

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 01/01/2021 To 12/31/2021	Worksheet S Parts I-III Date/Time Prepared: 5/31/2022 4:07 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 BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)
 MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAKEVIEW SPECIALTY HOSPT & REHAB (52-2005) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Christopher Slover	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Christopher Slover		2
3	Signatory Title	CHIEF EXECUTIVE OFFICER		3
4	Date	(Dated when report is electronica		4

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	-6,766	433	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	-6,766	433	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 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 4:07 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	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
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										3.00
5.00	Subprovider - IRF										4.00
6.00	Subprovider - (Other)										5.00
7.00	Swing Beds - SNF										6.00
8.00	Swing Beds - NF										7.00
9.00	Hospital-Based SNF										8.00
10.00	Hospital-Based NF										9.00
11.00	Hospital-Based OLTC										10.00
12.00	Hospital-Based HHA										11.00
13.00	Separately Certified ASC										12.00
14.00	Hospital-Based Hospice										13.00
15.00	Hospital-Based Health Clinic - RHC										14.00
16.00	Hospital-Based Health Clinic - FQHC										15.00
17.00	Hospital-Based (CMHC) I										16.00
18.00	Renal Dialysis										17.00
19.00	Other										18.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2021	12/31/2021		20.00	
21.00	Type of Control (see instructions)						4			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N		22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet S-2
Part I
Date/Time Prepared:
5/31/2022 4:07 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
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	24.00
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	0	25.00
					Urban/Rural S 1.00	Date of Geogr 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: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 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
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					N		
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		
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		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 52-2005		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 4:07 pm	
			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
			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
61.01	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
62.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 52-2005

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From 01/01/2021
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0
	Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 4:07 pm	
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		Y	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00	
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06	
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 4:07 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
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:	56,019	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB1836	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 52-2005		Period: From 01/01/2021 To 12/31/2021		Worksheet S-2 Part I Date/Time Prepared: 5/31/2022 4:07 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: LAKEVIEW MANAGEMENT INC.		Contractor's Name: WPS		Contractor's Number: 05901		141.00		
142.00	Street: 4814 CITY PARK ROAD		PO Box:				142.00		
143.00	City: AUSTIN		State: TX		Zip Code: 78730		143.00		
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N		146.00	
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		
156.00	Subprovider - IPF			N	N	N	N		
157.00	Subprovider - IRF			N	N	N	N		
158.00	SUBPROVIDER								
159.00	SNF			N	N	N	N		
160.00	HOME HEALTH AGENCY			N	N	N	N		
161.00	CMHC				N	N	N		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.00	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0		171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 4:07 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 a nursing program? 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 programs 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		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	03/15/2022	Y
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		N
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		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 4:07 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	20.00	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (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.	JUSTIN	LATTIMORE		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	JUSTINLATTIMORE@HRPLLC.ORG		43.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Prepared: 5/31/2022 4:07 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.	CONSULTANT		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 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 4:07 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	55	20,075	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)		55	20,075	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)		55	20,075	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)		55			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 4:07 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)	1,175	3,351	10,892			1.00
2.00	HMO and other (see instructions)	159	1,300				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)	1,175	3,351	10,892			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)	1,175	3,351	10,892	0.00	168.31	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	168.31	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	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet S-3
Part I
Date/Time Prepared:
5/31/2022 4:07 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	39	51	277	1.00
2.00 HMO and other (see instructions)			5	42		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	39	51	277	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			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/31/2022 4:07 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	2,027,189	2,027,189	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	138,002	138,002	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	264,394	866,537	1,130,931	-48,974	1,081,957	4.00
5.01	00550	DATA PROCESSING	117,645	73,754	191,399	0	191,399	5.01
5.02	00590	ADMITTING	97,047	9,995	107,042	0	107,042	5.02
5.03	00591	BUSINESS OFFICE	492,006	2,284,154	2,776,160	-1,879,492	896,668	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	838,386	798,834	1,637,220	85,693	1,722,913	5.04
6.00	00600	MAINTENANCE & REPAIRS	351,073	499,096	850,169	0	850,169	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	235,931	75,623	311,554	0	311,554	9.00
10.00	01000	DIETARY	415,439	314,406	729,845	0	729,845	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,625	204,009	231,634	-197,504	34,130	14.00
15.00	01500	PHARMACY	367,897	724,142	1,092,039	-684,450	407,589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,744	27,237	73,981	-6,123	67,858	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,302,485	5,090,613	9,393,098	-936,100	8,456,998	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	51,529	51,529	15,039	66,568	54.00
57.00	05700	CT SCAN	0	0	0	6,531	6,531	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	30,462	92,731	123,193	-31,703	91,490	60.00
65.00	06500	RESPIRATORY THERAPY	475,846	270,016	745,862	-79,783	666,079	65.00
66.00	06600	PHYSICAL THERAPY	378,142	34,822	412,964	-2,245	410,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	297,198	30,075	327,273	0	327,273	67.00
68.00	06800	SPEECH PATHOLOGY	254,171	24,050	278,221	-9	278,212	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	674,168	674,168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	238	238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	674,615	674,615	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	154,136	154,136	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)	8,992,491	11,471,623	20,464,114	-90,772	20,373,342	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	115,822	11,004	126,826	174	127,000	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	17,558	17,558	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	0	6,872	6,872	0	6,872	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	-918,630	1,344	-917,286	59,513	-857,773	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	13,527	13,527	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	8,189,683	11,490,843	19,680,526	0	19,680,526	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet A

Date/Time Prepared:
5/31/2022 4:07 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	2,027,189	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-270	137,732	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,820	1,079,137	4.00
5.01	00550	DATA PROCESSING	0	191,399	5.01
5.02	00590	ADMITTING	0	107,042	5.02
5.03	00591	BUSINESS OFFICE	-6,370	890,298	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	-212,111	1,510,802	5.04
6.00	00600	MAINTENANCE & REPAIRS	-18,680	831,489	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	311,554	9.00
10.00	01000	DIETARY	-18,343	711,502	10.00
11.00	01100	CAFETERIA	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,130	14.00
15.00	01500	PHARMACY	0	407,589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	67,858	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,742,823	6,714,175	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	66,568	54.00
57.00	05700	CT SCAN	0	6,531	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	91,490	60.00
65.00	06500	RESPIRATORY THERAPY	0	666,079	65.00
66.00	06600	PHYSICAL THERAPY	0	410,719	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	327,273	67.00
68.00	06800	SPEECH PATHOLOGY	0	278,212	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	674,168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	674,615	73.00
74.00	07400	RENAL DIALYSIS	0	154,136	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)	-2,001,417	18,371,925	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	127,000	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	17,558	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	0	6,872	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	934,844	77,071	194.03
194.04	07954	EMS/AMBULANCE	0	13,527	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,066,573	18,613,953	200.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-6

Date/Time Prepared:
5/31/2022 4:07 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	90,768		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	78,054		2.00
	0		0	168,822		
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	628,428		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	238		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	628,666		
	C - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	97,958		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	163,452		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	292,000		3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	51,570		4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8,378		5.00
	0		0	613,358		
	E - RECLASS PURCHASED SERVICES					
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	869		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	21,570		2.00
3.00	RENAL DIALYSIS	74.00	0	154,136		3.00
4.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	45,740		4.00
5.00	ADMINISTRATIVE AND GENERAL	5.04	0	106,341		5.00
6.00	LABORATORY	60.00	0	7,081		6.00
	0		0	335,737		
	F - MED DIRECTOR TO CLINIC					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	14,631	1,121		1.00
	0		14,631	1,121		
	G - COST OF DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	674,615		1.00
	0		0	674,615		
	H - OVERHEAD COST ALLOCATION					
1.00	LAKEVIEW CARE PARTNERS (CBRF)	194.03	59,513	0		1.00
2.00	EMS/AMBULANCE	194.04	13,527	0		2.00
3.00		0.00	0	0		3.00
	0		73,040	0		
	I - RECLASS CT SCAN AND MRI COST					
1.00	CT_SCAN	57.00	0	6,531		1.00
	0		0	6,531		
	M - EMPLOYEE HEALTH					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	13,483	1,281		1.00
	0		13,483	1,281		
	N - MARKETING RECLASS					
1.00	MARKETING DEPARTMENT	194.01	16,214	1,344		1.00
	TOTALS		16,214	1,344		
	O - RENTAL RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,383,011		1.00
	0		0	1,383,011		
500.00	Grand Total: Increases		117,368	3,814,486		500.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-6

Date/Time Prepared:
5/31/2022 4:07 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
	A - EQUIPMENT DEPRECIATION & AMORTIZATI					
1.00	BUSINESS OFFICE	5.03	0	168,822	9	1.00
2.00		0.00	0	0	9	2.00
	0		0	168,822		
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	197,504	0	1.00
2.00	PHARMACY	15.00	0	9,835	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	299,692	0	3.00
4.00	LABORATORY	60.00	0	38,784	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	79,783	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	2,245	0	6.00
7.00	SPEECH PATHOLOGY	68.00	0	9	0	7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	814	0	8.00
	0		0	628,666		
	C - OTHER CAPITAL COSTS					
1.00	BUSINESS OFFICE	5.03	0	318,268	12	1.00
2.00	ADMINISTRATIVE AND GENERAL	5.04	0	3,090	13	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	292,000	10	3.00
4.00		0.00	0	0	12	4.00
5.00		0.00	0	0	11	5.00
	0		0	613,358		
	E - RECLASS PURCHASED SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	0	328,656	0	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,081	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	0		0	335,737		
	F - MED DIRECTOR TO CLINIC					
1.00	ADULTS & PEDIATRICS	30.00	14,631	1,121	0	1.00
	0		14,631	1,121		
	G - COST OF DRUGS					
1.00	PHARMACY	15.00	0	674,615	0	1.00
	0		0	674,615		
	H - OVERHEAD COST ALLOCATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	56,657	0	0	1.00
2.00	BUSINESS OFFICE	5.03	9,391	0	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	6,992	0	0	3.00
	0		73,040	0		
	I - RECLASS CT SCAN AND MRI COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,531	0	1.00
	0		0	6,531		
	M - EMPLOYEE HEALTH					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	13,483	1,281	0	1.00
	0		13,483	1,281		
	N - MARKETING RECLASS					
1.00	ADMINISTRATIVE AND GENERAL	5.04	16,214	1,344	0	1.00
	TOTALS		16,214	1,344		
	O - RENTAL RECLASS					
1.00	BUSINESS OFFICE	5.03	0	1,383,011	10	1.00
	0		0	1,383,011		
500.00	Grand Total: Decreases		117,368	3,814,486		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part I
Date/Time Prepared:
5/31/2022 4:07 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	2,246,153	713,866	0	713,866	22,079	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	1,800,455	348,861	0	348,861	899,810	6.00	
7.00	HIT designated Assets	101,101	62,213	0	62,213	0	7.00	
8.00	Subtotal (sum of lines 1-7)	4,147,709	1,124,940	0	1,124,940	921,889	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	4,147,709	1,124,940	0	1,124,940	921,889	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	2,937,940	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	1,249,506	0					6.00
7.00	HIT designated Assets	163,314	0					7.00
8.00	Subtotal (sum of lines 1-7)	4,350,760	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	4,350,760	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet A-7
Part II
Date/Time Prepared:
5/31/2022 4:07 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 01/01/2021
To 12/31/2021Worksheet A-7
Part III
Date/Time Prepared:
5/31/2022 4:07 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	2,937,940	0	2,937,940	0.675271	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,412,820	0	1,412,820	0.324729	0	2.00
3.00	Total (sum of lines 1-2)	4,350,760	0	4,350,760	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	90,768	1,675,011	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	77,784	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	168,552	1,675,011	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	97,958	163,452	0	2,027,189	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,378	51,570	0	0	137,732	2.00
3.00	Total (sum of lines 1-2)	8,378	149,528	163,452	0	2,164,921	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/31/2022 4:07 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	-2,996	MAINTENANCE & REPAIRS	6.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-15,684	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	-285,453			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	-1,341,773			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-18,343	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		0	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		0	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8

Date/Time Prepared:
5/31/2022 4:07 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	
33.00	CBRF/EMS TRANSFER TO AFFILIATES	A	934,844	LAKEVIEW CARE PARTNERS (CBRF)	194.03	0	33.00
33.01	NONALLOWABLE PENALTIES	A	-3,892	BUSINESS OFFICE	5.03	0	33.01
33.02	HOSPITAL ASSESSMENT	A	-311,763	ADULTS & PEDIATRICS	30.00	0	33.02
34.00	PATIENT TELEPHONE SALARY	A	-15,945	ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	PATIENT TELEPHONE BENEFITS	A	-2,820	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	PATIENT TELEPHONE DEPRECIATION	A	-270	CAP REL COSTS-MVBLE EQUIP	2.00	9	36.00
39.00	GAIN ON SALE OF ASSET	A	-2,478	BUSINESS OFFICE	5.03	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,066,573				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 01/01/2021
To 12/31/2021

Worksheet A-8-1

Date/Time Prepared:
5/31/2022 4:07 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	HOME OFFICE COST	0	6,604	1.00
2.00	5.04	ADMINISTRATIVE AND GENERAL	PROFESSIONAL FEES	708,373	584,731	2.00
3.00	5.04	ADMINISTRATIVE AND GENERAL	PROFESSIONAL FEES	0	300,000	3.00
3.01	5.04	ADMINISTRATIVE AND GENERAL	PROFESSIONAL FEES	0	13,204	3.01
3.02	30.00	ADULTS & PEDIATRICS	LMI MANAGEMENT FEES	0	1,145,607	3.02
3.03	194.03	LAKEVIEW CARE PARTNERS (CBRF	LAKEVIEW CARE PARTNERS	59,513	59,513	3.03
4.00	194.04	EMS/AMBULANCE	LAKEVIEW EMS	13,527	13,527	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			781,413	2,123,186	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	Name	Percentage of Ownership	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	C		0.00	LAKEVIEW CARE P	100.00	7.00
8.00	C		0.00	LAKEVIEW EMS	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8-1

Date/Time Prepared:
5/31/2022 4:07 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	-6,604	0		1.00
2.00	123,642	0		2.00
3.00	-300,000	0		3.00
3.01	-13,204	0		3.01
3.02	-1,145,607	0		3.02
3.03	0	0		3.03
4.00	0	0		4.00
5.00	-1,341,773			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	EMS OWNER		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet A-8-2

Date/Time Prepared:
5/31/2022 4:07 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	432,791	236,310	196,481	211,500	1,449	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			432,791	236,310	196,481		1,449	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	147,338	7,367	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			147,338	7,367	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	147,338	49,143	285,453		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	147,338	49,143	285,453		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/31/2022 4:07 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
			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	2,027,189	2,027,189			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	137,732	137,732			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,079,137	8,638	921	1,088,696	4.00
5.01	00550	DATA PROCESSING	191,399	0	558	14,386	5.01
5.02	00590	ADMITTING	107,042	12,910	0	11,867	5.02
5.03	00591	BUSINESS OFFICE	890,298	40,576	173	59,014	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	1,510,802	504,123	56,558	100,535	5.04
6.00	00600	MAINTENANCE & REPAIRS	831,489	245,311	15,852	42,929	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,112	244	0	8.00
9.00	00900	HOUSEKEEPING	311,554	22,993	0	28,850	9.00
10.00	01000	DIETARY	711,502	116,644	6,116	50,800	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,130	4,208	0	3,378	14.00
15.00	01500	PHARMACY	407,589	14,207	1,438	44,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,858	85,930	0	4,861	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,714,175	632,350	40,544	524,319	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,568	0	301	0	54.00
57.00	05700	CT SCAN	6,531	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	91,490	2,911	6,013	3,725	60.00
65.00	06500	RESPIRATORY THERAPY	666,079	10,220	1,863	58,186	65.00
66.00	06600	PHYSICAL THERAPY	410,719	62,820	355	46,239	66.00
67.00	06700	OCCUPATIONAL THERAPY	327,273	73,716	0	36,341	67.00
68.00	06800	SPEECH PATHOLOGY	278,212	7,046	0	31,080	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	674,168	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	238	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	674,615	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	154,136	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)	18,371,925	1,879,715	130,936	1,061,496	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	127,000	34,743	6,796	14,303	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	17,558	0	0	1,983	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	6,872	2,637	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	77,071	110,094	0	9,260	194.03
194.04	07954	EMS/AMBULANCE	13,527	0	0	1,654	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	18,613,953	2,027,189	137,732	1,088,696	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/31/2022 4:07 pm

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	138,318					5.02
5.03	00591	BUSINESS OFFICE	0	1,004,684				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	0	2,204,513	2,204,513		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,156,703	155,460	1,312,163	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	36,981	4,970	37,901	8.00
9.00	00900	HOUSEKEEPING	0	0	363,397	48,840	24,819	9.00
10.00	01000	DIETARY	0	0	889,936	119,607	125,906	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	46,590	6,262	4,543	14.00
15.00	01500	PHARMACY	0	0	476,344	64,020	15,336	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	160,274	21,541	92,753	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	61,697	448,244	8,452,199	1,135,964	682,563	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	1,178	8,557	76,604	10,296	0	54.00
57.00	05700	CT SCAN	18	129	6,678	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	4,087	29,679	139,530	18,753	3,142	60.00
65.00	06500	RESPIRATORY THERAPY	25,879	187,940	955,041	128,357	11,032	65.00
66.00	06600	PHYSICAL THERAPY	4,437	32,219	589,284	79,199	67,809	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,811	34,941	477,082	64,119	79,570	67.00
68.00	06800	SPEECH PATHOLOGY	4,561	33,126	358,899	48,236	7,605	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,281	60,137	742,586	99,803	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3	23	264	35	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,191	161,159	857,965	115,310	0	73.00
74.00	07400	RENAL DIALYSIS	1,175	8,530	165,466	22,238	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)	138,318	1,004,684	18,156,336	2,143,010	1,152,979	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	194,215	26,102	37,502	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	19,541	2,626	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	0	0	9,509	1,278	2,846	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	215,922	29,020	118,836	194.03
194.04	07954	EMS/AMBULANCE	0	0	18,430	2,477	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)	138,318	1,004,684	18,613,953	2,204,513	1,312,163	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet B
Part I
Date/Time Prepared:
5/31/2022 4:07 pm

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	79,852				8.00
9.00	00900	HOUSEKEEPING	0	1,853	438,909			9.00
10.00	01000	DIETARY	0	1,407	44,229	1,181,085		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,596	0	0	14.00
15.00	01500	PHARMACY	0	0	5,387	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	32,583	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	75,267	239,773	716,758	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	1,104	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,875	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	23,820	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	27,951	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,672	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						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	78,527	382,990	716,758	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	13,174	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	0	0	1,000	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	1,325	41,745	464,327	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	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)	0	79,852	438,909	1,181,085	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	58,991					14.00
15.00	01500	PHARMACY	218	561,305				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	307,151			16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,900	0	137,025	11,441,449	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	2,616	89,516	0	54.00
57.00	05700	CT SCAN	0	0	39	6,717	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	109	0	9,074	171,712	0	60.00
65.00	06500	RESPIRATORY THERAPY	41	0	57,461	1,155,807	0	65.00
66.00	06600	PHYSICAL THERAPY	238	0	9,851	770,201	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	544	0	10,683	659,949	0	67.00
68.00	06800	SPEECH PATHOLOGY	275	0	10,128	427,815	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,487	0	18,386	916,262	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22	0	7	328	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	561,305	49,273	1,583,853	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	2,608	190,312	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)	58,834	561,305	307,151	17,413,921	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26	0	0	271,019	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	22,167	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	131	0	0	14,764	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	0	871,175	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	20,907	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)	58,991	561,305	307,151	18,613,953	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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 - REHAB	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

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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	8,638	921	9,559	4.00
5.01	00550	DATA PROCESSING	0	0	558	558	5.01
5.02	00590	ADMITTING	0	12,910	0	12,910	5.02
5.03	00591	BUSINESS OFFICE	0	40,576	173	40,749	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	87,727	504,123	56,558	648,408	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	245,311	15,852	261,163	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	35,112	244	35,356	8.00
9.00	00900	HOUSEKEEPING	0	22,993	0	22,993	9.00
10.00	01000	DIETARY	0	116,644	6,116	122,760	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,208	0	4,208	14.00
15.00	01500	PHARMACY	0	14,207	1,438	15,645	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	85,930	0	85,930	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	632,350	40,544	672,894	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	301	301	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	2,911	6,013	8,924	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,220	1,863	12,083	65.00
66.00	06600	PHYSICAL THERAPY	0	62,820	355	63,175	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	73,716	0	73,716	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,046	0	7,046	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	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)	87,727	1,879,715	130,936	2,098,378	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	34,743	6,796	41,539	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 - REHAB	0	2,637	0	2,637	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	110,094	0	110,094	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	87,727	2,027,189	137,732	2,252,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DATA PROCESSING	ADMITTING	BUSINESS OFFICE	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	684					5.01
5.02	00590	ADMITTING	22	13,036				5.02
5.03	00591	BUSINESS OFFICE	48	0	41,315			5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	109	0	0	649,400		5.04
6.00	00600	MAINTENANCE & REPAIRS	70	0	0	45,795	307,405	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5	0	0	1,464	8,879	8.00
9.00	00900	HOUSEKEEPING	0	0	0	14,387	5,814	9.00
10.00	01000	DIETARY	16	0	0	35,233	29,497	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16	0	0	1,845	1,064	14.00
15.00	01500	PHARMACY	27	0	0	18,859	3,593	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5	0	0	6,345	21,730	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	102	5,819	18,425	334,630	159,905	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	111	352	3,033	0	54.00
57.00	05700	CT SCAN	0	2	5	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	5	385	1,221	5,524	736	60.00
65.00	06500	RESPIRATORY THERAPY	16	2,437	7,731	37,811	2,585	65.00
66.00	06600	PHYSICAL THERAPY	108	418	1,325	23,330	15,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	453	1,437	18,888	18,641	67.00
68.00	06800	SPEECH PATHOLOGY	16	430	1,363	14,209	1,782	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	780	2,474	29,400	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1	10	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,090	6,630	33,968	0	73.00
74.00	07400	RENAL DIALYSIS	5	111	351	6,551	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)	570	13,036	41,315	631,282	270,112	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38	0	0	7,689	8,786	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	774	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	0	0	0	376	667	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	65	0	0	8,549	27,840	194.03
194.04	07954	EMS/AMBULANCE	11	0	0	730	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)	684	13,036	41,315	649,400	307,405	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	45,704				8.00
9.00	00900	HOUSEKEEPING	0	1,061	44,508			9.00
10.00	01000	DIETARY	0	805	4,485	193,242		10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	162	0	0	14.00
15.00	01500	PHARMACY	0	0	546	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,304	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	43,079	24,315	117,272	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	112	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	393	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	2,416	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,834	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	271	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						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	44,945	38,838	117,272	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,336	0	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	0	0	101	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	759	4,233	75,970	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	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)	0	45,704	44,508	193,242	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
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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	7,325					14.00
15.00	01500	PHARMACY	27	39,092				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	117,357			16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	236	0	52,351	1,433,631	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	1,000	4,797	0	54.00
57.00	05700	CT SCAN	0	0	15	22	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	14	0	3,467	20,421	0	60.00
65.00	06500	RESPIRATORY THERAPY	5	0	21,956	85,528	0	65.00
66.00	06600	PHYSICAL THERAPY	30	0	3,764	110,858	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	68	0	4,082	120,438	0	67.00
68.00	06800	SPEECH PATHOLOGY	34	0	3,870	29,294	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,889	0	7,025	46,568	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3	0	3	17	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,092	18,827	100,607	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	997	8,015	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)	7,306	39,092	117,357	1,960,196	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3	0	0	59,517	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	791	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	16	0	0	3,797	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	0	227,591	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	756	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)	7,325	39,092	117,357	2,252,648	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2021
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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 - REHAB	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 01/01/2021
To 12/31/2021

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (COMPUTER T IME)	ADMITTING (GROSS CHARGES)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (EQUIPMENT COST)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	192,198				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,848,483			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	819	12,357	8,903,307		4.00
5.01	00550	DATA PROCESSING	0	7,490	117,645	127	5.01
5.02	00590	ADMITTING	1,224	0	97,047	4	5.02
5.03	00591	BUSINESS OFFICE	3,847	2,318	482,615	9	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	47,796	759,073	822,172	20	5.04
6.00	00600	MAINTENANCE & REPAIRS	23,258	212,749	351,073	13	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,329	3,274	0	1	8.00
9.00	00900	HOUSEKEEPING	2,180	0	235,931	0	9.00
10.00	01000	DIETARY	11,059	82,082	415,439	3	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	399	0	27,625	3	14.00
15.00	01500	PHARMACY	1,347	19,301	367,897	5	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,147	0	39,752	1	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	59,953	544,131	4,287,854	19	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	4,042	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	276	80,696	30,462	1	60.00
65.00	06500	RESPIRATORY THERAPY	969	24,999	475,846	3	65.00
66.00	06600	PHYSICAL THERAPY	5,956	4,763	378,142	20	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,989	0	297,198	0	67.00
68.00	06800	SPEECH PATHOLOGY	668	0	254,171	3	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	1	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)	178,216	1,757,275	8,680,869	106	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,294	91,208	116,970	7	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	16,214	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	250	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	10,438	0	75,727	12	194.03
194.04	07954	EMS/AMBULANCE	0	0	13,527	2	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)	2,027,189	137,732	1,088,696	206,343	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.547399	0.074511	0.122280	1,624.748031	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,559	684	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001074	5.385827	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 01/01/2021
To 12/31/2021

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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	50,898,207				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	-2,204,513	16,402,762		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,156,703	115,254	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	36,981	3,329	8.00
9.00	00900	HOUSEKEEPING	0	0	363,397	2,180	9.00
10.00	01000	DIETARY	0	0	889,936	11,059	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	46,590	399	14.00
15.00	01500	PHARMACY	0	0	476,344	1,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	160,274	8,147	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,708,296	0	8,452,199	59,953	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	433,507	0	76,604	0	54.00
57.00	05700	CT SCAN	6,531	-6,678	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	1,503,593	0	139,530	276	60.00
65.00	06500	RESPIRATORY THERAPY	9,521,233	0	955,041	969	65.00
66.00	06600	PHYSICAL THERAPY	1,632,271	0	589,284	5,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,770,161	0	477,082	6,989	67.00
68.00	06800	SPEECH PATHOLOGY	1,678,189	0	358,899	668	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,046,603	0	742,586	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,188	0	264	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,164,475	0	857,965	0	73.00
74.00	07400	RENAL DIALYSIS	432,160	0	165,466	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)	50,898,207	-2,211,191	15,945,145	101,272	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	194,215	3,294	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	19,541	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	0	0	9,509	250	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	215,922	10,438	194.03
194.04	07954	EMS/AMBULANCE	0	0	18,430	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)	1,004,684		2,204,513	1,312,163	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019739		0.134399	11.384967	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,315		649,400	307,405	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000812		0.039591	2.667196	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 01/01/2021
To 12/31/2021

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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	5,904					8.00
9.00	00900	HOUSEKEEPING	137	109,745				9.00
10.00	01000	DIETARY	104	11,059	53,844			10.00
11.00	01100	CAFETERIA	0	0	0	0		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	399	0	0	634,844	14.00
15.00	01500	PHARMACY	0	1,347	0	0	2,345	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,147	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,565	59,953	32,676	0	20,442	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	0	1,178	60.00
65.00	06500	RESPIRATORY THERAPY	0	969	0	0	443	65.00
66.00	06600	PHYSICAL THERAPY	0	5,956	0	0	2,557	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,989	0	0	5,852	67.00
68.00	06800	SPEECH PATHOLOGY	0	668	0	0	2,958	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	597,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	238	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)	5,806	95,763	32,676	0	633,154	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,294	0	0	276	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE - REHAB	0	250	0	0	1,414	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	98	10,438	21,168	0	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	79,852	438,909	1,181,085	0	58,991	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.525068	3.999353	21.935313	0.000000	0.092922	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	45,704	44,508	193,242	0	7,325	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.741192	0.405558	3.588924	0.000000	0.011538	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 01/01/2021
To 12/31/2021

Worksheet B-1

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	674,615	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	674,615	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)	674,615	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 - REHAB	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)	561,305	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.832038	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,092	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.057947	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 01/01/2021
To 12/31/2021Worksheet 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	11,441,449		11,441,449	49,143	11,490,592	30.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,516		89,516	0	89,516	54.00
57.00	05700	CT SCAN	6,717		6,717	0	6,717	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	171,712		171,712	0	171,712	60.00
65.00	06500	RESPIRATORY THERAPY	1,155,807	0	1,155,807	0	1,155,807	65.00
66.00	06600	PHYSICAL THERAPY	770,201	0	770,201	0	770,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	659,949	0	659,949	0	659,949	67.00
68.00	06800	SPEECH PATHOLOGY	427,815	0	427,815	0	427,815	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	916,262		916,262	0	916,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	328		328	0	328	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,583,853		1,583,853	0	1,583,853	73.00
74.00	07400	RENAL DIALYSIS	190,312		190,312	0	190,312	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)	17,413,921	0	17,413,921	49,143	17,463,064	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	17,413,921	0	17,413,921	49,143	17,463,064	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet 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	22,708,296		22,708,296			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,448	10,059	433,507	0.206493	0.000000	54.00
57.00	05700	CT SCAN	6,531	0	6,531	1.028480	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	1,415,099	88,494	1,503,593	0.114201	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,521,233	0	9,521,233	0.121393	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,547,866	84,405	1,632,271	0.471859	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,730,034	40,127	1,770,161	0.372819	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,588,674	89,515	1,678,189	0.254927	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,046,603	0	3,046,603	0.300749	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,188	0	1,188	0.276094	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,158,495	5,980	8,164,475	0.193993	0.000000	73.00
74.00	07400	RENAL DIALYSIS	432,160	0	432,160	0.440374	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)	50,579,627	318,580	50,898,207			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,579,627	318,580	50,898,207			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		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	0.206493			54.00
57.00	05700 CT SCAN	1.028480			57.00
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.114201			60.00
65.00	06500 RESPIRATORY THERAPY	0.121393			65.00
66.00	06600 PHYSICAL THERAPY	0.471859			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.372819			67.00
68.00	06800 SPEECH PATHOLOGY	0.254927			68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.300749			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.276094			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193993			73.00
74.00	07400 RENAL DIALYSIS	0.440374			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 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
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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		
					Total Costs	RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,441,449		11,441,449	49,143	11,490,592	30.00	
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,516		89,516	0	89,516	54.00	
57.00	05700	CT SCAN	6,717		6,717	0	6,717	57.00	
58.00	05800	MRI	0		0	0	0	58.00	
60.00	06000	LABORATORY	171,712		171,712	0	171,712	60.00	
65.00	06500	RESPIRATORY THERAPY	1,155,807	0	1,155,807	0	1,155,807	65.00	
66.00	06600	PHYSICAL THERAPY	770,201	0	770,201	0	770,201	66.00	
67.00	06700	OCCUPATIONAL THERAPY	659,949	0	659,949	0	659,949	67.00	
68.00	06800	SPEECH PATHOLOGY	427,815	0	427,815	0	427,815	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	916,262		916,262	0	916,262	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	328		328	0	328	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,583,853		1,583,853	0	1,583,853	73.00	
74.00	07400	RENAL DIALYSIS	190,312		190,312	0	190,312	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)	17,413,921	0	17,413,921	49,143	17,463,064	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	17,413,921	0	17,413,921	49,143	17,463,064	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet C
Part I
Date/Time Prepared:
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					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	22,708,296		22,708,296			30.00	
46.00	04600	OTHER LONG TERM CARE	0		0			46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	423,448	10,059	433,507	0.206493	0.000000	54.00	
57.00	05700	CT SCAN	6,531	0	6,531	1.028480	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
60.00	06000	LABORATORY	1,415,099	88,494	1,503,593	0.114201	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	9,521,233	0	9,521,233	0.121393	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,547,866	84,405	1,632,271	0.471859	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,730,034	40,127	1,770,161	0.372819	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	1,588,674	89,515	1,678,189	0.254927	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,046,603	0	3,046,603	0.300749	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,188	0	1,188	0.276094	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	8,158,495	5,980	8,164,475	0.193993	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	432,160	0	432,160	0.440374	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)	50,579,627	318,580	50,898,207			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	50,579,627	318,580	50,898,207			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/31/2022 4:07 pm
				Title XIX	Hospital	Cost
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	0.000000			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 01/01/2021
To 12/31/2021Worksheet D
Part I
Date/Time Prepared:
5/31/2022 4:07 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		1,433,631	0	1,433,631	10,892	131.62	30.00
200.00	Total (lines 30 through 199)		1,433,631		1,433,631	10,892		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		1,175	154,654				
200.00	Total (lines 30 through 199)		1,175	154,654				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part II
Date/Time Prepared:
5/31/2022 4:07 pm

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	PPS Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,797	433,507	0.011066	59,063	654	54.00
57.00	05700 CT SCAN	22	6,531	0.003369	0	0	57.00
58.00	05800 MRI	0	0	0.000000	0	0	58.00
60.00	06000 LABORATORY	20,421	1,503,593	0.013581	201,840	2,741	60.00
65.00	06500 RESPIRATORY THERAPY	85,528	9,521,233	0.008983	1,112,698	9,995	65.00
66.00	06600 PHYSICAL THERAPY	110,858	1,632,271	0.067916	147,589	10,024	66.00
67.00	06700 OCCUPATIONAL THERAPY	120,438	1,770,161	0.068038	170,647	11,610	67.00
68.00	06800 SPEECH PATHOLOGY	29,294	1,678,189	0.017456	165,304	2,886	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	46,568	3,046,603	0.015285	294,072	4,495	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	17	1,188	0.014310	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	100,607	8,164,475	0.012323	694,762	8,562	73.00
74.00	07400 RENAL DIALYSIS	8,015	432,160	0.018546	156,060	2,894	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)	526,565	28,189,911		3,002,035	53,861	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 52-2005		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part III Date/Time Prepared: 5/31/2022 4:07 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description				Nursing Program Post-Stepdown Adjustments	Nursing Program	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	10,892	0.00	1,175	30.00			
200.00		Total (lines 30 through 199)	0	0	10,892		1,175	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 01/01/2021
To 12/31/2021

Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 4:07 pm

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 4:07 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	433,507	0.000000	54.00
57.00	05700 CT SCAN	0	0	0	6,531	0.000000	57.00
58.00	05800 MRI	0	0	0	0	0.000000	58.00
60.00	06000 LABORATORY	0	0	0	1,503,593	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	9,521,233	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	1,632,271	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	1,770,161	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	1,678,189	0.000000	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,046,603	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,188	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	8,164,475	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	432,160	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	28,189,911		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part IV
Date/Time Prepared:
5/31/2022 4:07 pm

				Title XVIII		Hospital	PPS		
Cost Center Description			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	59,063	0	2,675	0	54.00	
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.000000	201,840	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	1,112,698	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	147,589	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	170,647	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	165,304	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	294,072	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	694,762	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	156,060	0	0	0	74.00	
	OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)		3,002,035	0	2,675	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/31/2022 4:07 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	0.206493	2,675	0	0	552
57.00	05700	CT SCAN	1.028480	0	0	0	0
58.00	05800	MRI	0.000000	0	0	0	0
60.00	06000	LABORATORY	0.114201	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.121393	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0.471859	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	0.372819	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0.254927	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.300749	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.276094	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193993	0	0	0	0
74.00	07400	RENAL DIALYSIS	0.440374	0	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	0.000000		0		
200.00		Subtotal (see instructions)		2,675	0	0	552
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00		Net Charges (line 200 - line 201)		2,675	0	0	552

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 52-2005		Period: From 01/01/2021 To 12/31/2021		Worksheet D Part V Date/Time Prepared: 5/31/2022 4:07 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 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/31/2022 4:07 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	0.206493	0	1,825	0	0	54.00	
57.00	05700	CT SCAN	1.028480	0	0	0	0	57.00	
58.00	05800	MRI	0.000000	0	0	0	0	58.00	
60.00	06000	LABORATORY	0.114201	0	7,798	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.121393	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.471859	0	2,920	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.372819	0	2,918	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.254927	0	0	0	0	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.300749	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.276094	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.193993	0	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.440374	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	15,461	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	15,461	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021Worksheet D
Part V
Date/Time Prepared:
5/31/2022 4:07 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	377	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	891	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	1,378	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	1,088	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)	3,734	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,734	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/31/2022 4:07 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)		10,892	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,892	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)		10,892	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)		1,175	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)		11,490,592	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)		11,490,592	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)		11,490,592	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,054.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,239,578	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)		1,239,578	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/31/2022 4:07 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)					637,667	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,877,245	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)					154,654	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					53,861	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					208,515	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,668,730	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 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/31/2022 4:07 pm

		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	1,433,631	11,490,592	0.124766	0	0	90.00
91.00 Nursing Program cost	0	11,490,592	0.000000	0	0	91.00
92.00 Allied health cost	0	11,490,592	0.000000	0	0	92.00
93.00 All other Medical Education	0	11,490,592	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prepared: 5/31/2022 4:07 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)		10,892	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,892	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)		10,892	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)		3,351	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)		11,441,449	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)		11,441,449	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)		11,441,449	37.00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,050.45	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,520,058	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)		3,520,058	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/31/2022 4:07 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)					1,360,719	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,880,777	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 01/01/2021
To 12/31/2021

Worksheet D-1

Date/Time Prepared:
5/31/2022 4:07 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	1,433,631	11,441,449	0.125302	0	0	90.00
91.00	Nursing Program cost	0	11,441,449	0.000000	0	0	91.00
92.00	Allied health cost	0	11,441,449	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,441,449	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/31/2022 4:07 pm	
		Title XVIII	Hospital	PPS	
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		2,433,570		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.206493	59,063	12,196	54.00
57.00	05700 CT SCAN	1.028480	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.114201	201,840	23,050	60.00
65.00	06500 RESPIRATORY THERAPY	0.121393	1,112,698	135,074	65.00
66.00	06600 PHYSICAL THERAPY	0.471859	147,589	69,641	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.372819	170,647	63,620	67.00
68.00	06800 SPEECH PATHOLOGY	0.254927	165,304	42,140	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.300749	294,072	88,442	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.276094	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193993	694,762	134,779	73.00
74.00	07400 RENAL DIALYSIS	0.440374	156,060	68,725	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)		3,002,035	637,667	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)		3,002,035		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Prepared: 5/31/2022 4:07 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		6,279,177		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.206493	91,291	18,851	54.00
57.00	05700 CT SCAN	1.028480	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
60.00	06000 LABORATORY	0.114201	294,966	33,685	60.00
65.00	06500 RESPIRATORY THERAPY	0.121393	2,732,980	331,765	65.00
66.00	06600 PHYSICAL THERAPY	0.471859	383,476	180,947	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.372819	428,427	159,726	67.00
68.00	06800 SPEECH PATHOLOGY	0.254927	415,997	106,049	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.300749	843,179	253,585	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.276094	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.193993	1,315,163	255,132	73.00
74.00	07400 RENAL DIALYSIS	0.440374	47,638	20,979	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)		6,553,117	1,360,719	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)		6,553,117		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/31/2022 4:07 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)		552	2.00
3.00	OPPS payments		160	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		160	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)		32	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)		128	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)		128	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		128	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)		666	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		433	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		561	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)		561	40.00
40.01	Sequestration adjustment (see instructions)		0	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		128	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)		433	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 01/01/2021
To 12/31/2021Worksheet E-1
Part I
Date/Time Prepared:
5/31/2022 4:07 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		1,410,942		128	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)		1,410,942		128	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		433	6.01	
6.02	SETTLEMENT TO PROGRAM		6,766		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,404,176		561	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 01/01/2021 To 12/31/2021	Worksheet E-3 Part IV Date/Time Prepared: 5/31/2022 4:07 pm
		Title XVIII	Hospital	PPS
			1.00	
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		1,369,868	1.00
1.01	Full standard payment amount		942,667	1.01
1.02	Short stay outlier standard payment amount		427,201	1.02
1.03	Site neutral payment amount - Cost		0	1.03
1.04	Site neutral payment amount - IPPS comparable		0	1.04
2.00	Outlier Payments		215,489	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		1,585,357	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)		1,585,357	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		1,585,357	9.00
10.00	Deductibles		11,872	10.00
11.00	Subtotal (line 9 minus line 10)		1,573,485	11.00
12.00	Coinsurance		212,212	12.00
13.00	Subtotal (line 11 minus line 12)		1,361,273	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		66,004	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		42,903	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		22,356	16.00
17.00	Subtotal (sum of lines 13 and 15)		1,404,176	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
21.98	Recovery of accelerated depreciation.		0	21.98
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		1,404,176	22.00
22.01	Sequestration adjustment (see instructions)		0	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		1,410,942	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)		-6,766	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)		215,489	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 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2022 4:07 pm
		Title XIX	Hospital	Cost
			Inpatient	Outpatient
			1.00	2.00
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	4,880,777		1.00
2.00	Medical and other services		3,734	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	4,880,777	3,734	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	4,880,777	3,734	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	6,553,117	15,461	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)	6,553,117	15,461	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)	6,553,117	15,461	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,672,340	11,727	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	4,880,777	3,734	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	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	4,880,777	3,734	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	4,880,777	3,734	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	4,880,777	3,734	36.00
37.00	COST REPORT SETTLEMENT ELIMINATION	-4,880,777	-3,734	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	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	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 01/01/2021
To 12/31/2021

Worksheet G

Date/Time Prepared:
5/31/2022 4:07 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	871,299	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	5,420,913	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-224,989	0	0	0	6.00
7.00	Inventory	219,133	0	0	0	7.00
8.00	Prepaid expenses	130,574	0	0	0	8.00
9.00	Other current assets	-6,799,965	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)	-383,035	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	2,937,940	0	0	0	17.00
18.00	Accumulated depreciation	-795,216	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	1,412,820	0	0	0	23.00
24.00	Accumulated depreciation	-1,091,718	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)	2,463,826	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)	2,080,791	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	254,166	0	0	0	37.00
38.00	Salaries, wages, and fees payable	728,932	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	633,293	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	56,923	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,673,314	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	37,025	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	37,025	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,710,339	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	370,452	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)	370,452	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	2,080,791	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-1

Date/Time Prepared:
5/31/2022 4:07 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-2,056,313		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,426,772				2.00
3.00	Total (sum of line 1 and line 2)		370,459		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)		370,459		0		11.00
12.00	ROUNDING	7		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)		7		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		370,452		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	ROUNDING		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 01/01/2021
To 12/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2022 4:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	22,708,296		22,708,296	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)	22,708,296		22,708,296	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)	22,708,296		22,708,296	17.00
18.00	Ancillary services	29,279,924	318,580	29,598,504	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,988,220	318,580	52,306,800	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,680,526		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)		19,680,526		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2021
To 12/31/2021

Worksheet G-3

Date/Time Prepared:
5/31/2022 4:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	52,306,800	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,724,551	2.00
3.00	Net patient revenues (line 1 minus line 2)	20,582,249	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,680,526	4.00
5.00	Net income from service to patients (line 3 minus line 4)	901,723	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	18,343	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	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	111,098	24.00
24.50	COVID-19 PHE Funding	1,395,608	24.50
25.00	Total other income (sum of lines 6-24)	1,525,049	25.00
26.00	Total (line 5 plus line 25)	2,426,772	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)	2,426,772	29.00