

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/26/2020 12:27 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 6/26/2020	Time: 12:27 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAKEVIEW SPECIALTY HOSPT & REHAB (52-2005) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CHRISTOPHER SLOVER
Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-120,531	317	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	-120,531	317	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 52-2005		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 12:27 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1701 SHARP ROAD			PO Box:				1.00	
2.00	City: WATERFORD			State: WI		Zip Code: 53185		County: RACINE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			LAKEVIEW SPECIALTY HOSPT & REHAB	522005	39540	2	10/01/1996	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2019	12/31/2019	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for 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.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for 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)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to 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.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 52-2005		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 12:27 pm		
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	25.00	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0		35.00	
							Beginning:	Ending:		
							1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
							Y/N	Y/N		
							1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)						N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)						N	N	40.00	
							V	XVIII	XIX	
							1.00	2.00	3.00	
<u>Prospective Payment System (PPS)-Capital</u>										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)						N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.						N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00
<u>Teaching Hospitals</u>										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.						N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.						N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
					1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.				N				60.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet S-2
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00	
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 52-2005

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

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			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.		Y	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00	
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.		N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 12:27 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model 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.	N		112.00
Miscellaneous Cost Reporting Information				
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		0 115.00
116.00	Is 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	Is 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		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	94,535	0	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1836	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 52-2005		Period: From 01/01/2019 To 12/31/2019		Worksheet S-2 Part I Date/Time Prepared: 6/26/2020 12:27 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: LAKEVIEW MANAGEMENT INC.	Contractor's Name: WPS		Contractor's Number: 05901				141.00	
142.00	Street: 4814 CITY PARK ROAD	PO Box:						142.00	
143.00	City: AUSTIN	State: TX		Zip Code: 78730				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							N	146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/26/2020 12:27 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management 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		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
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 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/18/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/26/2020 12:27 pm
		Description	Y/N	Y/N
		0	1.00	3.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N	27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N	33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N	35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?		Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N	40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ADAM	MARCIN	41.00
42.00	Enter the employer/company name of the cost report preparer.	H R P L L C		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(972) 381-1150	AGMARCIN@HRPLLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Prepared: 6/26/2020 12:27 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRINCIPAL		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	39	14,235	0.00	0	1.00
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 beds) (see instructions)		39	14,235	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		39	14,235	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		39			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,395	3,158	11,267			1.00
2.00	HMO and other (see instructions)	0	1,835				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,395	3,158	11,267			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,395	3,158	11,267	0.00	180.04	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	180.04	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	280					33.00
33.01	LTCH site neutral days and discharges	135					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet S-3
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	43	52	234	1.00
2.00 HMO and other (see instructions)			0	47		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 beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	43	52	234	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
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 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			3			33.00
33.01 LTCH site neutral days and discharges			5			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 52-2005		Period: From 01/01/2019 To 12/31/2019		Worksheet A Date/Time Prepared: 6/26/2020 12:27 pm	
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
GENERAL SERVICE COST CENTERS									
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1,481,998	1,481,998	1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	274,920	274,920	2.00		
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	180,123	785,871	965,994	-18,390	947,604	4.00	
5.01	00550	DATA PROCESSING	82,879	127,308	210,187	0	210,187	5.01	
5.02	00590	ADMITTING	119,082	12,671	131,753	0	131,753	5.02	
5.03	00591	BUSINESS OFFICE	450,779	2,333,696	2,784,475	-1,763,494	1,020,981	5.03	
5.04	00592	ADMINISTRATIVE AND GENERAL	855,009	1,026,584	1,881,593	-3,994	1,877,599	5.04	
6.00	00600	MAINTENANCE & REPAIRS	278,479	1,001,334	1,279,813	0	1,279,813	6.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,676	4,676	0	4,676	8.00	
9.00	00900	HOUSEKEEPING	199,966	69,439	269,405	0	269,405	9.00	
10.00	01000	DIETARY	297,662	361,060	658,722	0	658,722	10.00	
11.00	01100	CAFETERIA	0	0	0	0	0	11.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	26,109	491,831	517,940	-468,966	48,974	14.00	
15.00	01500	PHARMACY	314,267	898,993	1,213,260	-11,486	1,201,774	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	42,589	40,820	83,409	-7,043	76,366	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	3,707,179	2,709,861	6,417,040	-457,600	5,959,440	30.00	
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00	
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	42,944	42,944	19,392	62,336	54.00	
57.00	05700	CT SCAN	0	0	0	32,228	32,228	57.00	
58.00	05800	MRI	0	0	0	0	0	58.00	
60.00	06000	LABORATORY	44,335	104,442	148,777	-18,563	130,214	60.00	
65.00	06500	RESPIRATORY THERAPY	328,768	80,068	408,836	-30,599	378,237	65.00	
66.00	06600	PHYSICAL THERAPY	0	4,159	4,159	370,658	374,817	66.00	
67.00	06700	OCCUPATIONAL THERAPY	817,063	103,950	921,013	-603,996	317,017	67.00	
68.00	06800	SPEECH PATHOLOGY	0	131	131	226,195	226,326	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	600,140	600,140	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,984	3,984	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,340	24,340	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	210,892	210,892	74.00	
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00	
SPECIAL PURPOSE COST CENTERS									
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,744,289	10,199,838	17,944,127	-139,384	17,804,743	118.00	
NONREIMBURSABLE COST CENTERS									
192.00	19200	PHYSICIANS' PRIVATE OFFICES	105,540	11,090	116,630	-32,337	84,293	192.00	
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00	
194.01	07951	MARKETING DEPARTMENT	0	0	0	3,994	3,994	194.01	
194.02	07952	OTHER NONALLOWABLE	0	0	0	0	0	194.02	
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	0	90,523	90,523	194.03	
194.04	07954	EMS/AMBULANCE	0	0	0	77,204	77,204	194.04	
200.00		TOTAL (SUM OF LINES 118 through 199)	7,849,829	10,210,928	18,060,757	0	18,060,757	200.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet A

Date/Time Prepared:
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Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-790,082	691,916	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-270	274,650	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,600	944,004	4.00
5.01	00550	DATA PROCESSING	0	210,187	5.01
5.02	00590	ADMITTING	-302	131,451	5.02
5.03	00591	BUSINESS OFFICE	-134,935	886,046	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	728,309	2,605,908	5.04
6.00	00600	MAINTENANCE & REPAIRS	-19,852	1,259,961	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,676	8.00
9.00	00900	HOUSEKEEPING	0	269,405	9.00
10.00	01000	DIETARY	-36,016	622,706	10.00
11.00	01100	CAFETERIA	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	48,974	14.00
15.00	01500	PHARMACY	-204	1,201,570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-440	75,926	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-459,139	5,500,301	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62,336	54.00
57.00	05700	CT SCAN	0	32,228	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	130,214	60.00
65.00	06500	RESPIRATORY THERAPY	0	378,237	65.00
66.00	06600	PHYSICAL THERAPY	0	374,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	317,017	67.00
68.00	06800	SPEECH PATHOLOGY	0	226,326	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	600,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,340	73.00
74.00	07400	RENAL DIALYSIS	0	210,892	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-716,531	17,088,212	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	84,293	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	3,994	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	90,523	194.03
194.04	07954	EMS/AMBULANCE	0	77,204	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-716,531	17,344,226	200.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
6/26/2020 12:27 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EQUIPMENT DEPRECIATION & AMORTIZATI					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25,846		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	77,016		2.00
	0		0	102,862		
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	600,140		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,984		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
	0		0	604,124		
	C - RECLASS INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	90,011		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	139,865		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	52,891		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,148		4.00
	0		0	287,915		
	D - RECLASS OUTPATIENT SALARIES					
1.00	PHYSICAL THERAPY	66.00	331,476	39,264		1.00
2.00	SPEECH PATHOLOGY	68.00	191,504	34,691		2.00
	0		522,980	73,955		
	E - RECLASS PURCHASED SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	0	4,491		1.00
2.00	BUSINESS OFFICE	5.03	0	4,004		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	19,392		3.00
4.00	CT SCAN	57.00	0	11,156		4.00
5.00	LABORATORY	60.00	0	4,556		5.00
6.00	RESPIRATORY THERAPY	65.00	0	2,352		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	24,340		7.00
8.00	RENAL DIALYSIS	74.00	0	210,892		8.00
9.00	LAKEVIEW CARE PARTNERS (CBRF)	194.03	0	29,004		9.00
10.00	EMS/AMBULANCE	194.04	0	70,248		10.00
	0		0	380,435		
	F - MED DIRECTOR TO CLINIC					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	12,500	1,127		1.00
	0		12,500	1,127		
	G - LAB					
1.00	LABORATORY	60.00	0	11,949		1.00
	0		0	11,949		
	H - OVERHEAD COST ALLOCATION					
1.00	LAKEVIEW CARE PARTNERS (CBRF)	194.03	61,519	0		1.00
2.00	EMS/AMBULANCE	194.04	6,956	0		2.00
3.00		0.00	0	0		3.00
	0		68,475	0		
	I - RECLASS CT SCAN AND MRI COST					
1.00	CT SCAN	57.00	0	21,072		1.00
	0		0	21,072		
	M - EMPLOYEE HEALTH					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	40,188	4,223		1.00
	0		40,188	4,223		
	N - MARKETING DEPARTMENT					
1.00	MARKETING DEPARTMENT	194.01	3,421	573		1.00
	0		3,421	573		
	O - RENTAL RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,366,141		1.00
	0		0	1,366,141		
500.00	Grand Total: Increases		647,564	2,854,376		500.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-6

Date/Time Prepared:
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	Decreases						6/26/2020 12:27 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EQUIPMENT DEPRECIATION & AMORTIZATI						
1.00	BUSINESS OFFICE	5.03	0	102,862	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	102,862			
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	468,966	0		1.00
2.00	PHARMACY	15.00	0	11,486	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	46,957	0		3.00
4.00	LABORATORY	60.00	0	35,068	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	32,951	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	82	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	7,061	0		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,553	0		8.00
	0		0	604,124			
	C - RECLASS INSURANCE						
1.00	BUSINESS OFFICE	5.03	0	287,915	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
4.00		0.00	0	0	11		4.00
	0		0	287,915			
	D - RECLASS OUTPATIENT SALARIES						
1.00	OCCUPATIONAL THERAPY	67.00	522,980	73,955	0		1.00
2.00		0.00	0	0	0		2.00
	0		522,980	73,955			
	E - RECLASS PURCHASED SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	0	380,435	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	0		0	380,435			
	F - MED DIRECTOR TO CLINIC						
1.00	ADULTS & PEDIATRICS	30.00	12,500	1,127	0		1.00
	0		12,500	1,127			
	G - LAB						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	11,949	0		1.00
	0		0	11,949			
	H - OVERHEAD COST ALLOCATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	50,852	0	0		1.00
2.00	BUSINESS OFFICE	5.03	10,580	0	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	7,043	0	0		3.00
	0		68,475	0			
	I - RECLASS CT SCAN AND MRI COST						
1.00	ADULTS & PEDIATRICS	30.00	0	21,072	0		1.00
	0		0	21,072			
	M - EMPLOYEE HEALTH						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	40,188	4,223	0		1.00
	0		40,188	4,223			
	N - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE AND GENERAL	5.04	3,421	573	0		1.00
	0		3,421	573			
	O - RENTAL RECLASS						
1.00	BUSINESS OFFICE	5.03	0	1,366,141	10		1.00
	0		0	1,366,141			
500.00	Grand Total: Decreases		647,564	2,854,376			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	656,103	851,861	0	851,861	0	2.00	
3.00	Buildings and Fixtures	290,159	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	1,257,416	103,745	0	103,745	0	6.00	
7.00	HIT designated Assets	101,101	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	2,304,779	955,606	0	955,606	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	2,304,779	955,606	0	955,606	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	1,507,964	0				2.00	
3.00	Buildings and Fixtures	290,159	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	1,361,161	0				6.00	
7.00	HIT designated Assets	101,101	0				7.00	
8.00	Subtotal (sum of lines 1-7)	3,260,385	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	3,260,385	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,798,123	0	1,798,123	0.551507	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,462,261	0	1,462,261	0.448493	0	2.00
3.00	Total (sum of lines 1-2)	3,260,384	0	3,260,384	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	25,846	576,059	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	76,746	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	102,592	576,059	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	90,011	0	0	691,916	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,148	52,891	139,865	0	274,650	2.00
3.00	Total (sum of lines 1-2)	5,148	142,902	139,865	0	966,566	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,475	MAINTENANCE & REPAIRS	6.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-15,377	MAINTENANCE & REPAIRS	6.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-219,073			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-34,265			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-33,398	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-440	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,618	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TUITION REIMBURSEMENT REFUND	B	-547	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8

Date/Time Prepared:
6/26/2020 12:27 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 CENTRAL SUPPLY PURCHASE INCOME	B	-204	PHARMACY	15.00	0	33.01
33.02 NONALLOWABLE MARKETING	A	-302	ADMITTING	5.02	0	33.02
34.00 MISCELLANEOUS INCOME	B	-3,964	ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00 NONALLOWABLE PENALTIES	A	-134,935	BUSINESS OFFICE	5.03	0	35.00
36.00 NONALLOWABLE DONATIONS	A	0	ADMINISTRATIVE AND GENERAL	5.04	0	36.00
39.00 HOSPITAL ASSESSMENT	A	-238,489	ADULTS & PEDIATRICS	30.00	0	39.00
41.00 POSTAGE INCOME	B	-182	ADMINISTRATIVE AND GENERAL	5.04	0	41.00
44.00 NONALLOWABLE MARKETING	A	-4,621	ADMINISTRATIVE AND GENERAL	5.04	0	44.00
44.01 NONALLOWABLE MARKETING	A	-1,577	ADULTS & PEDIATRICS	30.00	0	44.01
44.03 PATIENT TELEPHONE SALARY	A	-18,741	ADMINISTRATIVE AND GENERAL	5.04	0	44.03
44.04 PATIENT TELEPHONE BENEFITS	A	-3,053	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.04
44.05 PATIENT TELEPHONE DEPRECIATION	A	-270	CAP REL COSTS-MVBLE EQUIP	2.00	9	44.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-716,531				50.00

(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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
6/26/2020 12:27 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	935,817	180,000	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING RENT	576,059	1,366,141	2.00
3.00	5.04	ADMINISTRATIVE AND GENERAL	HOME OFFICE COST	15,527	15,527	3.00
4.00	5.04	ADMINISTRATIVE AND GENERAL	PROFESSIONAL FEES	592,485	592,485	4.00
4.01	194.03	LAKEVIEW CARE PARTNERS (CBRF	SHARED SERVICES	49,908	49,908	4.01
4.02	194.04	EMS/AMBULANCE	SHARED SERVICES	5,681	5,681	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,175,477	2,209,742	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	4.00	5.00
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	LAKEVIEW MANAGEMENT INC	100.00	6.00
7.00	B		0.00	SREHC LLC	100.00	7.00
8.00	B		0.00	LAKEVIEW CARE P	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-1

Date/Time Prepared:
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	755,817	0		1.00
2.00	-790,082	10		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	-34,265			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	
Type of Business	
6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:	

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	MANAGEMENT COMP	6.00
7.00	REAL ESTATE MGT	7.00
8.00	CBRF OWNER	8.00
9.00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet A-8-2

Date/Time Prepared:
6/26/2020 12:27 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	360,717	194,638	166,079	211,500	1,393	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			360,717	194,638	166,079		1,393	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	141,644	7,082	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			141,644	7,082	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	141,644	24,435	219,073		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	141,644	24,435	219,073		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	5.01
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	691,916	691,916			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	274,650		274,650		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	944,004	3,057	1,937	948,998	4.00
5.01	00550	DATA PROCESSING	210,187		1,174	10,241	221,602
5.02	00590	ADMITTING	131,451	4,568	0	14,714	6,980
5.03	00591	BUSINESS OFFICE	886,046	14,357	363	54,391	15,704
5.04	00592	ADMINISTRATIVE AND GENERAL	2,605,908	225,838	108,462	105,223	34,896
6.00	00600	MAINTENANCE & REPAIRS	1,259,961	86,799	33,343	34,409	22,684
8.00	00800	LAUNDRY & LINEN SERVICE	4,676	12,763	513	0	1,745
9.00	00900	HOUSEKEEPING	269,405	8,143	0	24,708	0
10.00	01000	DIETARY	622,706	42,963	9,020	36,779	5,235
11.00	01100	CAFETERIA	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	48,974	1,489	0	3,226	5,235
15.00	01500	PHARMACY	1,201,570	5,027	0	38,831	8,724
16.00	01600	MEDICAL RECORDS & LIBRARY	75,926	5,049	0	4,392	1,745
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,500,301	149,328	85,279	456,524	33,153
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,336	0	633	0	0
57.00	05700	CT SCAN	32,228	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	130,214	1,030	12,647	5,478	1,745
65.00	06500	RESPIRATORY THERAPY	378,237	3,616	3,213	40,623	5,235
66.00	06600	PHYSICAL THERAPY	374,817	22,228	746	40,958	34,898
67.00	06700	OCCUPATIONAL THERAPY	317,017	28,315	0	36,337	0
68.00	06800	SPEECH PATHOLOGY	226,326	2,493	0	23,662	5,235
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	600,140	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,984	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	24,340	0	3,025	0	0
74.00	07400	RENAL DIALYSIS	210,892	0	0	0	1,745
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,088,212	617,063	260,355	930,496	184,959
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	84,293	12,659	14,295	9,619	12,214
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0
194.01	07951	MARKETING DEPARTMENT	3,994	0	0	423	0
194.02	07952	OTHER NONALLOWABLE	0	933	0	0	0
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	90,523	61,261	0	7,601	20,939
194.04	07954	EMS/AMBULANCE	77,204	0	0	859	3,490
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	17,344,226	691,916	274,650	948,998	221,602

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMITTING	BUSINESS OFFICE	Subtotal	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING	157,713					5.02
5.03	00591	BUSINESS OFFICE	0	970,861				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	0	3,080,327	3,080,327		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,437,196	311,087	1,748,283	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	19,697	4,263	62,452	8.00
9.00	00900	HOUSEKEEPING	0	0	302,256	65,425	39,845	9.00
10.00	01000	DIETARY	0	0	716,703	155,133	210,220	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	58,924	12,754	7,286	14.00
15.00	01500	PHARMACY	0	0	1,254,152	271,466	24,597	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	87,112	18,856	24,707	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	69,019	424,921	6,718,525	1,454,251	730,676	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,392	27,032	94,393	20,432	0	54.00
57.00	05700	CT SCAN	113	693	33,034	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,266	26,258	181,638	39,316	5,040	60.00
65.00	06500	RESPIRATORY THERAPY	18,868	116,138	565,930	122,498	17,695	65.00
66.00	06600	PHYSICAL THERAPY	19,350	119,103	612,100	132,491	108,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,084	49,761	439,514	95,135	138,546	67.00
68.00	06800	SPEECH PATHOLOGY	5,486	33,771	296,973	64,281	12,198	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,398	70,159	681,697	147,556	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	62	380	4,426	958	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,100	80,637	121,102	26,213	0	73.00
74.00	07400	RENAL DIALYSIS	3,575	22,008	238,220	51,564	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	157,713	970,861	16,943,919	2,993,679	1,382,024	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	133,080	28,806	61,941	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	4,417	956	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	933	202	4,565	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	180,324	39,032	299,753	194.03
194.04	07954	EMS/AMBULANCE	0	0	81,553	17,652	0	194.04
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	157,713	970,861	17,344,226	3,080,327	1,748,283	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	
			8.00	9.00	10.00	11.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	86,412					8.00
9.00	00900	HOUSEKEEPING	2,692	410,218				9.00
10.00	01000	DIETARY	1,889	52,392	1,136,337			10.00
11.00	01100	CAFETERIA	0	0	222,898	222,898		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,816	0	1,658	82,438	14.00
15.00	01500	PHARMACY	0	6,130	0	7,429	457	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,158	0	1,409	118	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	79,675	182,101	552,599	175,439	3,783	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,256	0	1,841	1,136	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,410	0	10,961	29	65.00
66.00	06600	PHYSICAL THERAPY	0	27,106	0	7,993	220	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	34,529	0	7,114	533	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,040	0	4,626	16	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	75,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,256	318,938	775,497	218,470	82,295	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,437	0	2,123	143	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	365	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	1,138	7,707	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	2,156	74,705	353,133	1,758	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	182	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,412	410,218	1,136,337	222,898	82,438	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,564,231					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	138,360				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	60,550	9,957,599	0	9,957,599	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,853	118,678	0	118,678	54.00
57.00	05700	CT SCAN	0	99	33,133	0	33,133	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	3,742	233,969	0	233,969	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,553	738,076	0	738,076	65.00
66.00	06600	PHYSICAL THERAPY	0	16,975	905,647	0	905,647	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,092	722,463	0	722,463	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,813	385,947	0	385,947	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,999	914,754	0	914,754	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	54	5,939	0	5,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,564,231	11,493	1,723,039	0	1,723,039	73.00
74.00	07400	RENAL DIALYSIS	0	3,137	292,921	0	292,921	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,564,231	138,360	16,032,165	0	16,032,165	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	241,530	0	241,530	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	5,738	0	5,738	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	14,545	0	14,545	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	950,861	0	950,861	194.03
194.04	07954	EMS/AMBULANCE	0	0	99,387	0	99,387	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,564,231	138,360	17,344,226	0	17,344,226	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,057	1,937	4,994	4.00
5.01	00550	DATA PROCESSING	0	0	1,174	1,174	5.01
5.02	00590	ADMITTING	0	4,568	0	4,568	5.02
5.03	00591	BUSINESS OFFICE	0	14,357	363	14,720	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	36,562	225,838	108,462	370,862	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	86,799	33,343	120,142	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,763	513	13,276	8.00
9.00	00900	HOUSEKEEPING	0	8,143	0	8,143	9.00
10.00	01000	DIETARY	0	42,963	9,020	51,983	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,489	0	1,489	14.00
15.00	01500	PHARMACY	0	5,027	0	5,027	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,049	0	5,049	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	149,328	85,279	234,607	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	633	633	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,030	12,647	13,677	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,616	3,213	6,829	65.00
66.00	06600	PHYSICAL THERAPY	0	22,228	746	22,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28,315	0	28,315	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,493	0	2,493	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	07300	DRUGS CHARGED TO PATIENTS	0	0	3,025	3,025	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,562	617,063	260,355	913,980	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,659	14,295	26,954	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	933	0	933	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	61,261	0	61,261	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,562	691,916	274,650	1,003,128	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DATA PROCESSING	ADMITTING	BUSINESS OFFICE	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	1,228					5.01
5.02	00590	ADMITTING	39	4,684				5.02
5.03	00591	BUSINESS OFFICE	87	0	15,093			5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	192	0	0	371,608		5.04
6.00	00600	MAINTENANCE & REPAIRS	126	0	0	37,529	157,978	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	10	0	0	514	5,643	8.00
9.00	00900	HOUSEKEEPING	0	0	0	7,893	3,600	9.00
10.00	01000	DIETARY	29	0	0	18,715	18,996	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	29	0	0	1,539	658	14.00
15.00	01500	PHARMACY	48	0	0	32,750	2,223	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10	0	0	2,275	2,233	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	184	2,046	6,593	175,438	66,026	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	131	421	2,465	0	54.00
57.00	05700	CT SCAN	0	3	11	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10	127	409	4,743	455	60.00
65.00	06500	RESPIRATORY THERAPY	29	561	1,808	14,778	1,599	65.00
66.00	06600	PHYSICAL THERAPY	193	576	1,854	15,984	9,828	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	240	775	11,477	12,519	67.00
68.00	06800	SPEECH PATHOLOGY	29	163	526	7,755	1,102	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	339	1,092	17,801	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2	6	116	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	390	1,255	3,162	0	73.00
74.00	07400	RENAL DIALYSIS	10	106	343	6,221	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,025	4,684	15,093	361,155	124,882	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	68	0	0	3,475	5,597	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	115	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	24	413	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	116	0	0	4,709	27,086	194.03
194.04	07954	EMS/AMBULANCE	19	0	0	2,130	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,228	4,684	15,093	371,608	157,978	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	
			8.00	9.00	10.00	11.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,443					8.00
9.00	00900	HOUSEKEEPING	606	20,372				9.00
10.00	01000	DIETARY	425	2,602	92,943			10.00
11.00	01100	CAFETERIA	0	0	18,231	18,231		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	90	0	136	3,958	14.00
15.00	01500	PHARMACY	0	304	0	608	22	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	306	0	115	6	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,927	9,043	45,199	14,348	182	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	62	0	151	55	60.00
65.00	06500	RESPIRATORY THERAPY	0	219	0	896	1	65.00
66.00	06600	PHYSICAL THERAPY	0	1,346	0	654	11	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,715	0	582	26	67.00
68.00	06800	SPEECH PATHOLOGY	0	151	0	378	1	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,623	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	24	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,958	15,838	63,430	17,868	3,951	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	767	0	174	7	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	30	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	57	630	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	485	3,710	28,883	144	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	15	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	19,443	20,372	92,943	18,231	3,958	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	41,186					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,017				16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,385	578,382	0	578,382	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	279	3,929	0	3,929	54.00
57.00	05700	CT SCAN	0	7	21	0	21	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	271	19,989	0	19,989	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,198	28,132	0	28,132	65.00
66.00	06600	PHYSICAL THERAPY	0	1,229	54,864	0	54,864	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	513	56,353	0	56,353	67.00
68.00	06800	SPEECH PATHOLOGY	0	348	13,070	0	13,070	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	724	23,579	0	23,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4	152	0	152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41,186	832	49,850	0	49,850	73.00
74.00	07400	RENAL DIALYSIS	0	227	6,907	0	6,907	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,186	10,017	835,228	0	835,228	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	37,093	0	37,093	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	147	0	147	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	2,057	0	2,057	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	126,434	0	126,434	194.03
194.04	07954	EMS/AMBULANCE	0	0	2,169	0	2,169	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	41,186	10,017	1,003,128	0	1,003,128	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (COMPUTER TIME)	ADMITTING (GROSS CHARGES)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (EQUIPMENT COST)				
			1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	185,401					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,752,421				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	819	12,357	7,680,370			4.00
5.01	00550	DATA PROCESSING	0	7,490	82,879	127		5.01
5.02	00590	ADMITTING	1,224	0	119,082	4	45,115,506	5.02
5.03	00591	BUSINESS OFFICE	3,847	2,318	440,199	9	0	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	60,514	692,040	851,588	20	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	23,258	212,749	278,479	13	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,420	3,274	0	1	0	8.00
9.00	00900	HOUSEKEEPING	2,182	0	199,966	0	0	9.00
10.00	01000	DIETARY	11,512	57,552	297,662	3	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	399	0	26,109	3	0	14.00
15.00	01500	PHARMACY	1,347	0	314,267	5	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,353	0	35,546	1	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,013	544,131	3,694,679	19	19,745,382	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,042	0	0	1,256,200	54.00
57.00	05700	CT SCAN	0	0	0	0	32,227	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	276	80,696	44,335	1	1,220,201	60.00
65.00	06500	RESPIRATORY THERAPY	969	20,500	328,768	3	5,396,979	65.00
66.00	06600	PHYSICAL THERAPY	5,956	4,763	331,476	20	5,534,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,587	0	294,083	0	2,312,426	67.00
68.00	06800	SPEECH PATHOLOGY	668	0	191,504	3	1,569,362	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,260,322	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	17,638	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,301	0	0	3,747,255	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1	1,022,732	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,344	1,661,213	7,530,622	106	45,115,506	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,392	91,208	77,852	7	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	3,421	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	250	0	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	16,415	0	61,519	12	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	6,956	2	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	691,916	274,650	948,998	221,602	157,713	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.731997	0.156726	0.123561	1,744.897638	0.003496	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			4,994	1,228	4,684	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000650	9.669291	0.000104	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.03	5A.04	5.04	6.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00590	ADMITTING					5.02
5.03	00591	BUSINESS OFFICE	45,115,506				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	-3,080,327	14,230,865		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,437,196	95,739	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	19,697	3,420	8.00
9.00	00900	HOUSEKEEPING	0	0	302,256	2,182	9.00
10.00	01000	DIETARY	0	0	716,703	11,512	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	58,924	399	14.00
15.00	01500	PHARMACY	0	0	1,254,152	1,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	87,112	1,353	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,745,382	0	6,718,525	40,013	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,256,200	0	94,393	0	54.00
57.00	05700	CT SCAN	32,227	-33,034	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	1,220,201	0	181,638	276	60.00
65.00	06500	RESPIRATORY THERAPY	5,396,979	0	565,930	969	65.00
66.00	06600	PHYSICAL THERAPY	5,534,782	0	612,100	5,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,312,426	0	439,514	7,587	67.00
68.00	06800	SPEECH PATHOLOGY	1,569,362	0	296,973	668	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,260,322	0	681,697	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,638	0	4,426	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,747,255	0	121,102	0	73.00
74.00	07400	RENAL DIALYSIS	1,022,732	0	238,220	0	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,115,506	-3,113,361	13,830,558	75,682	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	133,080	3,392	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	4,417	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	933	250	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	180,324	16,415	194.03
194.04	07954	EMS/AMBULANCE	0	0	81,553	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	970,861		3,080,327	1,748,283	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.021519		0.216454	18.260928	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,093		371,608	157,978	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000335		0.026113	1.650090	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	90,137					9.00
10.00	01000	DIETARY	11,512	69,593				10.00
11.00	01100	CAFETERIA	0	13,651	13,442			11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	399	0	100	655,279		14.00
15.00	01500	PHARMACY	1,347	0	448	3,636	849,174	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,353	0	85	938	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	40,013	33,843	10,580	30,067	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	276	0	111	9,032	0	60.00
65.00	06500	RESPIRATORY THERAPY	969	0	661	231	0	65.00
66.00	06600	PHYSICAL THERAPY	5,956	0	482	1,748	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,587	0	429	4,234	0	67.00
68.00	06800	SPEECH PATHOLOGY	668	0	279	131	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	600,140	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,984	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	849,174	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,080	47,494	13,175	654,141	849,174	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,392	0	128	1,138	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	22	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	250	472	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	16,415	21,627	106	0	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	11	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	410,218	1,136,337	222,898	82,438	1,564,231	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.551050	16.328323	16.582205	0.125806	1.842062	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,372	92,943	18,231	3,958	41,186	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.226012	1.335522	1.356271	0.006040	0.048501	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00550	DATA PROCESSING	5.01
5.02	00590	ADMITTING	5.02
5.03	00591	BUSINESS OFFICE	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		45,115,506	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
		0	
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
		1,256,200	
		32,227	
		0	
		1,220,201	
		5,396,979	
		5,534,782	
		2,312,426	
		1,569,362	
		3,260,322	
		17,638	
		3,747,255	
		1,022,732	
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
		0	
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		45,115,506	
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONALLOWABLE	194.00
194.01	07951	MARKETING DEPARTMENT	194.01
194.02	07952	OTHER NONALLOWABLE	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	194.03
194.04	07954	EMS/AMBULANCE	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		138,360	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		0.003067	
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		10,017	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.000222	
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,957,599		9,957,599	24,435	9,982,034 30.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0 46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,678		118,678	0	118,678 54.00
57.00	05700	CT SCAN	33,133		33,133	0	33,133 57.00
58.00	05800	MRI	0		0	0	0 58.00
60.00	06000	LABORATORY	233,969		233,969	0	233,969 60.00
65.00	06500	RESPIRATORY THERAPY	738,076	0	738,076	0	738,076 65.00
66.00	06600	PHYSICAL THERAPY	905,647	0	905,647	0	905,647 66.00
67.00	06700	OCCUPATIONAL THERAPY	722,463	0	722,463	0	722,463 67.00
68.00	06800	SPEECH PATHOLOGY	385,947	0	385,947	0	385,947 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	914,754		914,754	0	914,754 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,939		5,939	0	5,939 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,723,039		1,723,039	0	1,723,039 73.00
74.00	07400	RENAL DIALYSIS	292,921		292,921	0	292,921 74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0		0	0	0 95.00
200.00		Subtotal (see instructions)	16,032,165	0	16,032,165	24,435	16,056,600 200.00
201.00		Less Observation Beds	0		0		0 201.00
202.00		Total (see instructions)	16,032,165	0	16,032,165	24,435	16,056,600 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,745,382		19,745,382			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,989	15,211	1,256,200	0.094474	0.000000	54.00
57.00	05700	CT SCAN	32,227	0	32,227	1.028113	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,120,460	99,741	1,220,201	0.191746	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,395,718	1,261	5,396,979	0.136757	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,428,369	106,413	5,534,782	0.163628	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,241,610	70,816	2,312,426	0.312426	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,544,783	24,579	1,569,362	0.245926	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,259,483	839	3,260,322	0.280572	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,638	0	17,638	0.336716	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,747,255	0	3,747,255	0.459814	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,022,732	0	1,022,732	0.286410	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	44,796,646	318,860	45,115,506			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	44,796,646	318,860	45,115,506			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/26/2020 12:27 pm
			Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio			
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094474		54.00
57.00	05700	CT SCAN	1.028113		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.191746		60.00
65.00	06500	RESPIRATORY THERAPY	0.136757		65.00
66.00	06600	PHYSICAL THERAPY	0.163628		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.312426		67.00
68.00	06800	SPEECH PATHOLOGY	0.245926		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.280572		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336716		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459814		73.00
74.00	07400	RENAL DIALYSIS	0.286410		74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
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			Title XIX		Hospital		Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,957,599		9,957,599	24,435	9,982,034	30.00	
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	118,678		118,678	0	118,678	54.00	
57.00	05700	CT SCAN	33,133		33,133	0	33,133	57.00	
58.00	05800	MRI	0		0	0	0	58.00	
60.00	06000	LABORATORY	233,969		233,969	0	233,969	60.00	
65.00	06500	RESPIRATORY THERAPY	738,076	0	738,076	0	738,076	65.00	
66.00	06600	PHYSICAL THERAPY	905,647	0	905,647	0	905,647	66.00	
67.00	06700	OCCUPATIONAL THERAPY	722,463	0	722,463	0	722,463	67.00	
68.00	06800	SPEECH PATHOLOGY	385,947	0	385,947	0	385,947	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	914,754		914,754	0	914,754	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,939		5,939	0	5,939	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,723,039		1,723,039	0	1,723,039	73.00	
74.00	07400	RENAL DIALYSIS	292,921		292,921	0	292,921	74.00	
	OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00	
200.00		Subtotal (see instructions)	16,032,165	0	16,032,165	24,435	16,056,600	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	16,032,165	0	16,032,165	24,435	16,056,600	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,745,382		19,745,382			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,240,989	15,211	1,256,200	0.094474	0.000000	54.00
57.00	05700	CT SCAN	32,227	0	32,227	1.028113	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,120,460	99,741	1,220,201	0.191746	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,395,718	1,261	5,396,979	0.136757	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,428,369	106,413	5,534,782	0.163628	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,241,610	70,816	2,312,426	0.312426	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,544,783	24,579	1,569,362	0.245926	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,259,483	839	3,260,322	0.280572	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,638	0	17,638	0.336716	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,747,255	0	3,747,255	0.459814	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,022,732	0	1,022,732	0.286410	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	44,796,646	318,860	45,115,506			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	44,796,646	318,860	45,115,506			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
60.00	06000	LABORATORY	0.000000			60.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		578,382	0	578,382	11,267	51.33	30.00
200.00	Total (lines 30 through 199)		578,382		578,382	11,267		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,395	71,605				
200.00	Total (lines 30 through 199)		1,395	71,605				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Prepared: 6/26/2020 12:27 pm		
				Title XVIII		Hospital		PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,929	1,256,200	0.003128	93,324	292	54.00
57.00	05700	CT SCAN	21	32,227	0.000652	9,540	6	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	19,989	1,220,201	0.016382	218,086	3,573	60.00
65.00	06500	RESPIRATORY THERAPY	28,132	5,396,979	0.005213	547,778	2,856	65.00
66.00	06600	PHYSICAL THERAPY	54,864	5,534,782	0.009913	205,864	2,041	66.00
67.00	06700	OCCUPATIONAL THERAPY	56,353	2,312,426	0.024370	240,812	5,869	67.00
68.00	06800	SPEECH PATHOLOGY	13,070	1,569,362	0.008328	151,185	1,259	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	23,579	3,260,322	0.007232	599,670	4,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	152	17,638	0.008618	10,366	89	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,850	3,747,255	0.013303	596,652	7,937	73.00
74.00	07400	RENAL DIALYSIS	6,907	1,022,732	0.006753	171,529	1,158	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	256,846	25,370,124		2,844,806	29,417	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 52-2005		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part III Date/Time Prepared: 6/26/2020 12:27 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments 1A	Nursing School 1.00	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2.00	All Other Medical Education Cost 3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6) 7.00	Inpatient Program Days 8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	11,267	0.00	1,395	30.00		
200.00		Total (lines 30 through 199)	0	0	11,267		1,395	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 12:27 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 52-2005		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part IV Date/Time Prepared: 6/26/2020 12:27 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,256,200	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	32,227	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	1,220,201	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,396,979	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,534,782	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,312,426	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,569,362	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,260,322	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	17,638	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,747,255	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,022,732	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	25,370,124		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part IV
Date/Time Prepared:
6/26/2020 12:27 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	93,324	0	2,095	0	54.00	
57.00	05700 CT SCAN	0.000000	9,540	0	0	0	57.00	
58.00	05800 MRI	0.000000	0	0	0	0	58.00	
60.00	06000 LABORATORY	0.000000	218,086	0	33,598	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	547,778	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	205,864	0	7,262	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	240,812	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	151,185	0	0	0	68.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	599,670	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,366	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	596,652	0	0	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	171,529	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES						95.00	
200.00	Total (lines 50 through 199)		2,844,806	0	42,955	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 12:27 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094474	2,095	0	0	198	54.00
57.00	05700	CT SCAN	1.028113	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.191746	33,598	0	0	6,442	60.00
65.00	06500	RESPIRATORY THERAPY	0.136757	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.163628	7,262	0	0	1,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.312426	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.245926	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.280572	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336716	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459814	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.286410	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		42,955	0	0	7,828	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		42,955	0	0	7,828	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 52-2005		Period: From 01/01/2019 To 12/31/2019		Worksheet D Part V Date/Time Prepared: 6/26/2020 12:27 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0					54.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	0	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	0	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0					67.00
68.00	06800	SPEECH PATHOLOGY	0	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 12:27 pm

			Title XIX		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.094474	0	4,640	0	0	54.00
57.00	05700	CT SCAN	1.028113	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.191746	0	51,056	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.136757	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.163628	0	29,889	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.312426	0	17,827	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.245926	0	13,538	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.280572	0	28	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.336716	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.459814	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.286410	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	116,978	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	116,978	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet D
Part V
Date/Time Prepared:
6/26/2020 12:27 pm

				Title XIX	Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	438	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	9,790	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	4,891	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,570	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,329	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	24,026	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	24,026	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/26/2020 12:27 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		11,267	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,267	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)		11,267	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,395	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	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 reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,982,034	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,982,034	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
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
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	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,982,034	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)		885.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,235,900	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)		1,235,900	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
6/26/2020 12:27 pm

		Title XVIII		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					776,673	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,012,573	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					71,605	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					29,417	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					101,022	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,911,551	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	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)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
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)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	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)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
6/26/2020 12:27 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	578,382	9,982,034	0.057942	0	90.00
91.00	Nursing School cost	0	9,982,034	0.000000	0	91.00
92.00	Allied health cost	0	9,982,034	0.000000	0	92.00
93.00	All other Medical Education	0	9,982,034	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared: 6/26/2020 12:27 pm
Cost Center Description		Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			11,267 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			11,267 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)			11,267 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			3,158 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 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 reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			9,957,599 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			9,957,599 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
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
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 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			9,957,599 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)			883.78 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,790,977 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)			2,790,977 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
6/26/2020 12:27 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,319,704	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,110,681	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					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 excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
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)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
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)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
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)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet D-1

Date/Time Prepared:
6/26/2020 12:27 pm

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	578,382	9,957,599	0.058084	0	0	90.00
91.00	Nursing School cost	0	9,957,599	0.000000	0	0	91.00
92.00	Allied health cost	0	9,957,599	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,957,599	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/26/2020 12:27 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,150,092		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.094474	93,324	8,817	54.00
57.00	05700 CT SCAN	1.028113	9,540	9,808	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.191746	218,086	41,817	60.00
65.00	06500 RESPIRATORY THERAPY	0.136757	547,778	74,912	65.00
66.00	06600 PHYSICAL THERAPY	0.163628	205,864	33,685	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.312426	240,812	75,236	67.00
68.00	06800 SPEECH PATHOLOGY	0.245926	151,185	37,180	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.280572	599,670	168,251	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.336716	10,366	3,490	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.459814	596,652	274,349	73.00
74.00	07400 RENAL DIALYSIS	0.286410	171,529	49,128	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,844,806	776,673	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		2,844,806		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet D-3 Date/Time Prepared: 6/26/2020 12:27 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,276,716		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.094474	52,241	4,935	54.00
57.00	05700 CT SCAN	1.028113	18,262	18,775	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.191746	267,397	51,272	60.00
65.00	06500 RESPIRATORY THERAPY	0.136757	1,462,269	199,976	65.00
66.00	06600 PHYSICAL THERAPY	0.163628	502,085	82,155	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.312426	552,872	172,732	67.00
68.00	06800 SPEECH PATHOLOGY	0.245926	366,272	90,076	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.280572	709,103	198,954	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.336716	3,760	1,266	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.459814	889,806	409,145	73.00
74.00	07400 RENAL DIALYSIS	0.286410	315,693	90,418	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,139,760	1,319,704	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		5,139,760		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/26/2020 12:27 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,828	2.00
3.00	OPPS payments		182	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		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	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		182	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		36	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		146	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		146	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		146	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		495	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		322	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		468	36.00
37.00	Subtotal (see instructions)		468	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		468	40.00
40.01	Sequestration adjustment (see instructions)		9	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		142	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		317	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet E-1
Part I
Date/Time Prepared:
6/26/2020 12:27 pm

		Title XVIII		Hospital	PPS	
		Inpatient Part A		Part 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		1,515,990		142	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)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,515,990		142	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		317	6.01
6.02	SETTLEMENT TO PROGRAM		120,531		0	6.02
7.00	Total Medicare program liability (see instructions)		1,395,459		459	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part IV Date/Time Prepared: 6/26/2020 12:27 pm
		Title XVIII	Hospital	PPS
			1.00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		1,235,175	1.00
1.01	Full standard payment amount		924,252	1.01
1.02	Short stay outlier standard payment amount		290,322	1.02
1.03	Site neutral payment amount - Cost		0	1.03
1.04	Site neutral payment amount - IPPS comparable		20,601	1.04
2.00	Outlier Payments		291,752	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		1,526,927	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		1,526,927	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		1,526,927	9.00
10.00	Deductibles		6,796	10.00
11.00	Subtotal (line 9 minus line 10)		1,520,131	11.00
12.00	Coinsurance		151,230	12.00
13.00	Subtotal (line 11 minus line 12)		1,368,901	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		84,672	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		55,037	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		37,315	16.00
17.00	Subtotal (sum of lines 13 and 15)		1,423,938	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		1,423,938	22.00
22.01	Sequestration adjustment (see instructions)		28,479	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		1,515,990	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		-120,531	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		291,752	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Prepared: 6/26/2020 12:27 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		4,110,681		1.00
2.00	Medical and other services			24,026	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4,110,681	24,026	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)		4,110,681	24,026	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		6,276,716		8.00
9.00	Ancillary service charges		5,139,760	116,978	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		11,416,476	116,978	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
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)		11,416,476	116,978	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		7,305,795	92,952	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		4,110,681	24,026	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		4,110,681	24,026	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4,110,681	24,026	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		4,110,681	24,026	36.00
37.00	ELIMINATE COST SETTLEMENT		-4,110,681	-24,026	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0		40.00
41.00	Interim payments		0		41.00
42.00	Balance due provider/program (line 40 minus line 41)		0		42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0		43.00

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

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet G

Date/Time Prepared:
6/26/2020 12:27 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	277,130	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,717,774	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-567,065	0	0	0	6.00
7.00	Inventory	201,597	0	0	0	7.00
8.00	Prepaid expenses	21,111	0	0	0	8.00
9.00	Other current assets	-6,987,978	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-1,337,431	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	1,507,963	0	0	0	17.00
18.00	Accumulated depreciation	-637,184	0	0	0	18.00
19.00	Fixed equipment	290,159	0	0	0	19.00
20.00	Accumulated depreciation	-283,401	0	0	0	20.00
21.00	Automobiles and trucks	166,547	0	0	0	21.00
22.00	Accumulated depreciation	-54,356	0	0	0	22.00
23.00	Major movable equipment	933,350	0	0	0	23.00
24.00	Accumulated depreciation	-765,965	0	0	0	24.00
25.00	Minor equipment depreciable	362,365	0	0	0	25.00
26.00	Accumulated depreciation	-360,511	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	1,158,967	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	-178,464	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,212,516	0	0	0	37.00
38.00	Salaries, wages, and fees payable	418,318	0	0	0	38.00
39.00	Payroll taxes payable	91,441	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,201,958	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,924,233	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,924,233	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-3,102,697	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-3,102,697	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	-178,464	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-1

Date/Time Prepared:
6/26/2020 12:27 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-2,764,695		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-338,003				2.00
3.00	Total (sum of line 1 and line 2)		-3,102,698		0		3.00
4.00	ROUNDING	1		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1		0		10.00
11.00	Subtotal (line 3 plus line 10)		-3,102,697		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-3,102,697		0		19.00
		Endowment Fund		Plant 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	ROUNDING		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
6/26/2020 12:27 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	20,768,114		20,768,114	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	20,768,114		20,768,114	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,768,114		20,768,114	17.00
18.00	Ancillary services	24,347,393	0	24,347,393	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN CHARGES	0	54,716	54,716	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	45,115,507	54,716	45,170,223	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,060,757		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		18,060,757		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2019
To 12/31/2019

Worksheet G-3

Date/Time Prepared:
6/26/2020 12:27 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	45,170,223	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,350,717	2.00
3.00	Net patient revenues (line 1 minus line 2)	16,819,506	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,060,757	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,241,251	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	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	33,398	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	204	16.00
17.00	Revenue from sale of drugs to other than patients	141,173	17.00
18.00	Revenue from sale of medical records and abstracts	440	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	547	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	2,618	21.00
22.00	Rental of hospital space	377,500	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	-86,861	24.00
24.01	LAKEVIEW CARE PARTNERS INCOME	389,877	24.01
24.02	EMS INCOME	44,352	24.02
25.00	Total other income (sum of lines 6-24)	903,248	25.00
26.00	Total (line 5 plus line 25)	-338,003	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-338,003	29.00