16 minus lines 16.0	03 and 18) times .80)		340, 019	16.04
(Titles V and XIX see instructions.)			0.47 040	4, 0
16.05 Total program cost (see instructions) 17.00 Primary payer amounts		0	347, 219 0	16. 05 17. 00
18.00 Less: Beneficiary deductible for RHC only (see instructions)) (from contractor		42, 704	
records)	, (,	
19.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ons) (from contractor		59, 565	19.00
20.00 Net program cost excluding injections/infusions (see instruct	ti ons)		347, 219	20.00
21.00 Program cost of vaccines and their administration (from Wkst.			25, 982	
21.50 Total program IOP OPPS payments (see instructions)				21.50
21.55 Total program IOP Costs (see instructions)				21. 55
21.60 Program IOP deductible and coinsurance (see instructions) 22.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21 60)		373, 201	21. 60 22. 00
23.00 Allowable bad debts (see instructions)	III 1143 11116 21. 00)		884	
23.01 Adjusted reimbursable bad debts (see instructions)			575	
24.00 Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	
25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	20)		0	
25.50 Pioneer ACO demonstration payment adjustment (see instruction 25.99 Demonstration payment adjustment amount before sequestration	15)		0	25. 50 25. 99
26.00 Net reimbursable amount (see instructions)			373, 776	
26.01 Sequestration adjustment (see instructions)			7, 476	
26.02 Demonstration payment adjustment amount after sequestration			0	
27.00 Interim payments			403, 498	
28.00 Tentative settlement (for contractor use only) 29.00 Balance due component/program (line 26 minus lines 26.01, 26.	02 27 and 20)		0 -37, 198	28.00
29.00 Barance due component/program (fine 26 minus fines 26.01, 26. 80.00 Protested amounts (nonallowable cost report items) in accorda			-37, 198 0	
chapter I, §115. 2		'	0	1 55.50

ealth Financial Systems WOODLAWN HOSF	PI TAL	In Lie	u of Form CMS-2	<u> 2552-</u> 1
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1313	Peri od: From 01/01/2023	Worksheet M-3	
SERVI CES	Component CCN: 15-8549	To 12/31/2023	Date/Time Pre	pared:
			5/29/2024 7: 2	6 am
<u> </u>	Title XVIII	RHC I V	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		340, 129	1.0	
Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		1, 673	2.0	
00 Total allowable cost excluding injections/infusions (line 1 minus line 2) 00 Total Visits (from Wkst. M-2, column 5, line 8)		338, 456 2, 081	3. 00 4. 00	
OPhysicians visits under agreement (from Wkst. M-2, column 5, line 9)		2, 001	5.0	
00 Total adjusted visits (line 4 plus line 5)		2, 081	6.0	
.00 Adjusted cost per visit (line 3 divided by line 6)		162. 64	7.0	
		Cal cul ati on	of Limit (1)	
			Rate Period 1	
		N/A	(01/01/2023	
			through 12/31/2023)	
		1. 00	2. 00	
8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	180. 24	8. 0
P. 00 Rate for Program covered visits (see instructions)		0.00	162. 64	9.0
0.00 Program covered visits excluding mental health services (from	contractor records)	0	399	10.0
1.00 Program cost excluding costs for mental health services (line	•	0	64, 893	
00 Program covered visits for mental health services (from contractor records)		0	0	12.0
00 Program covered cost from mental health services (line 9 x line 12)		0	13.0	
00 Limit adjustment for mental health services (see instructions)		0	14.0	
00 Graduate Medical Education Pass Through Cost (see instructions) 00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		44 902	15. 0 16. 0	
Of Total program charges (see instructions)(from contractor's records)		64, 893 61, 190		
	, , , , , , , , , , , , , , , , , , , ,		592	
Total program preventive costs ((line 16.02/line 16.01) times line 16)		628	16.0	
04 Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80)		38, 784	16.0	
(Titles V and XIX see instructions.) 6.05 Total program cost (see instructions)		0	39, 412	16. 0
00 Primary payer amounts		0	17. 0	
OD Less: Beneficiary deductible for RHC only (see instructions) (from contractor		15, 785	1	
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		8, 963	19.0
records) 20.00 Net program cost excluding injections/infusions (see instructions)	i ons)		39, 412	20.0
11.00 Program cost of vaccines and their administration (from Wkst.	•		558	
11.50 Total program IOP OPPS payments (see instructions)	,			21.50
11.55 Total program IOP Costs (see instructions)				21.5
21.60 Program IOP deductible and coinsurance (see instructions) 22.00 Total reimbursable Program cost (sum of lines 20, 21, 21,50, 1	minus line 21 40)		20.070	21. 6 22. 0
22.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, 1 23.00 Allowable bad debts (see instructions)	illitius Title 21.00)		39, 970 129	
23.01 Adjusted reimbursable bad debts (see instructions)			84	
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	1
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
15.50 Pioneer ACO demonstration payment adjustment (see instructions	s)		0	25.5
25.99 Demonstration payment adjustment amount before sequestration 16.00 Net reimbursable amount (see instructions)			0 40, 054	25. 9 26. 0
26.01 Sequestration adjustment (see instructions)			801	
5.02 Demonstration payment adjustment amount after sequestration		0	1	
7.00 Interim payments			66, 404	
18.00 Tentative settlement (for contractor use only)	00 07 00		07.454	28. 0
19.00 Balance due component/program (line 26 minus lines 26.01, 26.0 10.00 Protested amounts (nonallowable cost report items) in accorda	The state of the s		-27, 151 0	
io, oo jirotesten amounts (nonarrowable cost report rtems) III accordal	IICE WI LII CIVIS PUD. 13-11	· 1	U	J 30. 0

CALCUI	Financial Systems WOODLAWN HOSI ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI (CES	Component CCN: 15-8547	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title XVIII	RHC V	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 259, 120	
2.00	Cost of injections/infusions and their administration (from W	The state of the s		22, 564	2.00
3. 00 4. 00	Total allowable cost excluding injections/infusions (line 1 m Total Visits (from Wkst. M-2, column 5, line 8)	Thus Time 2)		1, 236, 556 5, 763	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6. 00	Total adjusted visits (line 4 plus line 5)			5, 763	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	214.57	7. 00
			Carcuration	OI LIIII (I)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2023	
				through 12/31/2023)	
			1.00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	225. 94	
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	214. 57	9.00
10.00	Program covered visits excluding mental health services (from	contractor records)	0	850	10.00
11. 00	Program cost excluding costs for mental health services (line	*	0	182, 385	
12. 00 13. 00	Program covered visits for mental health services (from contr Program covered cost from mental health services (line 9 x li	•	0	0	12. 00 13. 00
14. 00	Limit adjustment for mental health services (see instructions	*	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instruction	•			15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	182, 385	1
16. 01 16. 02	Total program charges (see instructions)(from contractor's re Total program preventive charges (see instructions)(from prov	*		139, 454 11, 877	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			15, 533	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		116, 954	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	132, 487	16. 05
17. 00	Pri mary payer amounts			0	17. 00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		20, 659	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	nc) (from contractor		21 204	19.00
17.00	records)	ris) (ITOIII COITTI actor		21, 384	19.00
20.00	Net program cost excluding injections/infusions (see instruct	•		132, 487	1
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		6, 052	1
21. 50 21. 55	Total program IOP OPPS payments (see instructions) Total program IOP Costs (see instructions)				21. 50 21. 55
21. 60	Program IOP deductible and coinsurance (see instructions)				21.60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21.60)		138, 539	1
23. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			171 111	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	1
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99 26. 00	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 138, 650	
26. 01	Sequestration adjustment (see instructions)			2, 773	
26. 02	Demonstration payment adjustment amount after sequestration			0	26.02
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			175, 021 0	27. 00 28. 00
29. 00		02, 27, and 28)		-39, 144	
30.00	, , ,			0	1

ealth Financial Systems WOODLAWN HOS		In Lie	u of Form CMS-2	<u> 2552-</u> 1
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1313	Peri od:	Worksheet M-3	
SERVI CES	Component CCN: 15-8548	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
	·		5/29/2024 7: 2	
	Title XVIII	RHC VI	Cost	
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro			3, 388, 221	1.00
2.00 Cost of injections/infusions and their administration (from W			108, 834	
B.OO Total allowable cost excluding injections/infusions (line 1 m H.OO Total Visits (from Wkst. M-2, column 5, line 8)	inus iine 2)		3, 279, 387 12, 500	3. 00 4. 00
5.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		6, 667	5.00
5.00 Total adjusted visits (line 4 plus line 5)			19, 167	6.00
7.00 Adjusted cost per visit (line 3 divided by line 6)			171. 10	7.00
		Cal cul ati on	of Limit (1)	
			Rate Period 1	
		N/A	(01/01/2023	
			through 12/31/2023)	
		1. 00	2. 00	
3.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	0.00	176. 29	
P. 00 Rate for Program covered visits (see instructions)		0.00	171. 10	9.00
CALCULATION OF SETTLEMENT 10.00 Program covered visits excluding mental health services (from	contractor records)	0	2, 363	10.00
11.00 Program cost excluding costs for mental health services (line		0	404, 309	
2.00 Program covered visits for mental health services (from contr	,	o	0	1
3.00 Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.0
14.00 Limit adjustment for mental health services (see instructions	•	0	0	
I5.00 Graduate Medical Education Pass Through Cost (see instruction 16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	404 200	15.00
16.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 16.01 Total program charges (see instructions)(from contractor's re	,	U	404, 309 383, 741	
16.02 Total program preventive charges (see instructions)(from prov			32, 935	
16.03 Total program preventive costs ((line 16.02/line 16.01) times			34, 700	
16.04 Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		256, 855	16.04
(Titles V and XIX see instructions.) 16.05 Total program cost (see instructions)		0	291, 555	16. 0!
<pre>16.05 Total program cost (see instructions) 17.00 Primary payer amounts</pre>		U	291, 555	17.00
18.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		48, 540	
records)				
19.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		60, 453	19.00
records) 20.00 Net program cost excluding injections/infusions (see instruct	ions)		291, 555	20.00
21.00 Program cost of vaccines and their administration (from Wkst.			29, 611	
21.50 Total program IOP OPPS payments (see instructions)				21.50
21.55 Total program IOP Costs (see instructions)				21.5
21.60 Program IOP deductible and coinsurance (see instructions) 22.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus Line 21 40)		221 144	21.60
22.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50, 23.00 Allowable bad debts (see instructions)	minus ime 21.60)		321, 166 240	23. 0
23.01 Adjusted reimbursable bad debts (see instructions)			156	
24.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25.50 Pioneer ACO demonstration payment adjustment (see instruction	s)		0	25. 50
25.99 Demonstration payment adjustment amount before sequestration 26.00 Net reimbursable amount (see instructions)			0 321, 322	
26.01 Sequestration adjustment (see instructions)			6, 426	
26.02 Demonstration payment adjustment amount after sequestration			0, 120	1
27.00 Interim payments			355, 531	27.00
28.00 Tentative settlement (for contractor use only)	00 07 1 00		0	
29.00 Balance due component/program (line 26 minus lines 26.01, 26.	•		-40, 635 0	
30.00 Protested amounts (nonallowable cost report items) in accorda	INCE WITH CIVIS PUB. 15-11	·	U	30.00

	Financial Systems WOODLAWN ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	HOSPITAL Provider CO	CN: 15-1313	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component (CCN: 15-8551	From 01/01/2023 To 12/31/2023		
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	335, 347 0. 000000		· ·	335, 347 0. 000000	1.00 2.00
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	0	1, 08	0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	0	1, 50		0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	0	2, 64		0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	971, 118				
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	757, 515 0. 000000				7.00 8.00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	0	2, 00	0 0	0	9.00
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	0	4, 70	00 0	0	10.00
11.00	Total number of injections/infusions (from your records)	0		13 0	0	11.00
2.00	Cost per injection/infusion (line 10/line 11)	0.00	109. 3	0.00	0.00	12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	0	•	0	0	13.00
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	1, 90	57 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
				1. 00	2.00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,			15. 00
16. 00			s (sum of		1 967	16.00

	Financial Systems WOODLAWN ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	CN: 15-1313	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component C	CCN: 15-8552	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	2, 316, 164 0. 001472	2, 316, 16 0. 00781		2, 316, 164 0. 000000	
. 00	Injection/infusion health care staff cost (line 1 x line 2)	3, 409	18, 09	0	0	
. 00	Injections/infusions and related medical supplies costs (from your records)	20, 354	18, 28		0	
. 00	Direct cost of injections/infusions (line 3 plus line 4)	23, 763	36, 37		0	
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	2, 753, 718	2, 753, 71			
. 00	Total overhead (from Wkst. M-2, line 19)	2, 017, 519	2, 017, 51			
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 008629	0. 01321		0. 000000	
. 00	Overhead cost - injection/infusion (line 7 x line 8)	17, 409	26, 65		0	
0.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	41, 172	63, 02		0	10.0
1.00	Total number of injections/infusions (from your records)	95	50		0	
2.00	Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	433. 39	125. 0	0.00		12.0
3.00	benefi ci ari es	0		4 0	0	
	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	50	0	0	14.00
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMINISTRATIO N	
				1. 00	2.00	
5. 00	Total cost of injections/infusions and their administratio	•	col umns 1,	1.00	104, 200	15. 0
6 00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. Total Program cost of injections/infusions and their admin		(SUM OF		500	l 16. 0
5. 00	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou]	10.0

	Financial Systems WOODLAWN ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC	`N: 15_1313	Peri od:	u of Form CMS-2 Worksheet M-4	
JOINII O I	ATTOM OF HOSELTAL-DASED KHOZEQUO VACCENE COSE			From 01/01/2023		
		Component C		To 12/31/2023	Date/Time Pre 5/29/2024 7:2	pared: 6 am
		Title		RHC III	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 399, 786 0. 000792	1, 399, 78 0. 01460		1, 399, 786 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	1, 109	20, 44	0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	5, 356	16, 72	25 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	6, 465	37, 1 <i>6</i>		0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 589, 258	1, 589, 25			
7. 00	Total overhead (from Wkst. M-2, line 19)	1, 510, 284	1, 510, 28		1, 510, 284	
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 004068	0. 02338		0. 000000	
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6, 144	35, 31		0	
0.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	12, 609	72, 48		0	
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	25 504. 36	4 <i>6</i> 157. 2		0	11.0
3. 00	Number of injection/infusion administered to Program	504.36	157. 2		0.00	
3. 00	Number of COVID-19 vaccine injections/infusions	0	14	0	0	
3.01	administered to MA enrollees			0	U	13.0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13	3, 026	22, 95	56 0	0	14.00
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI O	
					N	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration		columns 1,		85, 092	15. C
<i>,</i> 00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		5		25 222	1,,,
6.00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				25, 982	16.0

	Financial Systems WOODLAWN ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CC	N: 15-1313	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component C	CN: 15-8549	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title	XVIII	RHC IV	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	177, 062 0. 000407	177, 0 <i>6</i> 0. 00040		177, 062 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	72		72 0	0	
1. 00	Injections/infusions and related medical supplies costs (from your records)	643	10		0	
5. 00 5. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	715 182, 217	18 182, 21		0 182, 217	
7. 00 3. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	157, 912 0. 003924	157, 91 0. 00099		157, 912 0. 000000	
0. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	620 1, 335	15 33		0	
1. 00 2. 00 3. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11) Number of injection/infusion administered to Program	3 445. 00 1	112. <i>6</i>	3 0 57 0.00 1 0	0 0. 00 0	12.0
3. 01	beneficiaries Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	445	11	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	columns 1,	1.00	1, 673	15.00
6. 00	Total Program cost of injections/infusions and their admin		(sum of		558	16.0

	Financial Systems WOODLAWN ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO	CN: 15-1313	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component (CCN: 15-8547	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title	XVIII	RHC V	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
. 00 . 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	640, 822 0. 000070		· ·		1. C
. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	45	4, 41	17 0	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	429	•	47 O	0	4.0
. 00	Direct cost of injections/infusions (line 3 plus line 4)	474			0	5.0
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	671, 773	•	·		6.0
. 00	Total overhead (from Wkst. M-2, line 19)	587, 347				7.0
. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000706				8. (
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	415 889			0	9. (10. (
1. 00	Total number of injections/infusions (from your records)	2	19	97 0	0	11. (
2. 00	Cost per injection/infusion (line 10/line 11)	444. 50	110. (0.00	0.00	12. (
3. 00	Number of injection/infusion administered to Program beneficiaries	0	į	55 0	0	
	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	6, 05	52 0	0	14. (
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO	
				1. 00	N 2. 00	
5 00	Total cost of injections/infusions and their administration	n coete (sum of	f columns 1	1.00	2.00	15.
J. UU	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	COLUMNIS I,		22, 304	15.
6 00	Total Program cost of injections/infusions and their admin		s (sum of		6, 052	16
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou]	'

	Financial Systems WOODLAWN ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC		Peri od:	u of Form CMS-2 Worksheet M-4	
		Component C		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 7:2	
		Title	XVIII	RHC VI	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00 2.00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 003, 690 0. 003489	1, 003, 69 0. 01966		1, 003, 690 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	3, 502	19, 74	2 0	0	3.00
1. 00	Injections/infusions and related medical supplies costs (from your records)	19, 497	18, 61		0	
. 00	Direct cost of injections/infusions (line 3 plus line 4)	22, 999	38, 35		0	
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 910, 029	1, 910, 02			
. 00 . 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	1, 478, 192 0. 012041	1, 478, 19 0. 02008		1, 478, 192 0. 000000	
. 00	Overhead cost - injection/infusion (line 7 x line 8)	17, 799	29, 68	32 0	0	9.0
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	40, 798	68, 03	0	0	10.0
1. 00	Total number of injections/infusions (from your records)	91	51		0	
2. 00	Cost per injection/infusion (line 10/line 11)	448. 33	132. 6			12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	27	13	0	0	
	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	12, 105	17, 50	06 0	0	14.00
					COST OF INJECTIONS /	
					I NFUSIONS AND ADMINISTRATIO N	
				1. 00	2.00	
5. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		108, 834	15.0
6 00	Total Program cost of injections/infusions and their admin		(cum of		29, 611	14 0

Health Financial Systems	W	OODLAWN HOSPI	TAL		In Lieu	of Form C	MS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL- SERVICES RENDERED TO PROGRAM BENE				CCN: 15-1313 CCN: 15-8551	01/01/2023 12/31/2023	Worksheet Date/Time 5/29/2024	Prepared:

		Component CCN: 15-8551	10 12/31/2023	5/29/2024 7: 26	
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			264, 696	1. (
. 00	Interim payments payable on individual bills, either submitte the contractor for services rendered in the cost reporting pe "NONE" or enter a zero	eriod. If none, write		0	2. (
00	List separately each retroactive lump sum adjustment amount I revision of the interim rate for the cost reporting period. A payment. If none, write "NONE" or enter a zero. (1) Program to Provider				3. (
01				0	3. (
. 02				ol ol	3. (
03				ol ol	3. (
04				l ol	3. (
05					3.
03	Provider to Program			0	٥.
50	1 TOVI del Eto i l'ogi alli			0	3.
51				l ől	3.
52					3.
53					3.
54					3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	0)		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfe		е	264, 696	4.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after desk each payment. If none, write "NONE" or enter a zero. (1)	review. Also show date o	of		5.
	Program to Provider				
01	r rogi am to r rovi doi			0	5.
02					5.
03					5.
00	Provider to Program			Ü	Ο.
50	1 Tovi del Co i Togi din			0	5.
51					5.
52					5.
					Ο.
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.99	8)		ام	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98			0	
99 00	Determined net settlement amount (balance due) based on the				6.
99 00 01	Determined net settlement amount (balance due) based on the d SETTLEMENT TO PROVIDER			2, 549	6. 6.
99 00 01 02	Determined net settlement amount (balance due) based on the d SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			2, 549 0	6. 6. 6.
99 00 01 02	Determined net settlement amount (balance due) based on the d SETTLEMENT TO PROVIDER		Contract	2, 549 0 267, 245	6. 6. 6.
99 00 01 02	Determined net settlement amount (balance due) based on the d SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor	2,549 0 267,245 NPR Date	6. 6. 6.
99 00 01 02 00	Determined net settlement amount (balance due) based on the d SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor Number 1.00	2, 549 0 267, 245	5. 6. 6. 6. 7.

Health Financial Systems	WOODLAWN HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHOSERVICES RENDERED TO PROGRAM BENEFICIARIES	S		Worksheet M-5 Date/Time Prepared: 5/29/2024 7:26 am

		Component Con. 13-8332	10 12/31/2023	5/29/2024 7: 20	
			RHC II	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			134, 563	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero	•			
00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
1				0	3
2				0	3
3				0	3
)4				0	3
5				0	3
	Provider to Program		<u> </u>	•	
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	9	134, 563	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
0	List separately each tentative settlement payment after des	sk review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
1				0	5
2				0	5
3				0	5
	Provider to Program				
0				0	5
1				0	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
1	SETTLEMENT TO PROVIDER			0	6
2	SETTLEMENT TO PROGRAM			53, 815	6
0	Total Medicare program liability (see instructions)			80, 748	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor]	8

Health Financial Systems	WOODLAWN HOSPI	TAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/ SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-1313 Component CCN: 15-8550	From 01/01/2023	Worksheet M-5 Date/Time Prepared: 5/29/2024 7:26 am

				5/29/2024 7: 26	6 am
			RHC III	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			403, 498	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
02				0	3.
03				0	3.
04				0	3.
05				0	3.
	Provider to Program				
50				0	3
51				0	3
52				0	3
3				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		403, 498	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	5
)2				0	5
03				0	5
	Provi der to Program				
50				0	5
1				0	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	cost report. (1)			6
	SETTLEMENT TO PROVIDER			0	6
	SETTLEMENT TO PROGRAM		1	37, 198	6
)2					
)2	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)			366, 300	7
)2			Contractor	366, 300 NPR Date	7.
01 02 00			Number	366,300 NPR Date (Mo/Day/Yr)	7.
02 00		0		366, 300 NPR Date	7. 8.

Health Financial Systems	WOODLAWN HOSPITA	AL	In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA	RLES		From 01/01/2023 To 12/31/2023	
			DUIG 111	0 1

		Component CCN: 15-8549		Date/Time Prep 5/29/2024 7:20	
			RHC I V	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			66, 404	1.00
2.00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	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				0	3. 01
3. 02				0	3. 02
3. 03				0	3. 03
3.04				0	3. 04
3.05				0	3.05
	Provider to Program				
3. 50				0	3. 50
3. 51				0	3. 51
3. 52				0	3. 52
3.53				0	3. 53
3.54				0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.49			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line	е	66, 404	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desleach payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date o	of		5. 00
	Program to Provider				
5. 01				0	5. 01
5. 02				o	5. 02
5.03				o	5. 03
	Provider to Program		<u> </u>		
5.50	, and the second			0	5. 50
5. 51				o	5. 51
5. 52				o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5. 99
6.00	Determined net settlement amount (balance due) based on the	cost report. (1)			6. 00
6. 01	SETTLEMENT TO PROVIDER	, , ,		o	6. 01
6. 02	SETTLEMENT TO PROGRAM			27, 151	6. 02
7.00	Total Medicare program liability (see instructions)			39, 253	7. 00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	

Health Financial Systems	WOODLAWN HOS	PITAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1313 Component CCN: 15-8547		Worksheet M-5 Date/Time Prepared: 5/29/2024 7:26 am
				_

		Component Con. 13-8347	10 12/31/2023	5/29/2024 7: 20	
			RHC V	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			175, 021	1. (
2. 00	Interim payments payable on individual bills, either submit			0	2. (
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amount				3. (
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		_		
3. 01				0	3.
3. 02				0	3.
3. 03				0	3.
3. 04				0	3.
3. 05				0	3.
	Provider to Program		<u>"</u>		
. 50				0	3.
. 51				0	3.
. 52				l ol	3.
. 53				o	3.
3. 54				o	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		o	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		175, 021	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after des	k review. Also show date of	-		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program		_		
. 50				0	5.
5. 51				0	5.
. 52				0	5.
99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		98)		0	5.
. 99	0.00 Determined net settlement amount (balance due) based on the cost report. (1)				6.
	Determined net settlement amount (balance due) based on the				,
. 00	` '			0	6.
. 00 . 01	` '			0 39, 144	
. 00 . 01 . 02	SETTLEMENT TO PROVIDER			- 1	6.
. 00 . 01 . 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor	39, 144	6.
5. 00 5. 01 5. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		Contractor Number	39, 144 135, 877	6.
5. 99 5. 00 5. 01 5. 02 7. 00	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM	0		39, 144 135, 877 NPR Date	6. 6. 7.

Health Financial Systems	WOODLAWN HOS	PI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-1313 Component CCN: 15-8548	From 01/01/2023	
				_

		Component Con. 13-8348	10 12/31/2023	5/29/2024 7: 20	
			RHC VI	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			355, 531	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		o	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero	•			
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3
02				0	3
03				0	3
04				0	3
05				0	3
	Provider to Program				
50				0	3
51				0	3
52				0	3
53				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		355, 531	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				_
00	List separately each tentative settlement payment after des	k review. Also show date o	OT		5
	each payment. If none, write "NONE" or enter a zero. (1)				
01	Program to Provider			0	5
02					5
)2)3				0	5
	Provider to Program			0	٦
50	Tovider to Trogram			0	5
51				o o	5
52				Ö	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		o o	5
00	Determined net settlement amount (balance due) based on the				6
)1	SETTLEMENT TO PROVIDER			0	6
)2	SETTLEMENT TO PROGRAM			40, 635	6
00	Total Medicare program liability (see instructions)			314, 896	
-	Total mod. od. o program readility (300 restractions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	