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 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 52-2005	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/24/2018 5:14 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2018 Time: 5:14 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAKEVIEW SPECIALTY HOSPT & REHAB (52-2005) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	391,839	5,324	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	391,839	5,324	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 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 5:12 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	2.00

		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	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	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	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	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		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 5:12 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? 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) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	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	61.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 5:12 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 5:12 pm

		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	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	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	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			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	76.00

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		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	Y	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			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	109.00

		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	110.00

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	76,385	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			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	309000	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 5:12 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: 08001	141.00
142.00	Street: P.O. BOX 28890	PO Box:		142.00
143.00	City: AUSTIN	State: TX	Zip Code: 78755-8890	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	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 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2018 5:12 pm

		Y/N	Date	
		1.00	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	Date	V/I	
		1.00	2.00	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	Type	Date	
		1.00	2.00	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	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? 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		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/11/2018	Y	04/11/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 5:12 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.	ADAM		MARCIN		41.00
42.00	Enter the employer/company name of the cost report preparer.	H R P L L C				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(972) 381-1150		AGMARCIN@HRPLLC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 52-2005	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 5:12 pm

			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRINCIPAL			41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2018 5:12 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	39	14,235	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		39	14,235	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		39	14,235	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		39				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 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 5:12 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)	3,109	2,095	9,467			1.00
2.00	HMO and other (see instructions)	0	0				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)	3,109	2,095	9,467			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)	3,109	2,095	9,467	0.00	119.77	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	0	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	119.77	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	1,960					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 5:12 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	93	35	195	1.00
2.00	HMO and other (see instructions)			0	0		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	93	35	195	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			56			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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	2,039,857	2,039,857	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	71,167	71,167	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	167,039	749,282	916,321	-31,133	885,188	4.00
5.01	00550	DATA PROCESSING	61,906	55,601	117,507	0	117,507	5.01
5.02	00590	ADMITTING	103,527	9,932	113,459	0	113,459	5.02
5.03	00591	BUSINESS OFFICE	457,349	2,629,348	3,086,697	-2,119,284	967,413	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	566,619	961,753	1,528,372	829,351	2,357,723	5.04
6.00	00600	MAINTENANCE & REPAIRS	255,453	389,970	645,423	0	645,423	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	134,603	134,603	0	134,603	8.00
9.00	00900	HOUSEKEEPING	134,420	51,388	185,808	0	185,808	9.00
10.00	01000	DIETARY	302,843	272,430	575,273	0	575,273	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,348	371,041	394,389	-388,183	6,206	14.00
15.00	01500	PHARMACY	319,839	746,635	1,066,474	-3,009	1,063,465	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89,865	64,449	154,314	-11,008	143,306	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,961,282	4,084,239	7,045,521	-1,165,910	5,879,611	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	60,233	60,233	-11,716	48,517	54.00
57.00	05700	CT SCAN	0	0	0	11,716	11,716	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	33,323	114,287	147,610	5,819	153,429	60.00
65.00	06500	RESPIRATORY THERAPY	363,829	74,047	437,876	-40,438	397,438	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	323,502	323,502	66.00
67.00	06700	OCCUPATIONAL THERAPY	732,523	99,473	831,996	-496,312	335,684	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	156,726	156,726	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	485,153	485,153	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,101	24,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	258,889	258,889	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)	6,573,165	10,868,711	17,441,876	-60,712	17,381,164	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	100,673	12,578	113,251	-4,854	108,397	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	5,094	5,094	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	0	45,959	45,959	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	14,513	14,513	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	6,673,838	10,881,289	17,555,127	0	17,555,127	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 5:12 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	-597,391	1,442,466		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	71,167		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,328	880,860		4.00
5.01	00550	DATA PROCESSING	0	117,507		5.01
5.02	00590	ADMITTING	-174	113,285		5.02
5.03	00591	BUSINESS OFFICE	-178,439	788,974		5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	275,040	2,632,763		5.04
6.00	00600	MAINTENANCE & REPAIRS	-18,465	626,958		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	134,603		8.00
9.00	00900	HOUSEKEEPING	0	185,808		9.00
10.00	01000	DIETARY	-36,284	538,989		10.00
11.00	01100	CAFETERIA	0	0		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,206		14.00
15.00	01500	PHARMACY	0	1,063,465		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,993	138,313		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-375,889	5,503,722		30.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,517		54.00
57.00	05700	CT SCAN	0	11,716		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	153,429		60.00
65.00	06500	RESPIRATORY THERAPY	0	397,438		65.00
66.00	06600	PHYSICAL THERAPY	0	323,502		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	335,684		67.00
68.00	06800	SPEECH PATHOLOGY	0	156,726		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	485,153		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	24,101		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	258,889		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)	-940,923	16,440,241		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	108,397		192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0		194.00
194.01	07951	MARKETING DEPARTMENT	0	5,094		194.01
194.02	07952	OTHER NONALLOWABLE	0	0		194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	45,959		194.03
194.04	07954	EMS/AMBULANCE	0	14,513		194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-940,923	16,614,204		200.00

RECLASSIFICATIONS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 5:12 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	20,309	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	45,121	2.00
	0		0	65,430	
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	483,518	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	24,101	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
	0		0	507,619	
	C - RECLASS INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,794	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	132,031	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	26,046	3.00
	0		0	192,871	
	D - RECLASS OUTPATIENT SALARIES				
1.00	PHYSICAL THERAPY	66.00	277,364	31,569	1.00
2.00	SPEECH PATHOLOGY	68.00	131,864	15,008	2.00
	0		409,228	46,577	
	E - RECLASS PURCHASED SERVICES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,635	1.00
2.00	RENAL DIALYSIS	74.00	0	258,889	2.00
	0		0	260,524	
	F - MED DIRECTOR TO CLINIC				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	12,500	999	1.00
	0		12,500	999	
	G - LAB				
1.00	LABORATORY	60.00	0	5,918	1.00
	0		0	5,918	
	H - OVERHEAD COST ALLOCATION				
1.00	LAKEVIEW CARE PARTNERS (CBRF)	194.03	45,959	0	1.00
2.00	EMS/AMBULANCE	194.04	14,513	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		60,472	0	
	I - RECLASS CT SCAN AND MRI COST				
1.00	CT SCAN	57.00	0	11,716	1.00
	0		0	11,716	
	K - MANAGEMENT FEES				
1.00	ADMINISTRATIVE AND GENERAL	5.04	0	834,445	1.00
2.00		0.00	0	0	2.00
	0		0	834,445	
	L - RECLASS THERAPY ADMIN				
1.00	PHYSICAL THERAPY	66.00	13,080	1,489	1.00
2.00	SPEECH PATHOLOGY	68.00	8,847	1,007	2.00
	0		21,927	2,496	
	M - EMPLOYEE HEALTH				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	14,213	1,776	1.00
	0		14,213	1,776	
	N - MARKETING DEPARTMENT				
1.00	MARKETING DEPARTMENT	194.01	2,527	2,567	1.00
	0		2,527	2,567	
	O - RENTAL RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,852,723	1.00
	0		0	1,852,723	
500.00	Grand Total: Increases		520,867	3,785,661	500.00

RECLASSIFICATIONS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 5:12 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EQUIPMENT DEPRECIATION & AMORTIZATI						
1.00	BUSINESS OFFICE	5.03	0	65,430	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	65,430			
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	388,183	0		1.00
2.00	PHARMACY	15.00	0	3,009	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	71,645	0		3.00
4.00	LABORATORY	60.00	0	99	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	40,438	0		5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	1,881	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,364	0		7.00
	0		0	507,619			
	C - RECLASS INSURANCE						
1.00	BUSINESS OFFICE	5.03	0	192,871	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	192,871			
	D - RECLASS OUTPATIENT SALARIES						
1.00	OCCUPATIONAL THERAPY	67.00	409,228	46,577	0		1.00
2.00		0.00	0	0	0		2.00
	0		409,228	46,577			
	E - RECLASS PURCHASED SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	0	260,524	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	260,524			
	F - MED DIRECTOR TO CLINIC						
1.00	ADULTS & PEDIATRICS	30.00	12,500	999	0		1.00
	0		12,500	999			
	G - LAB						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,918	0		1.00
	0		0	5,918			
	H - OVERHEAD COST ALLOCATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	41,204	0	0		1.00
2.00	BUSINESS OFFICE	5.03	8,260	0	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	11,008	0	0		3.00
	TOTALS		60,472	0			
	I - RECLASS CT SCAN AND MRI COST						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,716	0		1.00
	0		0	11,716			
	K - MANAGEMENT FEES						
1.00	ADULTS & PEDIATRICS	30.00	0	820,242	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	0	14,203	0		2.00
	0		0	834,445			
	L - RECLASS THERAPY ADMIN						
1.00	OCCUPATIONAL THERAPY	67.00	21,927	2,496	0		1.00
2.00		0.00	0	0	0		2.00
	0		21,927	2,496			
	M - EMPLOYEE HEALTH						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	14,213	1,776	0		1.00
	0		14,213	1,776			
	N - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE AND GENERAL	5.04	2,527	2,567	0		1.00
	0		2,527	2,567			
	O - RENTAL RECLASS						
1.00	BUSINESS OFFICE	5.03	0	1,852,723	10		1.00
	0		0	1,852,723			
500.00	Grand Total: Decreases		520,867	3,785,661			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2018 5:12 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		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	673,319	0	0	0	17,217	2.00
3.00	Buildings and Fixtures	278,465	11,694	0	11,694	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	1,305,133	15,385	0	15,385	63,102	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,256,917	27,079	0	27,079	80,319	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,256,917	27,079	0	27,079	80,319	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	656,102	0	2.00
3.00	Buildings and Fixtures	290,159	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	1,257,416	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,203,677	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	2,203,677	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2018 5:12 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 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2018 5:12 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	946,262	0	946,262	0.429401	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,257,416	0	1,257,416	0.570599	0	2.00
3.00	Total (sum of lines 1-2)	2,203,678	0	2,203,678	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	20,309	1,255,332	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	45,121	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	65,430	1,255,332	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	34,794	132,031	0	1,442,466	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	26,046	0	0	71,167	2.00
3.00	Total (sum of lines 1-2)	0	60,840	132,031	0	1,513,633	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 5:12 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP 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)	A	-11,237	ADMINISTRATIVE AND GENERAL	5.04	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	-3,372	MAINTENANCE & REPAIRS	6.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-14,827	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	-241,138			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	-251,711			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-33,875	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,993	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,409	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	REFUND OF PAYROLL TAX	B	-28,200	ADMINISTRATIVE AND GENERAL	5.04	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 5:12 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	AMBULANCE INCOME	B	0	ADULTS & PEDIATRICS	30.00	0	33.01
33.02	OFFSET TO RECONCILE WTB	A	-3,496	ADMINISTRATIVE AND GENERAL	5.04	0	33.02
34.00	MISCELLANEOUS INCOME	B	-136	ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	NONALLOWABLE PENALTIES	A	-115,481	BUSINESS OFFICE	5.03	0	35.00
36.00	NONALLOWABLE DONATIONS	A	-50	ADMINISTRATIVE AND GENERAL	5.04	0	36.00
39.00	HOSPITAL ASSESSMENT	A	-138,987	ADULTS & PEDIATRICS	30.00	0	39.00
40.00	NONALLOWABLE PENALTIES	A	-174	ADMITTING	5.02	0	40.00
41.00	POSTAGE INCOME	B	-470	ADMINISTRATIVE AND GENERAL	5.04	0	41.00
44.00	NONALLOWABLE MARKETING	A	-15,685	ADMINISTRATIVE AND GENERAL	5.04	0	44.00
44.01	NONALLOWABLE MARKETING	A	-56	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.01
44.02	NONALLOWABLE PENALTIES	A	-266	MAINTENANCE & REPAIRS	6.00	0	44.02
44.03	PATIENT TELEPHONE SALARY	A	-11,366	ADMINISTRATIVE AND GENERAL	5.04	0	44.03
44.04	PATIENT TELEPHONE BENEFITS	A	-36	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.04
44.05	NONALLOWABLE INTEREST	A	-62,958	BUSINESS OFFICE	5.03	9	44.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-940,923				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 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2018 5:12 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	1,214,980	869,300	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING RENT	1,255,332	1,852,723	2.00
3.00	5.04	ADMINISTRATIVE AND GENERAL	HOME OFFICE COST	7,055	7,055	3.00
4.00	5.04	ADMINISTRATIVE AND GENERAL	PROFESSIONAL FEES	517,836	517,836	4.00
4.01	194.03	LAKEVIEW CARE PARTNERS (CBRF	SHARED SERVICES	45,959	45,959	4.01
4.02	194.04	EMS/AMBULANCE	SHARED SERVICES	14,513	14,513	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,055,675	3,307,386	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 52-2005	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/24/2018 5:12 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	345,680	0		1.00
2.00	-597,391	10		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	-251,711			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2018 5:12 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	4,236	4,236	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	393,900	197,509	196,391	211,500	1,544	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			398,136	201,745	196,391		1,544	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	156,998	7,850	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			156,998	7,850	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4,236		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	156,998	39,393	236,902		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	156,998	39,393	241,138		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 5:12 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	1,442,466	1,442,466				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	71,167		71,167			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	880,860	6,372	568	887,800		4.00
5.01	00550	DATA PROCESSING	117,507	0	158	8,412	126,077	5.01
5.02	00590	ADMITTING	113,285	9,523	0	14,067	3,981	5.02
5.03	00591	BUSINESS OFFICE	788,974	29,930	107	61,021	15,926	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	2,632,763	466,666	29,980	76,648	26,543	5.04
6.00	00600	MAINTENANCE & REPAIRS	626,958	189,983	4,700	34,710	10,617	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	134,603	26,694	151	0	1,327	8.00
9.00	00900	HOUSEKEEPING	185,808	17,972	0	18,265	0	9.00
10.00	01000	DIETARY	538,989	89,565	2,504	41,150	3,981	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,206	3,104	0	3,172	2,654	14.00
15.00	01500	PHARMACY	1,063,465	10,480	0	43,459	5,309	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138,313	63,385	0	10,715	3,981	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,503,722	274,350	22,858	400,677	26,543	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	48,517	0	186	0	0	54.00
57.00	05700	CT SCAN	11,716	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	153,429	4,614	3,711	4,528	1,327	60.00
65.00	06500	RESPIRATORY THERAPY	397,438	5,073	943	49,436	2,654	65.00
66.00	06600	PHYSICAL THERAPY	323,502	46,338	219	39,465	5,309	66.00
67.00	06700	OCCUPATIONAL THERAPY	335,684	59,028	0	40,949	0	67.00
68.00	06800	SPEECH PATHOLOGY	156,726	5,197	0	19,120	1,327	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	485,153	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,101	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	888	0	0	73.00
74.00	07400	RENAL DIALYSIS	258,889	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)	16,440,241	1,308,274	66,973	865,794	111,479	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	108,397	26,390	4,194	13,446	2,654	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	5,094	0	0	343	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	2,031	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	45,959	105,771	0	6,245	10,617	194.03
194.04	07954	EMS/AMBULANCE	14,513	0	0	1,972	1,327	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,614,204	1,442,466	71,167	887,800	126,077	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 5:12 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	140,856					5.02
5.03	00591	BUSINESS OFFICE	0	895,958				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	0	3,232,600	3,232,600		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	866,968	209,433	1,076,401	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	162,775	39,322	38,829	8.00
9.00	00900	HOUSEKEEPING	0	0	222,045	53,639	26,142	9.00
10.00	01000	DIETARY	0	0	676,189	163,347	130,282	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	15,136	3,656	4,516	14.00
15.00	01500	PHARMACY	0	0	1,122,713	271,214	15,244	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	216,394	52,274	92,200	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,280	345,284	6,627,714	1,601,062	399,073	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	752	4,785	54,240	13,103	0	54.00
57.00	05700	CT SCAN	187	1,191	13,094	3,163	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	10,820	68,820	247,249	59,728	6,711	60.00
65.00	06500	RESPIRATORY THERAPY	21,810	138,723	616,077	148,826	7,379	65.00
66.00	06600	PHYSICAL THERAPY	6,413	40,788	462,034	111,614	67,404	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,671	42,434	484,766	117,105	85,863	67.00
68.00	06800	SPEECH PATHOLOGY	4,337	27,588	214,295	51,767	7,560	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,173	51,982	545,308	131,730	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	303	1,928	26,332	6,361	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,966	152,440	177,294	42,829	0	73.00
74.00	07400	RENAL DIALYSIS	3,144	19,995	282,028	68,130	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)	140,856	895,958	16,265,251	3,148,303	881,203	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	155,081	37,463	38,388	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	5,437	1,313	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	2,031	491	2,954	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	168,592	40,727	153,856	194.03
194.04	07954	EMS/AMBULANCE	0	0	17,812	4,303	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)	140,856	895,958	16,614,204	3,232,600	1,076,401	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	
			8.00	9.00	10.00	11.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	240,926					8.00
9.00	00900	HOUSEKEEPING	149	301,975				9.00
10.00	01000	DIETARY	0	38,897	1,008,715			10.00
11.00	01100	CAFETERIA	0	0	244,450	244,450		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,348	0	3,528	28,184	14.00
15.00	01500	PHARMACY	0	4,551	0	17,689	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,528	0	7,363	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	238,377	119,149	463,831	98,772	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	2,004	0	3,246	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,203	0	24,182	0	65.00
66.00	06600	PHYSICAL THERAPY	0	20,124	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,203	25,635	0	23,288	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,257	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	26,844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,340	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)	240,729	243,696	708,281	178,068	28,184	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	197	11,461	0	9,433	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	9,407	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	882	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	45,936	291,027	12,702	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	44,247	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)	240,926	301,975	1,008,715	244,450	28,184	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,431,411					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	395,759				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	152,519	9,700,497	0	9,700,497	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,113	69,456	0	69,456	54.00
57.00	05700	CT SCAN	0	526	16,783	0	16,783	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	30,399	349,337	0	349,337	60.00
65.00	06500	RESPIRATORY THERAPY	0	61,276	859,943	0	859,943	65.00
66.00	06600	PHYSICAL THERAPY	0	18,016	679,192	0	679,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,744	757,604	0	757,604	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,186	288,065	0	288,065	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,961	726,843	0	726,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	852	34,885	0	34,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,431,411	67,335	1,718,869	0	1,718,869	73.00
74.00	07400	RENAL DIALYSIS	0	8,832	358,990	0	358,990	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,431,411	395,759	15,560,464	0	15,560,464	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	252,023	0	252,023	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	9,407	0	9,407	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	6,750	0	6,750	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	6,358	0	6,358	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	712,840	0	712,840	194.03
194.04	07954	EMS/AMBULANCE	0	0	66,362	0	66,362	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,431,411	395,759	16,614,204	0	16,614,204	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,372	568	6,940	6,940	4.00
5.01	00550	DATA PROCESSING	0	0	158	158	66	5.01
5.02	00590	ADMITTING	0	9,523	0	9,523	110	5.02
5.03	00591	BUSINESS OFFICE	0	29,930	107	30,037	477	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	52,445	466,666	29,980	549,091	599	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	189,983	4,700	194,683	271	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,694	151	26,845	0	8.00
9.00	00900	HOUSEKEEPING	0	17,972	0	17,972	143	9.00
10.00	01000	DIETARY	0	89,565	2,504	92,069	322	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,104	0	3,104	25	14.00
15.00	01500	PHARMACY	0	10,480	0	10,480	340	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,385	0	63,385	84	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	274,350	22,858	297,208	3,133	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	186	186	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	4,614	3,711	8,325	35	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,073	943	6,016	386	65.00
66.00	06600	PHYSICAL THERAPY	0	46,338	219	46,557	308	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	59,028	0	59,028	320	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,197	0	5,197	149	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	888	888	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		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)	52,445	1,308,274	66,973	1,427,692	6,768	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,390	4,194	30,584	105	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	3	194.01
194.02	07952	OTHER NONALLOWABLE	0	2,031	0	2,031	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	105,771	0	105,771	49	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	15	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,445	1,442,466	71,167	1,566,078	6,940	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 5:12 pm

		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	224					5.01
5.02	00590	ADMITTING	7	9,640				5.02
5.03	00591	BUSINESS OFFICE	28	0	30,542			5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	49	0	0	549,739		5.04
6.00	00600	MAINTENANCE & REPAIRS	19	0	0	35,617	230,590	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2	0	0	6,687	8,318	8.00
9.00	00900	HOUSEKEEPING	0	0	0	9,122	5,600	9.00
10.00	01000	DIETARY	7	0	0	27,779	27,909	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5	0	0	622	967	14.00
15.00	01500	PHARMACY	9	0	0	46,123	3,266	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7	0	0	8,890	19,751	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47	3,721	11,766	272,277	85,492	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	163	2,228	0	54.00
57.00	05700	CT SCAN	0	13	41	538	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2	740	2,346	10,157	1,438	60.00
65.00	06500	RESPIRATORY THERAPY	5	1,491	4,730	25,310	1,581	65.00
66.00	06600	PHYSICAL THERAPY	9	438	1,391	18,981	14,440	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	456	1,447	19,915	18,394	67.00
68.00	06800	SPEECH PATHOLOGY	2	297	941	8,804	1,619	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	559	1,772	22,402	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21	66	1,082	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,638	5,197	7,284	0	73.00
74.00	07400	RENAL DIALYSIS	0	215	682	11,586	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)	198	9,640	30,542	535,404	188,775	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5	0	0	6,371	8,223	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	223	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	83	633	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	19	0	0	6,926	32,959	194.03
194.04	07954	EMS/AMBULANCE	2	0	0	732	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)	224	9,640	30,542	549,739	230,590	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	
			8.00	9.00	10.00	11.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,852					8.00
9.00	00900	HOUSEKEEPING	26	32,863				9.00
10.00	01000	DIETARY	0	4,233	152,319			10.00
11.00	01100	CAFETERIA	0	0	36,913	36,913		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	147	0	533	5,403	14.00
15.00	01500	PHARMACY	0	495	0	2,671	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,996	0	1,112	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,409	12,966	70,040	14,915	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	218	0	490	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	240	0	3,652	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,190	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	383	2,790	0	3,517	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	246	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	257	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)	41,818	26,521	106,953	26,890	5,403	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	34	1,247	0	1,424	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	1,420	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	96	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	4,999	43,946	1,918	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	6,681	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)	41,852	32,863	152,319	36,913	5,403	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	63,384					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	96,225				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	37,094	850,068	0	850,068	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	514	3,142	0	3,142	54.00
57.00	05700	CT SCAN	0	128	720	0	720	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	7,390	31,141	0	31,141	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,896	58,307	0	58,307	65.00
66.00	06600	PHYSICAL THERAPY	0	4,380	88,694	0	88,694	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,556	110,806	0	110,806	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,962	20,217	0	20,217	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,582	35,461	0	35,461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	207	1,633	0	1,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,384	16,369	94,760	0	94,760	73.00
74.00	07400	RENAL DIALYSIS	0	2,147	14,630	0	14,630	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)	63,384	96,225	1,309,579	0	1,309,579	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	47,993	0	47,993	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	1,420	0	1,420	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	226	0	226	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	2,843	0	2,843	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	196,587	0	196,587	194.03
194.04	07954	EMS/AMBULANCE	0	0	7,430	0	7,430	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,384	96,225	1,566,078	0	1,566,078	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (EQUIPMENT COST)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (COMPUTER T IME)	ADMITTING (GROSS CHAR GES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	185,404					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,547,575				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	819	12,357	6,533,790			4.00
5.01	00550	DATA PROCESSING	0	3,443	61,906	95		5.01
5.02	00590	ADMITTING	1,224	0	103,527	3	44,789,854	5.02
5.03	00591	BUSINESS OFFICE	3,847	2,318	449,089	12	0	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	59,982	651,946	564,092	20	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	24,419	102,206	255,453	8	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,431	3,274	0	1	0	8.00
9.00	00900	HOUSEKEEPING	2,310	0	134,420	0	0	9.00
10.00	01000	DIETARY	11,512	54,462	302,843	3	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	399	0	23,348	2	0	14.00
15.00	01500	PHARMACY	1,347	0	319,839	4	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,147	0	78,857	3	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,263	497,059	2,948,782	20	17,261,652	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,042	0	0	239,190	54.00
57.00	05700	CT SCAN	0	0	0	0	59,521	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	593	80,696	33,323	1	3,440,331	60.00
65.00	06500	RESPIRATORY THERAPY	652	20,500	363,829	2	6,934,758	65.00
66.00	06600	PHYSICAL THERAPY	5,956	4,763	290,444	4	2,038,987	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,587	0	301,368	0	2,121,273	67.00
68.00	06800	SPEECH PATHOLOGY	668	0	140,711	1	1,379,147	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,598,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	96,403	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,301	0	0	7,620,474	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	999,531	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)	168,156	1,456,367	6,371,831	84	44,789,854	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,392	91,208	98,960	2	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	2,527	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	261	0	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	13,595	0	45,959	8	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	14,513	1	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)	1,442,466	71,167	887,800	126,077	140,856	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.780123	0.045986	0.135878	1,327.126316	0.003145	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,940	224	9,640	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001062	2.357895	0.000215	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 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
			5.03	5A.04	5.04	6.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE	44,789,854					5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	-3,232,600	13,381,604			5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	866,968	95,113		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	162,775	3,431	161,323	8.00
9.00	00900	HOUSEKEEPING	0	0	222,045	2,310	100	9.00
10.00	01000	DIETARY	0	0	676,189	11,512	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	15,136	399	0	14.00
15.00	01500	PHARMACY	0	0	1,122,713	1,347	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	216,394	8,147	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,261,652	0	6,627,714	35,263	159,616	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	239,190	0	54,240	0	0	54.00
57.00	05700	CT SCAN	59,521	0	13,094	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,440,331	0	247,249	593	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,934,758	0	616,077	652	0	65.00
66.00	06600	PHYSICAL THERAPY	2,038,987	0	462,034	5,956	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,121,273	0	484,766	7,587	1,475	67.00
68.00	06800	SPEECH PATHOLOGY	1,379,147	0	214,295	668	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,598,587	0	545,308	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,403	0	26,332	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,620,474	0	177,294	0	0	73.00
74.00	07400	RENAL DIALYSIS	999,531	0	282,028	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)	44,789,854	-3,232,600	13,032,651	77,865	161,191	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	155,081	3,392	132	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	5,437	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	2,031	261	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	168,592	13,595	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	17,812	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)	895,958		3,232,600	1,076,401	240,926	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.020004		0.241570	11.317075	1.493439	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,542		549,739	230,590	41,852	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000682		0.041082	2.424379	0.259430	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 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	89,372					9.00
10.00	01000	DIETARY	11,512	61,765				10.00
11.00	01100	CAFETERIA	0	14,968	10,392			11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	399	0	150	506,928		14.00
15.00	01500	PHARMACY	1,347	0	752	0	681,488	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,147	0	313	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,263	28,401	4,199	0	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	593	0	138	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	652	0	1,028	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,956	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,587	0	990	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	668	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	482,827	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,101	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	681,488	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)	72,124	43,369	7,570	506,928	681,488	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,392	0	401	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	576	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	261	0	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	13,595	17,820	540	0	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	1,881	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)	301,975	1,008,715	244,450	28,184	1,431,411	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.378855	16.331498	23.522902	0.055598	2.100420	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,863	152,319	36,913	5,403	63,384	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.367710	2.466105	3.552059	0.010658	0.093008	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 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 5:12 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	DATA PROCESSING			5.01
5.02	00590	ADMITTING			5.02
5.03	00591	BUSINESS OFFICE			5.03
5.04	00592	ADMINISTRATIVE AND GENERAL			5.04
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,789,854		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	17,261,652		30.00
46.00	04600	OTHER LONG TERM CARE	0		46.00
		ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,190		54.00
57.00	05700	CT SCAN	59,521		57.00
58.00	05800	MRI	0		58.00
60.00	06000	LABORATORY	3,440,331		60.00
65.00	06500	RESPIRATORY THERAPY	6,934,758		65.00
66.00	06600	PHYSICAL THERAPY	2,038,987		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,121,273		67.00
68.00	06800	SPEECH PATHOLOGY	1,379,147		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,598,587		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,403		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,620,474		73.00
74.00	07400	RENAL DIALYSIS	999,531		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)	44,789,854		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	OTHER NONREIMBURSABLE	0		194.00
194.01	07951	MARKETING DEPARTMENT	0		194.01
194.02	07952	OTHER NONALLOWABLE	0		194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0		194.03
194.04	07954	EMS/AMBULANCE	0		194.04
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	395,759		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008836		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	96,225		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002148		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 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,700,497		9,700,497	39,393	9,739,890	30.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,456		69,456	0	69,456	54.00
57.00	05700	CT SCAN	16,783		16,783	0	16,783	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	349,337		349,337	0	349,337	60.00
65.00	06500	RESPIRATORY THERAPY	859,943	0	859,943	0	859,943	65.00
66.00	06600	PHYSICAL THERAPY	679,192	0	679,192	0	679,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	757,604	0	757,604	0	757,604	67.00
68.00	06800	SPEECH PATHOLOGY	288,065	0	288,065	0	288,065	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	726,843		726,843	0	726,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,885		34,885	0	34,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,718,869		1,718,869	0	1,718,869	73.00
74.00	07400	RENAL DIALYSIS	358,990		358,990	0	358,990	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)	15,560,464	0	15,560,464	39,393	15,599,857	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	15,560,464	0	15,560,464	39,393	15,599,857	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,261,652		17,261,652			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	228,959	10,231	239,190	0.290380	0.000000	54.00
57.00	05700	CT SCAN	59,521	0	59,521	0.281968	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	3,154,080	286,251	3,440,331	0.101542	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,932,886	1,872	6,934,758	0.124005	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,838,339	200,648	2,038,987	0.333103	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,964,393	156,880	2,121,273	0.357146	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,267,633	111,514	1,379,147	0.208872	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,587,599	10,988	2,598,587	0.279707	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,403	0	96,403	0.361866	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,620,474	0	7,620,474	0.225559	0.000000	73.00
74.00	07400	RENAL DIALYSIS	999,531	0	999,531	0.359158	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	44,011,470	778,384	44,789,854			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	44,011,470	778,384	44,789,854			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290380	54.00
57.00	05700	CT SCAN	0.281968	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.101542	60.00
65.00	06500	RESPIRATORY THERAPY	0.124005	65.00
66.00	06600	PHYSICAL THERAPY	0.333103	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357146	67.00
68.00	06800	SPEECH PATHOLOGY	0.208872	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.279707	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.361866	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225559	73.00
74.00	07400	RENAL DIALYSIS	0.359158	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 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,700,497		9,700,497	39,393	9,739,890	30.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	69,456		69,456	0	69,456	54.00
57.00	05700	CT SCAN	16,783		16,783	0	16,783	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	349,337		349,337	0	349,337	60.00
65.00	06500	RESPIRATORY THERAPY	859,943	0	859,943	0	859,943	65.00
66.00	06600	PHYSICAL THERAPY	679,192	0	679,192	0	679,192	66.00
67.00	06700	OCCUPATIONAL THERAPY	757,604	0	757,604	0	757,604	67.00
68.00	06800	SPEECH PATHOLOGY	288,065	0	288,065	0	288,065	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	726,843		726,843	0	726,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,885		34,885	0	34,885	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,718,869		1,718,869	0	1,718,869	73.00
74.00	07400	RENAL DIALYSIS	358,990		358,990	0	358,990	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)	15,560,464	0	15,560,464	39,393	15,599,857	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	15,560,464	0	15,560,464	39,393	15,599,857	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,261,652		17,261,652			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	228,959	10,231	239,190	0.290380	0.000000	54.00
57.00	05700	CT SCAN	59,521	0	59,521	0.281968	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	3,154,080	286,251	3,440,331	0.101542	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,932,886	1,872	6,934,758	0.124005	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,838,339	200,648	2,038,987	0.333103	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,964,393	156,880	2,121,273	0.357146	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,267,633	111,514	1,379,147	0.208872	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,587,599	10,988	2,598,587	0.279707	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,403	0	96,403	0.361866	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,620,474	0	7,620,474	0.225559	0.000000	73.00
74.00	07400	RENAL DIALYSIS	999,531	0	999,531	0.359158	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	44,011,470	778,384	44,789,854			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	44,011,470	778,384	44,789,854			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:12 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 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	850,068	0	850,068	9,467	89.79	30.00
200.00	Total (lines 30 through 199)	850,068		850,068	9,467		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	3,109	279,157	30.00
200.00	Total (lines 30 through 199)	3,109	279,157	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,142	239,190	0.013136	72,152	948	54.00
57.00	05700	CT SCAN	720	59,521	0.012097	50,879	615	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	31,141	3,440,331	0.009052	1,292,009	11,695	60.00
65.00	06500	RESPIRATORY THERAPY	58,307	6,934,758	0.008408	1,349,617	11,348	65.00
66.00	06600	PHYSICAL THERAPY	88,694	2,038,987	0.043499	476,552	20,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	110,806	2,121,273	0.052236	546,863	28,566	67.00
68.00	06800	SPEECH PATHOLOGY	20,217	1,379,147	0.014659	300,741	4,409	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,461	2,598,587	0.013646	853,926	11,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,633	96,403	0.016939	30,987	525	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	94,760	7,620,474	0.012435	2,419,616	30,088	73.00
74.00	07400	RENAL DIALYSIS	14,630	999,531	0.014637	148,006	2,166	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)	459,511	27,528,202		7,541,348	122,743	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30 through 199)	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	9,467	0.00	3,109	30.00
200.00		Total (lines 30 through 199)		0	9,467		3,109	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 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	239,190	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	59,521	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	3,440,331	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,934,758	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,038,987	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,121,273	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,379,147	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,598,587	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	96,403	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,620,474	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	999,531	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	27,528,202		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:12 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	72,152	0	3,709	0	54.00
57.00	05700	CT SCAN	0.000000	50,879	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,292,009	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,349,617	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	476,552	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	546,863	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	300,741	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	853,926	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	30,987	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,419,616	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	148,006	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)		7,541,348	0	3,709	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290380	3,709	0	0	1,077	54.00
57.00	05700	CT SCAN	0.281968	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.101542	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.124005	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.333103	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357146	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.208872	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.279707	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.361866	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225559	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.359158	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		3,709	0	0	1,077	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		3,709	0	0	1,077	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: 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 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 5:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290380	0	3,180	0	0	54.00
57.00	05700	CT SCAN	0.281968	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.101542	0	51,898	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.124005	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.333103	0	35,855	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357146	0	18,504	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.208872	0	13,197	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.279707	0	110	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.361866	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225559	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.359158	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	122,744	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	122,744	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 5:12 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	923	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	5,270	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	11,943	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,609	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,756	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31	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)	27,532	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	27,532	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 52-2005	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/24/2018 5:12 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)	9,467	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,467	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)	9,467	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)	3,109	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,739,890	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,739,890	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,739,890	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)	1,028.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,198,632	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)	3,198,632	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	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)	1,599,702	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,798,334	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)	279,157	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	122,743	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	401,900	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,396,434	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 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:12 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	850,068	9,739,890	0.087277	0	0	90.00
91.00	Nursing School cost	0	9,739,890	0.000000	0	0	91.00
92.00	Allied health cost	0	9,739,890	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,739,890	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:12 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)	9,467	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,467	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)	9,467	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)	2,095	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,700,497	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,700,497	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,700,497	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)	1,024.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,146,663	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,146,663	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:12 pm

Title XIX | Hospital | Cost

	Cost Center Description	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)	1,006,290	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,152,953	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 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:12 pm

Title XIX | Hospital | Cost

	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	850,068	9,700,497	0.087631	0	0	90.00
91.00	Nursing School cost	0	9,700,497	0.000000	0	0	91.00
92.00	Allied health cost	0	9,700,497	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,700,497	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 5:12 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		5,405,720		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290380	72,152	20,951	54.00
57.00	05700	CT SCAN	0.281968	50,879	14,346	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.101542	1,292,009	131,193	60.00
65.00	06500	RESPIRATORY THERAPY	0.124005	1,349,617	167,359	65.00
66.00	06600	PHYSICAL THERAPY	0.333103	476,552	158,741	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357146	546,863	195,310	67.00
68.00	06800	SPEECH PATHOLOGY	0.208872	300,741	62,816	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.279707	853,926	238,849	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.361866	30,987	11,213	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225559	2,419,616	545,766	73.00
74.00	07400	RENAL DIALYSIS	0.359158	148,006	53,158	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)		7,541,348	1,599,702	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)		7,541,348		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 5:12 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		3,905,448		30.00
		ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.290380	27,767	8,063	54.00
57.00	05700	CT SCAN	0.281968	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.101542	506,317	51,412	60.00
65.00	06500	RESPIRATORY THERAPY	0.124005	908,668	112,679	65.00
66.00	06600	PHYSICAL THERAPY	0.333103	460,640	153,441	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357146	473,277	169,029	67.00
68.00	06800	SPEECH PATHOLOGY	0.208872	322,623	67,387	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.279707	511,530	143,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.361866	5,311	1,922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225559	1,149,086	259,187	73.00
74.00	07400	RENAL DIALYSIS	0.359158	111,625	40,091	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)		4,476,844	1,006,290	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)		4,476,844		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 52-2005	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/24/2018 5:12 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)	1,077	2.00
3.00	OPPS payments	341	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)	341	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	68	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)	273	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)	273	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	273	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)	8,357	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	5,432	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	7,411	36.00
37.00	Subtotal (see instructions)	5,705	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)		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)	5,705	40.00
40.01	Sequestration adjustment (see instructions)	114	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	267	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	5,324	43.00
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 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2018 5:12 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		2,480,110		267	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)		2,480,110		267	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		391,839		5,324	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,871,949		5,591	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 01/01/2017 To 12/31/2017	Worksheet E-3 Part IV Date/Time Prepared: 5/24/2018 5:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART IV - MEDICARE PART A SERVICES - LTCH PPS		
1.00	Net Federal PPS Payments (see instructions)	2,311,238	1.00
1.01	Full standard payment amount	1,771,632	1.01
1.02	Short stay outlier standard payment amount	320,272	1.02
1.03	Site neutral payment amount - Cost	7,768	1.03
1.04	Site neutral payment amount - IPPS comparable	211,566	1.04
2.00	Outlier Payments	865,258	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)	3,176,496	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)		5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)	0	6.00
7.00	Subtotal (see instructions)	3,176,496	7.00
8.00	Primary payer payments	8,540	8.00
9.00	Subtotal (line 7 less line 8).	3,167,956	9.00
10.00	Deductibles	7,868	10.00
11.00	Subtotal (line 9 minus line 10)	3,160,088	11.00
12.00	Coinsurance	629,363	12.00
13.00	Subtotal (line 11 minus line 12)	2,530,725	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	615,131	14.00
15.00	Adjusted reimbursable bad debts (see instructions)	399,835	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	269,610	16.00
17.00	Subtotal (sum of lines 13 and 15)	2,930,560	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	18.00
19.00	Other pass through costs (see instructions)	0	19.00
20.00	Outlier payments reconciliation	0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	21.50
21.99	Demonstration payment adjustment amount before sequestration	0	21.99
22.00	Total amount payable to the provider (see instructions)	2,930,560	22.00
22.01	Sequestration adjustment (see instructions)	58,611	22.01
22.02	Demonstration payment adjustment amount after sequestration	0	22.02
23.00	Interim payments	2,480,110	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)	391,839	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)	865,258	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 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/24/2018 5:12 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	3,152,953		1.00
2.00	Medical and other services		27,532	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	3,152,953	27,532	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)	3,152,953	27,532	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,905,448		8.00
9.00	Ancillary service charges	4,476,844	122,744	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)	8,382,292	122,744	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)	8,382,292	122,744	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	5,229,339	95,212	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)	3,152,953	27,532	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	3,152,953	27,532	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)	3,152,953	27,532	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	3,152,953	27,532	36.00
37.00	ELIMINATE COST SETTLEMENT	-3,152,953	-27,532	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	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 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/24/2018 5:12 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	40,828	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	6,495,219	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-442,805	0	0	0	6.00
7.00	Inventory	227,314	0	0	0	7.00
8.00	Prepaid expenses	94,468	0	0	0	8.00
9.00	Other current assets	76,066	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)	6,491,090	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	656,103	0	0	0	17.00
18.00	Accumulated depreciation	-594,907	0	0	0	18.00
19.00	Fixed equipment	290,159	0	0	0	19.00
20.00	Accumulated depreciation	-274,868	0	0	0	20.00
21.00	Automobiles and trucks	121,452	0	0	0	21.00
22.00	Accumulated depreciation	-105,446	0	0	0	22.00
23.00	Major movable equipment	773,599	0	0	0	23.00
24.00	Accumulated depreciation	-672,605	0	0	0	24.00
25.00	Minor equipment depreciable	362,365	0	0	0	25.00
26.00	Accumulated depreciation	-356,862	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)	198,990	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)	6,690,080	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,035,381	0	0	0	37.00
38.00	Salaries, wages, and fees payable	495,917	0	0	0	38.00
39.00	Payroll taxes payable	526,155	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,150,136	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,207,589	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	13,207,589	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-6,517,509				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-6,517,509	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,690,080	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 52-2005 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/24/2018 5:12 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-3,053,107		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-743,655				2.00
3.00	Total (sum of line 1 and line 2)		-3,796,762		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)		-3,796,762		0		11.00
12.00	2016 ADJUSTMENTS	2,689,426		0		0	12.00
13.00	2015 ADJUSTMENTS	31,321		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)		2,720,747		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-6,517,509		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	2016 ADJUSTMENTS		0			12.00
13.00	2015 ADJUSTMENTS		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 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2018 5:12 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	14,828,035		14,828,035	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)	14,828,035		14,828,035	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)	14,828,035		14,828,035	17.00
18.00	Ancillary services	28,775,461	0	28,775,461	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN CHARGES	42,203	0	42,203	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	43,645,699	0	43,645,699	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,555,127		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)		17,555,127		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 52-2005	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/24/2018 5:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,645,699	1.00
2.00	Less contractual allowances and discounts on patients' accounts	28,550,847	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,094,852	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,555,127	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,460,275	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	39,437	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	33,255	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	4,993	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	2,409	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	253,801	24.00
24.01	LAKEVIEW CARE PARTNERS INCOME	1,299,048	24.01
24.02	EMS INCOME	83,677	24.02
25.00	Total other income (sum of lines 6-24)	1,716,620	25.00
26.00	Total (line 5 plus line 25)	-743,655	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)	-743,655	29.00