

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 01/01/2020 To 12/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/30/2021 5:13 pm
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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 01/01/2020 and ending 12/31/2020 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	-79,244	1,016	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	-79,244	1,016	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 01/01/2020 To 12/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/30/2021 5:13 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)						01/01/2020	12/31/2020	
21.00	Type of Control (see instructions)						4		
							1.00	2.00	
							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		
22.01	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		
22.02	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		
22.03	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	
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		
				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

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From 01/01/2020
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Part I
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	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	
Prospective Payment System (PPS)-Capital								
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
Teaching Hospitals								
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

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Part I
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	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		
64.00 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. 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

Worksheet S-2
Part I
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MCRIF32 - 16.10.172.3

MCRIF32 - 16.10.172.3

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		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:	87,464	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

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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			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				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			166.00
								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		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 5:13 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.		Y	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	05/06/2021	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 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 5:13 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	
				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.	MARK	PATTON	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	MARKPATTON@HRPLLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/30/2021 5:13 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.	DIRECTOR		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 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 5:13 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	40	14,834	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)		40	14,834	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)		40	14,834	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)		40			0	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)		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 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 5:13 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)	1,360	3,646	11,165			1.00
2.00	HMO and other (see instructions)	585	2,313				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)	1,360	3,646	11,165			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)	1,360	3,646	11,165	0.00	183.49	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	183.49	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	0					33.00
33.01	LTCH site neutral days and discharges	149					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/30/2021 5:13 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	45	60	241	1.00
2.00 HMO and other (see instructions)			16	51		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	45	60	241	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			0			33.00
33.01 LTCH site neutral days and discharges			2			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/30/2021 5:13 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati 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	1,496,434	1,496,434	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	271,989	271,989	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	398,914	723,736	1,122,650	-10,754	1,111,896	4.00
5.01	00550	DATA PROCESSING	108,362	107,579	215,941	0	215,941	5.01
5.02	00590	ADMITTING	116,353	10,490	126,843	0	126,843	5.02
5.03	00591	BUSINESS OFFICE	489,496	2,302,324	2,791,820	-1,775,947	1,015,873	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	750,674	814,034	1,564,708	112,481	1,677,189	5.04
6.00	00600	MAINTENANCE & REPAIRS	336,871	602,904	939,775	0	939,775	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	251,714	62,828	314,542	0	314,542	9.00
10.00	01000	DIETARY	326,186	304,430	630,616	0	630,616	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,101	404,955	432,056	-360,356	71,700	14.00
15.00	01500	PHARMACY	397,270	705,205	1,102,475	-13,475	1,089,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	43,832	52,984	96,816	-7,427	89,389	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,201,335	3,371,890	7,573,225	-459,943	7,113,282	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	35,076	35,076	16,213	51,289	54.00
57.00	05700	CT SCAN	0	0	0	16,417	16,417	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	40,365	100,643	141,008	-29,370	111,638	60.00
65.00	06500	RESPIRATORY THERAPY	376,023	66,634	442,657	-36,296	406,361	65.00
66.00	06600	PHYSICAL THERAPY	348,158	85,383	433,541	-1,632	431,909	66.00
67.00	06700	OCCUPATIONAL THERAPY	279,458	7,205	286,663	0	286,663	67.00
68.00	06800	SPEECH PATHOLOGY	182,698	2,667	185,365	-40	185,325	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	521,569	521,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,979	1,979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	87,952	87,952	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	147,204	147,204	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)	8,674,810	9,760,967	18,435,777	-23,002	18,412,775	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	133,253	13,324	146,577	-47,785	98,792	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	5,918	5,918	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	0	54,562	54,562	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	10,307	10,307	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	8,808,063	9,774,291	18,582,354	0	18,582,354	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet A

Date/Time Prepared:
7/30/2021 5:13 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	1,496,434	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-450	271,539	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,831	1,109,065	4.00
5.01	00550	DATA PROCESSING	0	215,941	5.01
5.02	00590	ADMITTING	0	126,843	5.02
5.03	00591	BUSINESS OFFICE	-5,886	1,009,987	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	226,595	1,903,784	5.04
6.00	00600	MAINTENANCE & REPAIRS	-23,901	915,874	6.00
7.00	00700	OPERATION OF PLANT	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	314,542	9.00
10.00	01000	DIETARY	-28,762	601,854	10.00
11.00	01100	CAFETERIA	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,700	14.00
15.00	01500	PHARMACY	0	1,089,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-146	89,243	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-607,732	6,505,550	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,289	54.00
57.00	05700	CT SCAN	0	16,417	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	111,638	60.00
65.00	06500	RESPIRATORY THERAPY	0	406,361	65.00
66.00	06600	PHYSICAL THERAPY	0	431,909	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	286,663	67.00
68.00	06800	SPEECH PATHOLOGY	0	185,325	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-3,357	518,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	87,952	73.00
74.00	07400	RENAL DIALYSIS	0	147,204	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)	-446,470	17,966,305	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	98,792	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	5,918	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	54,562	194.03
194.04	07954	EMS/AMBULANCE	0	10,307	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-446,470	18,135,884	200.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/30/2021 5:13 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	68,828		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	87,788		2.00
	0		0	156,616		
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	521,569		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,979		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	523,548		
	C - RECLASS INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78,454		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	144,000		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	37,157		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,044		4.00
	0		0	262,655		
	D - RECLASS OUTPATIENT SALARIES					
1.00		0.00	0	0		1.00
	0		0	0		
	E - RECLASS PURCHASED SERVICES					
1.00	ADMINISTRATIVE AND GENERAL	5.04	0	118,399		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,213		2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	87,952		3.00
4.00	RENAL DIALYSIS	74.00	0	147,204		4.00
5.00	LAKEVIEW CARE PARTNERS (CBRF)	194.03	0	14,013		5.00
	0		0	383,781		
	F - MED DIRECTOR TO CLINIC					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	12,500	1,077		1.00
4.00	ADULTS & PEDIATRICS	30.00	14,136	1,378		4.00
	0		26,636	2,455		
	G - LAB					
1.00	LABORATORY	60.00	0	19,134		1.00
	0		0	19,134		
	H - OVERHEAD COST ALLOCATION					
1.00	LAKEVIEW CARE PARTNERS (CBRF)	194.03	40,549	0		1.00
2.00	EMS/AMBULANCE	194.04	10,307	0		2.00
3.00		0.00	0	0		3.00
	0		50,856	0		
	I - RECLASS CT SCAN AND MRI COST					
1.00	CT SCAN	57.00	0	16,417		1.00
	0		0	16,417		
	M - EMPLOYEE HEALTH					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	40,259	4,026		1.00
	0		40,259	4,026		
	N - MARKETING DEPARTMENT					
1.00	MARKETING DEPARTMENT	194.01	0	564		1.00
4.00	MARKETING DEPARTMENT	194.01	3,964	1,390		4.00
	0		3,964	1,954		
	O - RENTAL RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,349,152		1.00
	0		0	1,349,152		
500.00	Grand Total: Increases		121,715	2,719,738		500.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-6

Date/Time Prepared:
7/30/2021 5:13 pm

	Decreases						7/30/2021 5:13 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	156,616	9		1.00
2.00		0.00	0	0	9		2.00
			0	156,616			
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	360,356	0		1.00
2.00	PHARMACY	15.00	0	13,475	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	61,682	0		3.00
4.00	LABORATORY	60.00	0	48,504	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	36,296	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	1,632	0		6.00
7.00	SPEECH PATHOLOGY	68.00	0	40	0		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,563	0		8.00
			0	523,548			
	C - RECLASS INSURANCE						
1.00	BUSINESS OFFICE	5.03	0	262,655	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	262,655			
	D - RECLASS OUTPATIENT SALARIES						
1.00		0.00	0	0	0		1.00
			0	0			
	E - RECLASS PURCHASED SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	0	383,781	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
			0	383,781			
	F - MED DIRECTOR TO CLINIC						
1.00	ADULTS & PEDIATRICS	30.00	12,500	1,077	0		1.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	14,136	1,378	0		4.00
			26,636	2,455			
	G - LAB						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,134	0		1.00
			0	19,134			
	H - OVERHEAD COST ALLOCATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	35,905	0	0		1.00
2.00	BUSINESS OFFICE	5.03	7,524	0	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	7,427	0	0		3.00
			50,856	0			
	I - RECLASS CT SCAN AND MRI COST						
1.00	ADULTS & PEDIATRICS	30.00	0	16,417	0		1.00
			0	16,417			
	M - EMPLOYEE HEALTH						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	40,259	4,026	0		1.00
			40,259	4,026			
	N - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE AND GENERAL	5.04	0	564	0		1.00
4.00	ADMINISTRATIVE AND GENERAL	5.04	3,964	1,390	0		4.00
			3,964	1,954			
	O - RENTAL RECLASS						
1.00	BUSINESS OFFICE	5.03	0	1,349,152	10		1.00
			0	1,349,152			
500.00	Grand Total: Decreases		121,715	2,719,738			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/30/2021 5:13 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	1,798,123	448,030	0	448,030	0	2.00	
3.00	Buildings and Fixtures	0	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	1,361,161	439,294	0	439,294	0	6.00	
7.00	HIT designated Assets	101,101	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	3,260,385	887,324	0	887,324	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	3,260,385	887,324	0	887,324	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	2,246,153	0				2.00	
3.00	Buildings and Fixtures	0	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	1,800,455	0				6.00	
7.00	HIT designated Assets	101,101	0				7.00	
8.00	Subtotal (sum of lines 1-7)	4,147,709	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	4,147,709	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/30/2021 5:13 pm

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 01/01/2020
To 12/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/30/2021 5:13 pm

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	2,246,153	0	2,246,153	0.541541	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,901,556	0	1,901,556	0.458459	0	2.00
3.00	Total (sum of lines 1-2)	4,147,709	0	4,147,709	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	68,828	1,349,152	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	87,338	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	156,166	1,349,152	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	78,454	0	0	1,496,434	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,044	37,157	144,000	0	271,539	2.00
3.00	Total (sum of lines 1-2)	3,044	115,611	144,000	0	1,767,973	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/30/2021 5:13 pm

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	2.00	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	-2,749	MAINTENANCE & REPAIRS	6.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-21,152	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	-217,531			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	288,858			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-23,785	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	-146	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	-4,977	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	MISCELLANEOUS INCOME	B	-4,735	ADMINISTRATIVE AND GENERAL	5.04	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet A-8

Date/Time Prepared:
7/30/2021 5:13 pm

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	2.00	3.00	4.00	5.00	
33.01	NONALLOWABLE PENALTIES	A	-5,886	BUSINESS OFFICE	5.03	0	33.01
33.02	HOSPITAL ASSESSMENT	A	-390,201	ADULTS & PEDIATRICS	30.00	0	33.02
34.00	PATIENT TELEPHONE SALARY	A	-18,801	ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	PATIENT TELEPHONE BENEFITS	A	-2,831	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	PATIENT TELEPHONE DEPRECIATION	A	-450	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
39.00	NON-ALLOWABLE MARKETING	A	-38,727	ADMINISTRATIVE AND GENERAL	5.04	0	39.00
41.00	MEDICAL SUPPLY REFUND	B	-3,357	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	41.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
44.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.03
44.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.04
44.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-446,470				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 01/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/30/2021 5:13 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	929,008	640,150	1.00
2.00	194.03	LAKEVIEW CARE PARTNERS (CBRF	SHARED SERVICES	54,562	54,562	2.00
3.00	194.04	EMS/AMBULANCE	SHARED SERVICES	5,681	5,681	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			989,251	700,393	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	Name	Percentage of Ownership	
	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	LAKEVIEW CARE P	100.00	7.00
8.00			0.00		0.00	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 01/01/2020
To 12/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/30/2021 5:13 pm

	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	288,858	0		1.00
2.00	0	10		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	288,858			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	CBRF OWNER		7.00
8.00			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 01/01/2020
To 12/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/30/2021 5:13 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	AGGREGATE-ADULTS & PEDIATRICS	357,548	179,859	177,689	211,500	1,377	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			357,548	179,859	177,689		1,377	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	AGGREGATE-ADULTS & PEDIATRICS	140,017	7,001	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			140,017	7,001	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	AGGREGATE-ADULTS & PEDIATRICS	0	140,017	37,672	217,531		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	140,017	37,672	217,531		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
Date/Time Prepared:
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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	1,496,434	1,496,434			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	271,539		271,539		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,109,065	6,377	1,861	1,117,303	4.00
5.01	00550	DATA PROCESSING	215,941	0	1,128	14,405	5.01
5.02	00590	ADMITTING	126,843	9,530	0	15,468	5.02
5.03	00591	BUSINESS OFFICE	1,009,987	29,952	349	64,071	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	1,903,784	323,037	111,874	99,265	5.04
6.00	00600	MAINTENANCE & REPAIRS	915,874	516,461	32,034	44,782	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,919	493	0	8.00
9.00	00900	HOUSEKEEPING	314,542	16,973	0	33,462	9.00
10.00	01000	DIETARY	601,854	86,104	8,666	43,362	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,700	3,107	0	3,603	14.00
15.00	01500	PHARMACY	1,089,000	10,488	0	52,811	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89,243	63,432	0	4,840	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,505,550	180,508	81,931	558,729	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,289	0	609	0	54.00
57.00	05700	CT SCAN	16,417	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	111,638	2,149	12,151	5,366	60.00
65.00	06500	RESPIRATORY THERAPY	406,361	7,545	3,087	49,987	65.00
66.00	06600	PHYSICAL THERAPY	431,909	46,373	717	46,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	286,663	54,416	0	37,150	67.00
68.00	06800	SPEECH PATHOLOGY	185,325	5,201	0	24,287	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	518,212	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,979	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	87,952	0	2,906	0	73.00
74.00	07400	RENAL DIALYSIS	147,204	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	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,966,305	1,387,572	257,806	1,097,871	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	98,792	25,647	13,733	12,145	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	5,918	0	0	527	194.01
194.02	07952	OTHER NONALLOWABLE	0	1,946	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	54,562	81,269	0	5,390	194.03
194.04	07954	EMS/AMBULANCE	10,307	0	0	1,370	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,135,884	1,496,434	271,539	1,117,303	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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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	158,316					5.02
5.03	00591	BUSINESS OFFICE	0	1,118,927				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	0	2,470,334	2,470,334		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,530,194	241,561	1,771,755	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	28,031	4,425	75,150	8.00
9.00	00900	HOUSEKEEPING	0	0	364,977	57,616	49,212	9.00
10.00	01000	DIETARY	0	0	744,842	117,583	249,651	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	83,266	13,145	9,007	14.00
15.00	01500	PHARMACY	0	0	1,160,392	183,183	30,408	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	159,134	25,121	183,914	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	75,526	533,733	7,992,632	1,261,739	523,365	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	2,517	17,792	72,207	11,399	0	54.00
57.00	05700	CT SCAN	65	456	16,938	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	5,347	37,795	176,065	27,794	6,231	60.00
65.00	06500	RESPIRATORY THERAPY	15,345	108,462	595,643	94,030	21,875	65.00
66.00	06600	PHYSICAL THERAPY	12,650	89,418	659,724	104,146	134,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,753	61,868	448,850	70,857	157,773	67.00
68.00	06800	SPEECH PATHOLOGY	5,995	42,378	268,042	42,314	15,080	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,155	64,713	592,080	93,468	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35	250	2,264	357	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,787	146,929	258,574	40,819	0	73.00
74.00	07400	RENAL DIALYSIS	2,141	15,133	166,097	26,221	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)	158,316	1,118,927	17,790,286	2,415,778	1,456,119	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	161,648	25,518	74,360	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	6,445	1,017	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	1,946	307	5,644	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	160,645	25,360	235,632	194.03
194.04	07954	EMS/AMBULANCE	0	0	14,914	2,354	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)	158,316	1,118,927	18,135,884	2,470,334	1,771,755	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
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
7.00	00700	OPERATION OF PLANT	0					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,606				8.00
9.00	00900	HOUSEKEEPING	0	2,958	474,763			9.00
10.00	01000	DIETARY	0	1,846	71,947	1,185,869		10.00
11.00	01100	CAFETERIA	0	0	0	203,781	203,781	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,596	0	1,536	14.00
15.00	01500	PHARMACY	0	0	8,763	0	8,308	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	53,002	0	1,444	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	100,767	150,829	580,856	158,446	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	0	1,796	0	1,551	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,304	0	10,504	65.00
66.00	06600	PHYSICAL THERAPY	0	0	38,748	0	7,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	45,469	0	6,327	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	4,346	0	3,440	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						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)	0	105,571	383,800	784,637	199,219	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	21,430	0	2,795	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	415	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	1,626	5,636	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	2,035	67,907	395,596	1,106	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	246	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)	0	107,606	474,763	1,185,869	203,781	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
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
7.00	00700	OPERATION OF PLANT						7.00
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	109,550					14.00
15.00	01500	PHARMACY	620	1,391,674				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	215	0	422,830			16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,215	0	201,695	10,973,544	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	6,723	90,329	0	54.00
57.00	05700	CT SCAN	0	0	172	17,110	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	149	0	14,282	227,868	0	60.00
65.00	06500	RESPIRATORY THERAPY	29	0	40,986	769,371	0	65.00
66.00	06600	PHYSICAL THERAPY	3,953	0	33,789	982,476	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	388	0	23,379	753,043	0	67.00
68.00	06800	SPEECH PATHOLOGY	56	0	16,014	349,292	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100,492	0	24,454	810,494	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	381	0	95	3,097	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,391,674	55,522	1,746,589	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	5,719	198,037	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)	109,498	1,391,674	422,830	16,921,250	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	52	0	0	285,803	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	7,877	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	15,159	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	0	888,281	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	17,514	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	109,550	1,391,674	422,830	18,135,884	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part I
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Cost Center Description		Total	
		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
7.00	00700	OPERATION OF PLANT	7.00
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
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	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
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
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
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		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet B
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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	6,377	1,861	8,238	4.00
5.01	00550	DATA PROCESSING	0	0	1,128	1,128	5.01
5.02	00590	ADMITTING	0	9,530	0	9,530	5.02
5.03	00591	BUSINESS OFFICE	0	29,952	349	30,301	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	-8,431	323,037	111,874	426,480	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	516,461	32,034	548,495	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,919	493	26,412	8.00
9.00	00900	HOUSEKEEPING	0	16,973	0	16,973	9.00
10.00	01000	DIETARY	0	86,104	8,666	94,770	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,107	0	3,107	14.00
15.00	01500	PHARMACY	0	10,488	0	10,488	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,432	0	63,432	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	180,508	81,931	262,439	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	609	609	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	2,149	12,151	14,300	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,545	3,087	10,632	65.00
66.00	06600	PHYSICAL THERAPY	0	46,373	717	47,090	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	54,416	0	54,416	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,201	0	5,201	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	2,906	2,906	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)	-8,431	1,387,572	257,806	1,636,947	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	25,647	13,733	39,380	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	1,946	0	1,946	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	81,269	0	81,269	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	201.00
202.00		TOTAL (sum lines 118 through 201)	-8,431	1,496,434	271,539	1,759,542	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

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From 01/01/2020
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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	1,234					5.01
5.02	00590	ADMITTING	35	9,679				5.02
5.03	00591	BUSINESS OFFICE	78	0	30,851			5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	173	0	0	427,385		5.04
6.00	00600	MAINTENANCE & REPAIRS	112	0	0	41,791	590,728	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9	0	0	766	25,056	8.00
9.00	00900	HOUSEKEEPING	0	0	0	9,968	16,408	9.00
10.00	01000	DIETARY	26	0	0	20,342	83,237	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26	0	0	2,274	3,003	14.00
15.00	01500	PHARMACY	43	0	0	31,691	10,138	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9	0	0	4,346	61,320	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	299	4,613	14,724	218,293	174,497	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	154	490	1,972	0	54.00
57.00	05700	CT SCAN	0	4	13	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	9	327	1,042	4,809	2,077	60.00
65.00	06500	RESPIRATORY THERAPY	26	939	2,989	16,268	7,293	65.00
66.00	06600	PHYSICAL THERAPY	173	774	2,464	18,018	44,829	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	536	1,705	12,259	52,604	67.00
68.00	06800	SPEECH PATHOLOGY	26	367	1,168	7,320	5,028	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	560	1,783	16,170	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2	7	62	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,272	4,049	7,062	0	73.00
74.00	07400	RENAL DIALYSIS	9	131	417	4,536	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)	1,053	9,679	30,851	417,947	485,490	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60	0	0	4,415	24,793	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	176	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	53	1,882	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	104	0	0	4,387	78,563	194.03
194.04	07954	EMS/AMBULANCE	17	0	0	407	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)	1,234	9,679	30,851	427,385	590,728	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
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Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
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
7.00	00700	OPERATION OF PLANT	0					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,243				8.00
9.00	00900	HOUSEKEEPING	0	1,436	45,032			9.00
10.00	01000	DIETARY	0	896	6,824	206,415		10.00
11.00	01100	CAFETERIA	0	0	0	35,471	35,471	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	246	0	267	14.00
15.00	01500	PHARMACY	0	0	831	0	1,446	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	5,027	0	251	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	48,923	14,308	101,105	27,582	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	0	170	0	270	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	598	0	1,828	65.00
66.00	06600	PHYSICAL THERAPY	0	0	3,675	0	1,334	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,313	0	1,101	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	412	0	599	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						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)	0	51,255	36,404	136,576	34,678	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,033	0	486	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	72	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	154	981	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	988	6,441	68,858	192	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	43	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)	0	52,243	45,032	206,415	35,471	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
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Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
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
7.00	00700	OPERATION OF PLANT						7.00
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	8,950					14.00
15.00	01500	PHARMACY	51	55,077				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18	0	134,439			16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	263	0	64,122	935,286	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	2,138	5,363	0	54.00
57.00	05700	CT SCAN	0	0	55	72	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	12	0	4,541	27,597	0	60.00
65.00	06500	RESPIRATORY THERAPY	2	0	13,033	53,977	0	65.00
66.00	06600	PHYSICAL THERAPY	323	0	10,745	129,766	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	32	0	7,434	134,674	0	67.00
68.00	06800	SPEECH PATHOLOGY	5	0	5,092	25,397	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,209	0	7,776	34,498	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31	0	30	132	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55,077	17,655	88,021	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,818	6,911	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)	8,946	55,077	134,439	1,441,694	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4	0	0	71,261	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	252	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	5,016	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	0	240,842	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	477	0	194.04
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,950	55,077	134,439	1,759,542	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet B
Part II
Date/Time Prepared:
7/30/2021 5:13 pm

Cost Center Description		Total	
		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
7.00	00700	OPERATION OF PLANT	7.00
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
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	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
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
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
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		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
7/30/2021 5:13 pm

	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				
	GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	192,198				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,803,367			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	819	12,357	8,404,795		4.00
5.01	00550	DATA PROCESSING	0	7,490	108,362	143	5.01
5.02	00590	ADMITTING	1,224	0	116,353	4	44,241,478
5.03	00591	BUSINESS OFFICE	3,847	2,318	481,972	9	0
5.04	00592	ADMINISTRATIVE AND GENERAL	41,490	742,986	746,710	20	0
6.00	00600	MAINTENANCE & REPAIRS	66,333	212,749	336,871	13	0
7.00	00700	OPERATION OF PLANT	0	0	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	3,329	3,274	0	1	0
9.00	00900	HOUSEKEEPING	2,180	0	251,714	0	0
10.00	01000	DIETARY	11,059	57,552	326,186	3	0
11.00	01100	CAFETERIA	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	399	0	27,101	3	0
15.00	01500	PHARMACY	1,347	0	397,270	5	0
16.00	01600	MEDICAL RECORDS & LIBRARY	8,147	0	36,405	1	0
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,184	544,131	4,202,971	35	21,102,970
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
	ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,042	0	0	703,503
57.00	05700	CT SCAN	0	0	0	0	18,036
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	276	80,696	40,365	1	1,494,393
65.00	06500	RESPIRATORY THERAPY	969	20,500	376,023	3	4,288,574
66.00	06600	PHYSICAL THERAPY	5,956	4,763	348,158	20	3,535,575
67.00	06700	OCCUPATIONAL THERAPY	6,989	0	279,458	0	2,446,262
68.00	06800	SPEECH PATHOLOGY	668	0	182,698	3	1,675,626
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,558,718
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,895
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,301	0	0	5,809,555
74.00	07400	RENAL DIALYSIS	0	0	0	1	598,371
	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)	178,216	1,712,159	8,258,617	122	44,241,478
	NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,294	91,208	91,358	7	0
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0
194.01	07951	MARKETING DEPARTMENT	0	0	3,964	0	0
194.02	07952	OTHER NONALLOWABLE	250	0	0	0	0
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	10,438	0	40,549	12	0
194.04	07954	EMS/AMBULANCE	0	0	10,307	2	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,496,434	271,539	1,117,303	231,474	158,316
203.00		Unit cost multiplier (Wkst. B, Part I)	7.785898	0.150573	0.132936	1,618.699301	0.003578
204.00		Cost to be allocated (per Wkst. B, Part II)			8,238	1,234	9,679
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000980	8.629371	0.000219
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

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)	OPERATION OF PLANT (SQUARE FEET)	
		5.03	5A.04	5.04	6.00	7.00	
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	44,241,478				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	-2,470,334	15,648,612		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,530,194	78,485	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	28,031	3,329	8.00
9.00	00900	HOUSEKEEPING	0	0	364,977	2,180	9.00
10.00	01000	DIETARY	0	0	744,842	11,059	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	83,266	399	14.00
15.00	01500	PHARMACY	0	0	1,160,392	1,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	159,134	8,147	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	21,102,970	0	7,992,632	23,184	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	703,503	0	72,207	0	54.00
57.00	05700	CT SCAN	18,036	-16,938	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	1,494,393	0	176,065	276	60.00
65.00	06500	RESPIRATORY THERAPY	4,288,574	0	595,643	969	65.00
66.00	06600	PHYSICAL THERAPY	3,535,575	0	659,724	5,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,446,262	0	448,850	6,989	67.00
68.00	06800	SPEECH PATHOLOGY	1,675,626	0	268,042	668	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,558,718	0	592,080	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,895	0	2,264	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,809,555	0	258,574	0	73.00
74.00	07400	RENAL DIALYSIS	598,371	0	166,097	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)	44,241,478	-2,487,272	15,303,014	64,503	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	161,648	3,294	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	6,445	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	1,946	250	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	160,645	10,438	194.03
194.04	07954	EMS/AMBULANCE	0	0	14,914	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)	1,118,927		2,470,334	1,771,755	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.025291		0.157863	22.574441	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,851		427,385	590,728	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000697		0.027311	7.526636	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 01/01/2020
To 12/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description			LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
			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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,712					8.00
9.00	00900	HOUSEKEEPING	157	72,976				9.00
10.00	01000	DIETARY	98	11,059	68,383			10.00
11.00	01100	CAFETERIA	0	0	11,751	13,270		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	399	0	100	568,585	14.00
15.00	01500	PHARMACY	0	1,347	0	541	3,218	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,147	0	94	1,117	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,349	23,184	33,495	10,318	16,687	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	276	0	101	775	60.00
65.00	06500	RESPIRATORY THERAPY	0	969	0	684	152	65.00
66.00	06600	PHYSICAL THERAPY	0	5,956	0	499	20,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,989	0	412	2,013	67.00
68.00	06800	SPEECH PATHOLOGY	0	668	0	224	290	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	521,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,979	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)	5,604	58,994	45,246	12,973	568,315	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,294	0	182	270	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	27	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	250	325	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	108	10,438	22,812	72	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	16	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)	107,606	474,763	1,185,869	203,781	109,550	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.838585	6.505742	17.341576	15.356518	0.192671	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	52,243	45,032	206,415	35,471	8,950	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.146183	0.617080	3.018513	2.673022	0.015741	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:
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Date/Time Prepared:
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Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		15.00	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
7.00	00700	OPERATION OF PLANT		7.00
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	630,979	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	630,979	73.00
74.00	07400	RENAL DIALYSIS	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	95.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	630,979	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	194.03
194.04	07954	EMS/AMBULANCE	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)	1,391,674	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.205579	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,077	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.087288	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII	Hospital	PPS			
	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	10,973,544		10,973,544	37,672	11,011,216	30.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,329		90,329	0	90,329	54.00
57.00	05700	CT SCAN	17,110		17,110	0	17,110	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	227,868		227,868	0	227,868	60.00
65.00	06500	RESPIRATORY THERAPY	769,371	0	769,371	0	769,371	65.00
66.00	06600	PHYSICAL THERAPY	982,476	0	982,476	0	982,476	66.00
67.00	06700	OCCUPATIONAL THERAPY	753,043	0	753,043	0	753,043	67.00
68.00	06800	SPEECH PATHOLOGY	349,292	0	349,292	0	349,292	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	810,494		810,494	0	810,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,097		3,097	0	3,097	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,746,589		1,746,589	0	1,746,589	73.00
74.00	07400	RENAL DIALYSIS	198,037		198,037	0	198,037	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)	16,921,250	0	16,921,250	37,672	16,958,922	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	16,921,250	0	16,921,250	37,672	16,958,922	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
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			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	21,102,970		21,102,970			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,475	9,028	703,503	0.128399	0.000000	54.00
57.00	05700	CT SCAN	18,036	0	18,036	0.948658	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,377,347	117,046	1,494,393	0.152482	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,288,574	0	4,288,574	0.179400	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,460,318	75,257	3,535,575	0.277883	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,401,157	45,105	2,446,262	0.307834	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,648,845	26,781	1,675,626	0.208455	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,557,685	1,033	2,558,718	0.316758	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,895	0	9,895	0.312986	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,809,550	5	5,809,555	0.300641	0.000000	73.00
74.00	07400	RENAL DIALYSIS	598,371	0	598,371	0.330960	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)	43,967,223	274,255	44,241,478			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43,967,223	274,255	44,241,478			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 52-2005	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/30/2021 5:13 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	0.128399		54.00
57.00	05700	CT SCAN	0.948658		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.152482		60.00
65.00	06500	RESPIRATORY THERAPY	0.179400		65.00
66.00	06600	PHYSICAL THERAPY	0.277883		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.307834		67.00
68.00	06800	SPEECH PATHOLOGY	0.208455		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.316758		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.312986		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300641		73.00
74.00	07400	RENAL DIALYSIS	0.330960		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 01/01/2020
To 12/31/2020Worksheet 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	10,973,544		10,973,544	37,672	11,011,216	30.00	
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	90,329		90,329	0	90,329	54.00	
57.00	05700	CT SCAN	17,110		17,110	0	17,110	57.00	
58.00	05800	MRI	0		0	0	0	58.00	
60.00	06000	LABORATORY	227,868		227,868	0	227,868	60.00	
65.00	06500	RESPIRATORY THERAPY	769,371	0	769,371	0	769,371	65.00	
66.00	06600	PHYSICAL THERAPY	982,476	0	982,476	0	982,476	66.00	
67.00	06700	OCCUPATIONAL THERAPY	753,043	0	753,043	0	753,043	67.00	
68.00	06800	SPEECH PATHOLOGY	349,292	0	349,292	0	349,292	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	810,494		810,494	0	810,494	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,097		3,097	0	3,097	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,746,589		1,746,589	0	1,746,589	73.00	
74.00	07400	RENAL DIALYSIS	198,037		198,037	0	198,037	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)	16,921,250	0	16,921,250	37,672	16,958,922	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	16,921,250	0	16,921,250	37,672	16,958,922	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet C
Part I
Date/Time Prepared:
7/30/2021 5:13 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	21,102,970		21,102,970			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	694,475	9,028	703,503	0.128399	0.000000	54.00
57.00	05700	CT SCAN	18,036	0	18,036	0.948658	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,377,347	117,046	1,494,393	0.152482	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,288,574	0	4,288,574	0.179400	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,460,318	75,257	3,535,575	0.277883	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,401,157	45,105	2,446,262	0.307834	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,648,845	26,781	1,675,626	0.208455	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,557,685	1,033	2,558,718	0.316758	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,895	0	9,895	0.312986	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,809,550	5	5,809,555	0.300641	0.000000	73.00
74.00	07400	RENAL DIALYSIS	598,371	0	598,371	0.330960	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)	43,967,223	274,255	44,241,478			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	43,967,223	274,255	44,241,478			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet 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 01/01/2020
To 12/31/2020Worksheet D
Part I
Date/Time Prepared:
7/30/2021 5:13 pm

			Title XVIII		Hospital	PPS	
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	935,286	0	935,286	11,165	83.77	30.00
200.00	Total (lines 30 through 199)	935,286		935,286	11,165		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	1,360	113,927				30.00
200.00	Total (lines 30 through 199)	1,360	113,927				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part II
Date/Time Prepared:
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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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,363	703,503	0.007623	33,576	256	54.00
57.00	05700 CT SCAN	72	18,036	0.003992	10,950	44	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	27,597	1,494,393	0.018467	221,186	4,085	60.00
65.00	06500 RESPIRATORY THERAPY	53,977	4,288,574	0.012586	967,672	12,179	65.00
66.00	06600 PHYSICAL THERAPY	129,766	3,535,575	0.036703	172,108	6,317	66.00
67.00	06700 OCCUPATIONAL THERAPY	134,674	2,446,262	0.055053	219,607	12,090	67.00
68.00	06800 SPEECH PATHOLOGY	25,397	1,675,626	0.015157	134,475	2,038	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	34,498	2,558,718	0.013483	425,316	5,735	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	132	9,895	0.013340	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	88,021	5,809,555	0.015151	677,278	10,261	73.00
74.00	07400 RENAL DIALYSIS	6,911	598,371	0.011550	53,805	621	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)	506,408	23,138,508		2,915,973	53,626	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 52-2005		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part III Date/Time Prepared: 7/30/2021 5:13 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	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)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	11,165	0.00	1,360		30.00	
200.00		Total (lines 30 through 199)			0	11,165		1,360		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 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 5:13 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	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	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	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	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	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 5:13 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		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	703,503	0.000000	54.00
57.00	05700 CT SCAN	0	0	0	18,036	0.000000	57.00
58.00	05800 MRI	0	0	0	0	0.000000	58.00
60.00	06000 LABORATORY	0	0	0	1,494,393	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	4,288,574	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	3,535,575	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	2,446,262	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	1,675,626	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,558,718	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,895	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	5,809,555	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	598,371	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	23,138,508		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet D
Part IV
Date/Time Prepared:
7/30/2021 5:13 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	33,576	0	5,613	0
57.00	05700	CT SCAN	0.000000	10,950	0	0	0
58.00	05800	MRI	0.000000	0	0	0	0
60.00	06000	LABORATORY	0.000000	221,186	0	49,356	0
65.00	06500	RESPIRATORY THERAPY	0.000000	967,672	0	0	0
66.00	06600	PHYSICAL THERAPY	0.000000	172,108	0	13,697	0
67.00	06700	OCCUPATIONAL THERAPY	0.000000	219,607	0	4,290	0
68.00	06800	SPEECH PATHOLOGY	0.000000	134,475	0	4,347	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	425,316	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	677,278	0	0	0
74.00	07400	RENAL DIALYSIS	0.000000	53,805	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					
200.00		Total (lines 50 through 199)		2,915,973	0	77,303	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/30/2021 5:13 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	0.128399	5,613	0	0	721	54.00
57.00	05700	CT SCAN	0.948658	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.152482	49,356	0	0	7,526	60.00
65.00	06500	RESPIRATORY THERAPY	0.179400	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.277883	13,697	0	0	3,806	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.307834	4,290	0	0	1,321	67.00
68.00	06800	SPEECH PATHOLOGY	0.208455	4,347	0	0	906	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.316758	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.312986	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300641	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.330960	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)		77,303	0	0	14,280	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		77,303	0	0	14,280	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 52-2005		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/30/2021 5:13 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 01/01/2020
To 12/31/2020Worksheet D
Part V
Date/Time Prepared:
7/30/2021 5:13 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	0.128399	0	2,749	0	0	54.00	
57.00	05700	CT SCAN	0.948658	0	0	0	0	57.00	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.152482	0	38,558	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.179400	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.277883	0	42,201	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.307834	0	16,129	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.208455	0	13,530	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.316758	0	49	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.312986	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.300641	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.330960	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	113,216	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	113,216	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 52-2005		Period: From 01/01/2020 To 12/31/2020		Worksheet D Part V Date/Time Prepared: 7/30/2021 5:13 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	353	0					54.00
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	5,879	0					60.00
65.00	06500	RESPIRATORY THERAPY	0	0					65.00
66.00	06600	PHYSICAL THERAPY	11,727	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	4,965	0					67.00
68.00	06800	SPEECH PATHOLOGY	2,820	0					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16	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)	25,760	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	25,760	0					202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 5:13 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)		11,165	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,165	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)		11,165	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)		1,360	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)		11,011,216	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)		11,011,216	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)		11,011,216	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)		986.23	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,341,273	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)		1,341,273	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/30/2021 5:13 pm

		Title XVIII		Hospital	PPS		
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		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)					721,634	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,062,907	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)					113,927	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					53,626	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					167,553	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,895,354	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 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
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		Title XVIII		Hospital	PPS	
Cost Center Description	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	935,286	11,011,216	0.084939	0	0	90.00
91.00 Nursing School cost	0	11,011,216	0.000000	0	0	91.00
92.00 Allied health cost	0	11,011,216	0.000000	0	0	92.00
93.00 All other Medical Education	0	11,011,216	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Prepared: 7/30/2021 5:13 pm	
		Title XIX	Hospital	Cost	
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)		11,165	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,165	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)		11,165	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)		3,646	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)		10,973,544	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)		10,973,544	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)		10,973,544	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)		982.85	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,583,471	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)		3,583,471	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/30/2021 5:13 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)				1,701,499	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				5,284,970	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 01/01/2020
To 12/31/2020

Worksheet D-1

Date/Time Prepared:
7/30/2021 5:13 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	935,286	10,973,544	0.085231	0	0	90.00
91.00	Nursing School cost	0	10,973,544	0.000000	0	0	91.00
92.00	Allied health cost	0	10,973,544	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,973,544	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 5:13 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		2,826,719		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128399	33,576	4,311	54.00
57.00	05700 CT SCAN	0.948658	10,950	10,388	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.152482	221,186	33,727	60.00
65.00	06500 RESPIRATORY THERAPY	0.179400	967,672	173,600	65.00
66.00	06600 PHYSICAL THERAPY	0.277883	172,108	47,826	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.307834	219,607	67,603	67.00
68.00	06800 SPEECH PATHOLOGY	0.208455	134,475	28,032	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.316758	425,316	134,722	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.312986	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.300641	677,278	203,618	73.00
74.00	07400 RENAL DIALYSIS	0.330960	53,805	17,807	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)		2,915,973	721,634	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)		2,915,973		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Prepared: 7/30/2021 5:13 pm	
		Title XIX	Hospital	Cost	
Cost Center Description		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		8,947,351		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.128399	26,084	3,349	54.00
57.00	05700 CT SCAN	0.948658	7,086	6,722	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.152482	400,538	61,075	60.00
65.00	06500 RESPIRATORY THERAPY	0.179400	1,441,916	258,680	65.00
66.00	06600 PHYSICAL THERAPY	0.277883	530,357	147,377	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.307834	763,031	234,887	67.00
68.00	06800 SPEECH PATHOLOGY	0.208455	675,423	140,795	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.316758	985,020	312,013	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.312986	196	61	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.300641	1,550,622	466,181	73.00
74.00	07400 RENAL DIALYSIS	0.330960	212,592	70,359	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)		6,592,865	1,701,499	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)		6,592,865		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/30/2021 5:13 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)		14,280	2.00
3.00	OPPS payments		575	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 charge basis 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)		575	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)		115	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)		460	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)		460	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		460	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)		1,575	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,024	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		997	36.00
37.00	Subtotal (see instructions)		1,484	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)		1,484	40.00
40.01	Sequestration adjustment (see instructions)		10	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		458	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)		1,016	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 01/01/2020
To 12/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/30/2021 5:13 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		1,493,670		458	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)		1,493,670		458	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		1,016	6.01	
6.02	SETTLEMENT TO PROGRAM		79,244		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,414,426		1,474	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 01/01/2020 To 12/31/2020	Worksheet E-3 Part IV Date/Time Prepared: 7/30/2021 5:13 pm
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		1,345,724	1.00
1.01	Full standard payment amount		1,028,483	1.01
1.02	Short stay outlier standard payment amount		300,944	1.02
1.03	Site neutral payment amount - Cost		0	1.03
1.04	Site neutral payment amount - IPPS comparable		16,297	1.04
2.00	Outlier Payments		204,475	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		1,550,199	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)		1,550,199	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		1,550,199	9.00
10.00	Deductibles		12,584	10.00
11.00	Subtotal (line 9 minus line 10)		1,537,615	11.00
12.00	Coinsurance		118,855	12.00
13.00	Subtotal (line 11 minus line 12)		1,418,760	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		7,789	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		5,063	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,263	16.00
17.00	Subtotal (sum of lines 13 and 15)		1,423,823	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)		1,423,823	22.00
22.01	Sequestration adjustment (see instructions)		9,397	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		1,493,670	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)		-79,244	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)		204,475	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 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/30/2021 5:13 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		5,284,970		1.00
2.00	Medical and other services			25,760	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,284,970	25,760	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)		5,284,970	25,760	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		8,947,351		8.00
9.00	Ancillary service charges		6,592,865	113,216	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)		15,540,216	113,216	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)		15,540,216	113,216	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		10,255,246	87,456	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)		5,284,970	25,760	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)		5,284,970	25,760	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)		5,284,970	25,760	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)		5,284,970	25,760	36.00
37.00	ELIMINATE COST SETTLEMENT		-5,284,970	-25,760	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 01/01/2020
To 12/31/2020

Worksheet G

Date/Time Prepared:
7/30/2021 5:13 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	1,016,334	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	5,616,788	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-807,948	0	0	0	6.00
7.00	Inventory	203,906	0	0	0	7.00
8.00	Prepaid expenses	201,838	0	0	0	8.00
9.00	Other current assets	-6,986,211	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)	-755,293	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	2,246,153	0	0	0	17.00
18.00	Accumulated depreciation	-706,012	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,800,455	0	0	0	23.00
24.00	Accumulated depreciation	-1,549,110	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	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)	1,791,486	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)	1,036,193	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	325,715	0	0	0	37.00
38.00	Salaries, wages, and fees payable	773,866	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,856,755	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	79,724	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,036,060	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	56,446	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	56,446	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,092,506	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-2,056,313	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)	-2,056,313	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,036,193	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-1

Date/Time Prepared:
7/30/2021 5:13 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		-3,102,697		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,046,384				2.00
3.00	Total (sum of line 1 and line 2)		-2,056,313		0		3.00
4.00	Additions (credit adjustments) (specify)	0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-2,056,313		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)		-2,056,313		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	Additions (credit adjustments) (specify)		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 01/01/2020
To 12/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/30/2021 5:13 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	24,269,953		24,269,953	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)	24,269,953		24,269,953	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)	24,269,953		24,269,953	17.00
18.00	Ancillary services	19,971,524	0	19,971,524	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	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	44,241,477	0	44,241,477	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,582,354		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)		18,582,354		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2020
To 12/31/2020

Worksheet G-3

Date/Time Prepared:
7/30/2021 5:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,241,477	1.00
2.00	Less contractual allowances and discounts on patients' accounts	26,367,184	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,874,293	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	18,582,354	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-708,061	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	3,091	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	23,785	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	3,357	16.00
17.00	Revenue from sale of drugs to other than patients	113,966	17.00
18.00	Revenue from sale of medical records and abstracts	146	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	4,977	21.00
22.00	Rental of hospital space	427,577	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	187,199	24.00
24.01	EMS OVERHEAD	300,000	24.01
24.02	LCP OVERHEAD	44,352	24.02
24.50	COVID-19 PHE Funding	645,995	24.50
25.00	Total other income (sum of lines 6-24)	1,754,445	25.00
26.00	Total (line 5 plus line 25)	1,046,384	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)	1,046,384	29.00