In Lieu of Form CMS-2552-10
Health Financial Systems
LAKEVIEW SPECI ALTY HOSPITAL & REHAB

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).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY
Provider CCN: 522005
Period: From 01/01/2015 To 12/31/2015
Worksheet S
Parts I-III
5/31/2016 11:37 am

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 SPECI ALTY HOSPITAL & REHAB (522005) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

(Signed) Officer or Administrator of Provider(s)
Title
Date

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Title V</th>
<th>Title XVII</th>
<th>Part A</th>
<th>Part B</th>
<th>HIT</th>
<th>Title XI X</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 Hospital</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.00 Subprovider - IPF</td>
<td>0</td>
<td>-408,696</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>3.00 Subprovider - IRF</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2.00</td>
</tr>
<tr>
<td>5.00 Swing bed - SNF</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3.00</td>
</tr>
<tr>
<td>6.00 Swing bed - NF</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6.00</td>
</tr>
<tr>
<td>200.00 Total</td>
<td>0</td>
<td>-408,696</td>
<td>0</td>
<td>0</td>
<td>200.00</td>
<td></td>
</tr>
</tbody>
</table>

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 this 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 this information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports 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 this address. 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.
**State:** 2.00  
**Street:** Hospital-Based SNF  
**City:** RACINE  
**County:** WI  
**PO Box:** 23.00  
**ZIP Code:** 53185  
**State:** W  
**County:** RACINE  

### Hospital and Hospital-Based Component Identification

<table>
<thead>
<tr>
<th>Component Name</th>
<th>CCN Number</th>
<th>CBSA Number</th>
<th>Provider Type</th>
<th>Date Certified</th>
<th>Payment System (P, T, Q, or O)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITAL &amp; HOSPITAL &amp; REHAB</td>
<td>522005</td>
<td>39540</td>
<td>2</td>
<td>10/01/1996</td>
<td>N P O 3.00</td>
</tr>
</tbody>
</table>

### Inpatient PPS Information

<table>
<thead>
<tr>
<th>Cost Reporting Period (mm/dd/yyyy)</th>
<th>Type of Control (see instructions)</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2015 to 12/31/2015</td>
<td>4</td>
<td>21.00</td>
<td></td>
</tr>
</tbody>
</table>

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 §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.

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)

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 occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.

22.03 Did this hospital report a geographic reclassification from urban to rural as a result of the CMS 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.

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.

<table>
<thead>
<tr>
<th>In-State Medicaid paid days</th>
<th>In-State Medicaid eligible unpaid days</th>
<th>Out-of-State Medicaid paid days</th>
<th>Out-of-State Medicaid eligible unpaid days</th>
<th>Medicaid HMO days</th>
<th>Other Medicaid days</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-State Medicaid paid days</td>
<td>In-State Medicaid eligible unpaid days</td>
<td>Out-of-State Medicaid paid days</td>
<td>Out-of-State Medicaid eligible unpaid days</td>
<td>Medicaid HMO days</td>
<td>Other Medicaid days</td>
</tr>
<tr>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td>4.00</td>
<td>5.00</td>
<td>6.00</td>
</tr>
</tbody>
</table>

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.

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 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.
If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

Would you like to proceed with the current results of the conversion or go back to the main page?
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted FTE Count</th>
<th>Unweighted Direct GME FTE Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>61.10</td>
<td></td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>61.20</td>
<td></td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

**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)

62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during this cost reporting period of HRSA THC program (see instructions)

**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 64-67 (see instructions)

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted FTEs Nonprovider Site</th>
<th>Unweighted FTEs in Hospital</th>
<th>Ratio (col. 1/ (col. 1 + col. 2))</th>
</tr>
</thead>
<tbody>
<tr>
<td>64.00</td>
<td></td>
<td>0.00</td>
<td>0.00</td>
<td>0.000000</td>
</tr>
</tbody>
</table>

**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.

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 resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 4, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 2)). (see instructions)
### HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

<table>
<thead>
<tr>
<th>Provider CCN</th>
<th>522005</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Period: From 01/01/2015 To 12/31/2015</th>
<th>Worksheet S-2</th>
<th>Date/Time Prepared: 3/31/2016 11:36 am</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Unweighted FTEs Nonprovider Site</th>
<th>Unweighted FTEs in Hospital</th>
<th>Ratio (col. 1/col. 1 + col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
</tr>
</tbody>
</table>

### 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)

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-providing 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)

### 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.

71.00 If line 70 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)

### 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.

76.00 If line 75 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)(ii)(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)

### Long Term Care Hospital PPS

80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.

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.

### 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.

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.

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.

93.00 Does this facility operate an IC/FIID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.

94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.
<table>
<thead>
<tr>
<th>Period: From 01/01/2015 To 12/31/2015</th>
<th>Worksheet S-2 Date/Time Prepared: 5/31/2016 11:36 am</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V</strong> 1.00 <strong>X</strong> 2.00</td>
<td></td>
</tr>
<tr>
<td>95.00</td>
<td>If line 94 is &quot;Y&quot;, enter the reduction percentage in the applicable column.</td>
</tr>
<tr>
<td>96.00</td>
<td>Does title V or XIIX reduce operating cost? Enter &quot;Y&quot; for yes or &quot;N&quot; for no in the applicable column.</td>
</tr>
<tr>
<td>97.00</td>
<td>If line 96 is &quot;Y&quot;, enter the reduction percentage in the applicable column.</td>
</tr>
<tr>
<td><strong>Rural Providers</strong></td>
<td></td>
</tr>
<tr>
<td>105.00</td>
<td>Does this hospital qualify as a critical access hospital (CAH)?</td>
</tr>
<tr>
<td>106.00</td>
<td>If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)</td>
</tr>
<tr>
<td>107.00</td>
<td>If this facility qualifies as a CAH, is it eligible for cost reimbursement for 18R training programs? Enter &quot;Y&quot; for yes or &quot;N&quot; for no in column 1, (see instructions) if yes, the ORM evaluation is not made on Wkst. 8, col. 25 and the program's cost is reimbursed. If yes complete Wkst. D-2, Pt. II.</td>
</tr>
<tr>
<td>108.00</td>
<td>Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
</tr>
<tr>
<td><strong>Physical</strong></td>
<td><strong>Occupational</strong></td>
</tr>
<tr>
<td>1.00</td>
<td>2.00</td>
</tr>
<tr>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>110.00</td>
<td>Did this hospital participate in the Rural Community Hospital Demonstration project (410A Dem) for the current cost reporting period? Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
</tr>
<tr>
<td><strong>Miscellaneous Cost Reporting Information</strong></td>
<td></td>
</tr>
<tr>
<td>115.00</td>
<td>Is this an all-inclusive rate provider? Enter &quot;Y&quot; for yes or &quot;N&quot; 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 &quot;E&quot;, enter in column 3 either &quot;93&quot; percent for short term hospital or &quot;98&quot; percent for long term care (includes psychiatric, rehabilitation and long term hosp providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.</td>
</tr>
<tr>
<td>116.00</td>
<td>Is this facility classified as a referral center? Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
</tr>
<tr>
<td>117.00</td>
<td>Is this facility legally required to carry malpractice insurance? Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
</tr>
<tr>
<td>118.00</td>
<td>Is the malpractice insurance a claim-made or occurrence policy? Enter 1 if the policy is claim made, Enter 2 if the policy is occurrence.</td>
</tr>
<tr>
<td><strong>Premiums</strong></td>
<td><strong>Losses</strong></td>
</tr>
<tr>
<td>1.00</td>
<td>2.00</td>
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<tr>
<td>118.01</td>
<td>List amounts of malpractice premiums and paid losses:</td>
</tr>
<tr>
<td>126.948</td>
<td>0</td>
</tr>
<tr>
<td>118.02</td>
<td>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.</td>
</tr>
<tr>
<td>119.00</td>
<td>DO NOT USE THIS LINE.</td>
</tr>
<tr>
<td>120.00</td>
<td>Is this a SOH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, &quot;Y&quot; for yes or &quot;N&quot; for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
</tr>
<tr>
<td>121.00</td>
<td>Did this facility incur and report costs for high cost implantable devices charged to patients? Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
</tr>
<tr>
<td><strong>Transplant Center Information</strong></td>
<td></td>
</tr>
<tr>
<td>125.00</td>
<td>Does this facility operate a transplant center? Enter &quot;Y&quot; for yes and &quot;N&quot; for no. If yes, enter certification date(s) (mm/dd/yyyy) below.</td>
</tr>
<tr>
<td>126.00</td>
<td>If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</td>
</tr>
<tr>
<td>127.00</td>
<td>If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</td>
</tr>
<tr>
<td>128.00</td>
<td>If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</td>
</tr>
<tr>
<td>129.00</td>
<td>If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</td>
</tr>
<tr>
<td>130.00</td>
<td>If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</td>
</tr>
<tr>
<td>131.00</td>
<td>If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</td>
</tr>
<tr>
<td>132.00</td>
<td>If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</td>
</tr>
<tr>
<td>133.00</td>
<td>If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.</td>
</tr>
<tr>
<td>134.00</td>
<td>If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.</td>
</tr>
</tbody>
</table>
### HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

| Provider CCN | 522005 |

#### Period:
- From: 01/01/2015
- To: 12/31/2015

#### Worksheet S-2

#### Part 1

**Date/Time Prepared:** 3/31/2016 11:36 am

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### Part I

**Provider CCN:** 522005

#### To: 01/01/2015

#### From: 12/31/2015

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#### 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.

- **Name:** LAKEVIEW MANAGEMENT INC.
- **Contractor’s Name:** WPS
- **Contractor’s Number:** 52280

#### Street: 2011 RUTLAND DRIVE

#### PO Box: 

#### City: AUSTIN

#### State: TX

#### Zip Code: 78758

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#### 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**

---

#### Are provider based physicians’ costs included in Worksheet A?

- **Y**

---

#### 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)

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#### 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**
- **11/23/2015**

---

#### 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)

- **Hospital**
- **Subprovider - IPF**
- **Subprovider - IRF**
- **HOME HEALTH AGENCY**
- **CMHC**

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#### 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**

---

#### Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

---

### Part A

#### Name

<table>
<thead>
<tr>
<th>County</th>
<th>State</th>
<th>Zip Code</th>
<th>CBSA</th>
<th>FTE/Campus</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td>4.00</td>
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</table>

#### Begining

<table>
<thead>
<tr>
<th>Ending</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
</tr>
</tbody>
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#### End of Document
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. (see instructions)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>1.00</td>
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</tr>
<tr>
<td>171.00</td>
<td></td>
</tr>
<tr>
<td>Provider Organization and Operation</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>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)</td>
<td>N</td>
</tr>
<tr>
<td>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.</td>
<td>N</td>
</tr>
<tr>
<td>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)</td>
<td>Y</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Data and Reports</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>4.00 Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter &quot;A&quot; for Audited, &quot;C&quot; for Compiled, or &quot;R&quot; for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)</td>
<td>Y</td>
</tr>
<tr>
<td>5.00 Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approved Educational Activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?</td>
<td>N</td>
</tr>
<tr>
<td>7.00 Are costs claimed for Allied Health Programs? If &quot;Y&quot; see instructions.</td>
<td>N</td>
</tr>
<tr>
<td>8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.</td>
<td>N</td>
</tr>
<tr>
<td>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.</td>
<td>N</td>
</tr>
<tr>
<td>10.00 Were an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.</td>
<td>N</td>
</tr>
<tr>
<td>11.00 Are GME costs directly assigned to cost centers other than I &amp; R in an Approved Teaching Program on Worksheet A? If yes, see instructions.</td>
<td>N</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bad Debts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions.</td>
<td>Y</td>
</tr>
<tr>
<td>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.</td>
<td>N</td>
</tr>
<tr>
<td>14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.</td>
<td>N</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Bed Complement</th>
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<tbody>
<tr>
<td>15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions.</td>
<td>N</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PS&amp;R Data</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16.00 Was the cost report prepared using the PS&amp;R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&amp;R Report used in columns 2 and 4. (see instructions)</td>
<td>N</td>
</tr>
<tr>
<td>17.00 Was the cost report prepared using the PS&amp;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 column 2 and 4. (see instructions)</td>
<td>Y</td>
</tr>
<tr>
<td>18.00 If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for additional claims that have been billed but are not included on the PS&amp;R Report used to file this cost report? If yes, see instructions.</td>
<td>N</td>
</tr>
<tr>
<td>19.00 If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for corrections of other PS&amp;R Report information? If yes, see instructions.</td>
<td>N</td>
</tr>
<tr>
<td>20.00 If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for Other? Describe the other adjustments:</td>
<td>N</td>
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</tbody>
</table>
### HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

**Part II**

<table>
<thead>
<tr>
<th>Description</th>
<th>Y/N</th>
<th>Date</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.</td>
<td>N</td>
<td>1.00</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

**Completed by Cost Reimbursement and TEFRA Hospitals Only (Except Children's Hospitals)**

#### Capital Related Cost

- 22.00 Have assets been relieved for Medicare purposes? If yes, see instructions
- 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions
- 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions
- 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions
- 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions
- 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.

#### Interest Expense

- 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions
- 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
- 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions
- 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.

#### 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
- 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions

#### Provider-Based Physicians

- 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.
- 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.

#### Home Office Costs

<table>
<thead>
<tr>
<th>Description</th>
<th>Y/N</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>36.00 Were home office costs claimed on the cost report?</td>
<td>Y</td>
<td>1.00</td>
</tr>
<tr>
<td>37.00 If line 36 is yes, has a home office cost statement been prepared by the home office?</td>
<td>Y</td>
<td>2.00</td>
</tr>
<tr>
<td>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.</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

#### 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.
- 42.00 Enter the employer/company name of the cost report preparer.
- 43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.
### HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

#### Part B

<table>
<thead>
<tr>
<th>PS&amp;R Data</th>
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<td>16.00</td>
<td>Was the cost report prepared using the PS&amp;R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&amp;R Report used in columns 2 and 4. (see instructions)</td>
<td>16.00</td>
</tr>
<tr>
<td>17.00</td>
<td>Was the cost report prepared using the PS&amp;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)</td>
<td>17.00</td>
</tr>
<tr>
<td>18.00</td>
<td>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for additional claims that have been billed but are not included on the PS&amp;R Report used to file this cost report? If yes, see instructions.</td>
<td>18.00</td>
</tr>
<tr>
<td>19.00</td>
<td>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for corrections of other PS&amp;R Report information? If yes, see instructions.</td>
<td>19.00</td>
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<td>20.00</td>
<td>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for Other? Describe the other adjustments:</td>
<td>20.00</td>
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<tr>
<td>21.00</td>
<td>Was the cost report prepared only using the provider’s records? If yes, see instructions.</td>
<td>21.00</td>
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#### Cost Report Preparer Contact Information

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<td>41.00</td>
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<tr>
<td>Component</td>
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<td>--------------------------------------------------------------------------</td>
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<td>1.00 Hospital Adults &amp; 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)</td>
</tr>
<tr>
<td>2.00 HMO and other (see instructions)</td>
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<tr>
<td>3.00 HMO I/F Subprovider</td>
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<tr>
<td>4.00 HMO I/F Subprovider</td>
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<tr>
<td>5.00 Hospital Adults &amp; Peds. Swing Bed SNF</td>
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<tr>
<td>6.00 Hospital Adults &amp; Peds. Swing Bed NF</td>
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<tr>
<td>7.00 Total Adults and Peds. (exclude observation beds) (see instructions)</td>
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<tr>
<td>8.00 INTENSIVE CARE UNIT</td>
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<tr>
<td>9.00 CORONARY CARE UNIT</td>
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<td>10.00 BURN INTENSIVE CARE UNIT</td>
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<tr>
<td>11.00 SURGICAL INTENSIVE CARE UNIT</td>
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<td>12.00 OTHER SPECIAL CARE (SPEC FY)</td>
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<td>14.00 Total (see instructions)</td>
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<td>15.00 CAH visits</td>
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<td>17.00 SUBPROVIDER - I/R</td>
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<td>20.00 NURSING FACILITY</td>
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<tr>
<td>21.00 OTHER LONG TERM CARE</td>
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<tr>
<td>22.00 HOME HEALTH AGENCY</td>
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<td>23.00 AMBULATORY SURGICAL CENTER (D.P.)</td>
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<td>24.00 HOSPICE</td>
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<td>25.00 CMHC - CMHC</td>
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<td>26.25 FEDERALLY QUALIFIED HEALTH CENTER</td>
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<tr>
<td>27.00 Total (sum of lines 14-26)</td>
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<tr>
<td>28.00 Observation Bed Days</td>
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<tr>
<td>29.00 Ambulance Trips</td>
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<tr>
<td>30.00 Employee discount days (see instructions)</td>
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<tr>
<td>31.00 Employee discount days - I/R</td>
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<tr>
<td>32.00 Labor &amp; delivery days (see instructions)</td>
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<tr>
<td>32.01 Total ancillary labor &amp; delivery room outpatient days (see instructions)</td>
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<tr>
<td>33.00 LTCH non-covered days</td>
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<td>Component</td>
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<tr>
<td>Hospital Adults &amp; 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)</td>
</tr>
<tr>
<td>HMO and other (see instructions)</td>
</tr>
<tr>
<td>HMO IPF Subprovider</td>
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<tr>
<td>HMO IRF Subprovider</td>
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<tr>
<td>Hospital Adults &amp; Peds. Swing Bed SNF</td>
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<td>Hospital Adults &amp; Peds. Swing Bed NF</td>
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<td>Total Adults and Peds. (exclude observation beds) (see instructions)</td>
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<tr>
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<td>BURN INTENSIVE CARE UNIT</td>
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<tr>
<td>OTHER SPECIAL CARE (SPECIFY)</td>
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<td>NURSERY</td>
</tr>
<tr>
<td>Total (see instructions)</td>
</tr>
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<td>CAH visits</td>
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<td>SKILLED NURSING FACILITY</td>
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<tr>
<td>OTHER LONG TERM CARE</td>
</tr>
<tr>
<td>HOME HEALTH AGENCY</td>
</tr>
<tr>
<td>AMBULATORY SURGICAL CENTER (D.P.)</td>
</tr>
<tr>
<td>OBSERVATION Bed Days</td>
</tr>
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<td>CMHC - CMHC</td>
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<td>RURAL HEALTH CLINIC</td>
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<td>FEDERALLY QUALIFIED HEALTH CENTER</td>
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<tr>
<td>Observation Bed Days</td>
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<td>Ambulance Trips</td>
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<td>Employee discount days (see instructions)</td>
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<td>Employee discount days - IRF</td>
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<td>Labor &amp; delivery days (see instructions)</td>
</tr>
<tr>
<td>Total ancillary labor &amp; delivery room outpatient days (see instructions)</td>
</tr>
<tr>
<td>LTCH non-covered days</td>
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### RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

**Provider CCN:** 522005  
**Period:** From 01/01/2015 To 12/31/2015

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Reclassification (See A-6)</th>
<th>Reclassified Trial Balance (col. 3 + col. 4)</th>
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<tbody>
<tr>
<td><strong>GENERAL SERVICE COST CENTERS</strong></td>
<td></td>
<td></td>
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<td></td>
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<td>1.00 00100 CAP REL COSTS-BLDG &amp; FI XT</td>
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<td>0</td>
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<td>2,121,717</td>
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<td>3.00 00300 OTHER CAP REL COSTS</td>
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<td>5.03 00591 BUSI NESS OFFICE</td>
<td>435,556</td>
<td>2,832,625</td>
<td>3,268,181</td>
<td>-2,270,983</td>
<td>997,198</td>
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<td>5.04 00592 ADMI S NUTRIENT &amp; VITAMIN</td>
<td>842,748</td>
<td>1,106,672</td>
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<td>1,061,307</td>
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<td>6.00 00600 MANU NITENANCE &amp; REPAIR</td>
<td>327,380</td>
<td>533,732</td>
<td>861,112</td>
<td>34,444</td>
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<td>14.00 01400 CENTRAL SERV CEES &amp; SUPPLY</td>
<td>63,320</td>
<td>275,796</td>
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**ANCILLARY SERVICE COST CENTERS**

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<th>Cost Center Description</th>
<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Reclassification (See A-6)</th>
<th>Reclassified Trial Balance (col. 3 + col. 4)</th>
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<tr>
<td>30.00 03000 ADULTS &amp; PEDIATRICS</td>
<td>3,520,235</td>
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<td>46.00 04600 OTHER LONG TERM CARE</td>
<td>2,911,238</td>
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**OUTPATIENT ROUTINE SERVICE COST CENTERS**

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<th>Cost Center Description</th>
<th>Salaries</th>
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<th>Total (col. 1 + col. 2)</th>
<th>Reclassification (See A-6)</th>
<th>Reclassified Trial Balance (col. 3 + col. 4)</th>
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**NONREIMBURSABLE COST CENTERS**

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<th>Cost Center Description</th>
<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Reclassification (See A-6)</th>
<th>Reclassified Trial Balance (col. 3 + col. 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>192.00 01920 PHYSICIAN OFFICE</td>
<td>172,140</td>
<td>28,465</td>
<td>200,605</td>
<td>-23,030</td>
<td>177,575</td>
</tr>
<tr>
<td>194.00 01940 OTHER NON-REIMBURSABLE</td>
<td>0</td>
<td>0</td>
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**SPECIAL PURPOSE COST CENTERS**

<table>
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<tr>
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<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Reclassification (See A-6)</th>
<th>Reclassified Trial Balance (col. 3 + col. 4)</th>
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<tbody>
<tr>
<td>118.00 SUBTOTALS (SUM OF LINES 1-117)</td>
<td>10,615,675</td>
<td>12,258,930</td>
<td>22,874,605</td>
<td>-20,922</td>
<td>22,853,683</td>
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<table>
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<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Reclassification (See A-6)</th>
<th>Reclassified Trial Balance (col. 3 + col. 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>192.00 01920 PHYSICIAN OFFICE</td>
<td>172,140</td>
<td>28,465</td>
<td>200,605</td>
<td>-23,030</td>
<td>177,575</td>
</tr>
<tr>
<td>194.00 01940 OTHER NON-REIMBURSABLE</td>
<td>0</td>
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**TOTAL (SUM OF LINES 118-199) | 10,787,815 | 12,287,395 | 23,075,210            | 0                         | 23,075,210                         |
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<td>10.00 01000 DI ETARY</td>
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<td>11.00 01100 CAFETERIA A</td>
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<td>95.00 09500 AMBULANCE SERVI CES</td>
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<td>NONREIMBURSABLE COST CENTERS</td>
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<td>194.00 01940 OTHER NONREIMBURSABLE</td>
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## RECLASSIFICATIONS

### A - EQUIPMENT DEPRECIATION & AMORTIZATION

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<tr>
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<th>Salary</th>
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<tbody>
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<td>4.00</td>
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- **CAP REL COSTS - BLDG & FI XT**: 1.00
- **CAP REL COSTS - MBLLE EQUIP**: 2.00

### B - RECLASS CHARGEABLE MEDICAL SUPPLIES

<table>
<thead>
<tr>
<th>Line #</th>
<th>Salary</th>
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<tbody>
<tr>
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- **IMPLANTABLE DEVICES CHARGED TO PATIENTS**: 72.00
- **CAP REL COSTS - BLDG & FIXT**: 1.00

### C - RECLASS INSURANCE

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<thead>
<tr>
<th>Line #</th>
<th>Salary</th>
<th>Other</th>
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<tbody>
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- **CAP REL COSTS - BLDG & FIXT**: 1.00

### D - RECLASS OUTPATIENT SALARIES

<table>
<thead>
<tr>
<th>Line #</th>
<th>Salary</th>
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</thead>
<tbody>
<tr>
<td>2.00</td>
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</table>

- **PHYSICAL THERAPY**: 66.00
- **SPEECH PATHOLOGY**: 68.00

### E - RECLASS PURCHASED SERVICES

<table>
<thead>
<tr>
<th>Line #</th>
<th>Salary</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
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- **MEDICAL SUPPLIES CHARGED TO PATIENTS**: 71.00
- **CAP REL COSTS - BLDG & FIXT**: 1.00

### G - LAB

<table>
<thead>
<tr>
<th>Line #</th>
<th>Salary</th>
<th>Other</th>
</tr>
</thead>
<tbody>
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- **LABORATORY**: 60.00

### H - HOSPITAL SPECIFIC SALARY & BENEFITS

<table>
<thead>
<tr>
<th>Line #</th>
<th>Salary</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>2.00</td>
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</table>

- **ADULTS & PEDIATRICS**: 30.00
- **PHYSICIAN PRIVATE OFFICES**: 192.00

### I - RECLASS CT SCAN AND MRI COST

<table>
<thead>
<tr>
<th>Line #</th>
<th>Salary</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
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- **CT SCAN**: 57.00
- **MAGNETIC RESONANCE / MRI**: 58.00

### J - EOC DIRECTOR

<table>
<thead>
<tr>
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<th>Salary</th>
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<tbody>
<tr>
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- **MAINTENANCE & REPAIRS**: 6.00
- **HOUSEKEEPING**: 9.00

### K - MANAGEMENT FEES

<table>
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<tr>
<th>Line #</th>
<th>Salary</th>
<th>Other</th>
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- **ADM IN STRATIFIED GENERAL**: 5.04

### L - RECLASS THERAPY ADM

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- **PHYSICAL THERAPY**: 66.00
- **SPEECH PATHOLOGY**: 68.00

### M - EMPLOYEE HEALTH

<table>
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<tr>
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<th>Salary</th>
<th>Other</th>
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<tbody>
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- **EMPLOYEE BENEFITS DEPARTMENT**: 4.00

### N - MARKETING DEPARTMENT

<table>
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<th>Salary</th>
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<tbody>
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- **MARKETING DEPARTMENT**: 194.01

### O - RENTAL RECLASS

<table>
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<tr>
<th>Line #</th>
<th>Salary</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.00</td>
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- **CAP REL COSTS - BLDG & FI XT**: 1.00

### Grand Total: Increases

<table>
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<tr>
<th></th>
<th>683,167</th>
<th>4,249,731</th>
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<tr>
<td><strong>TOTALS</strong></td>
<td>500.00</td>
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<tr>
<td>Cost Center</td>
<td>Line #</td>
<td>Salary</td>
</tr>
<tr>
<td>------------</td>
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<tr>
<td>A - EQUIPMENT DEPRECIATION &amp; AMORTIZATION</td>
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Grand Total: Decreases 683,167 4,249,731
### PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

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<th>Description</th>
<th>Beginning Balance</th>
<th>Acquisitions</th>
<th>Disposals and Retirements</th>
<th>Ending Balance</th>
<th>Fully Depreciated Assets</th>
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### PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

<table>
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<tr>
<th>Description</th>
<th>Beginning Balance</th>
<th>Acquisitions</th>
<th>Disposals and Retirements</th>
<th>Ending Balance</th>
<th>Fully Depreciated Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Land Improvements</td>
<td>656,103</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Buildings and Fixtures</td>
<td>278,465</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Building Improvements</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fixed Equipment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Movable Equipment</td>
<td>1,180,642</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>HIT designated Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Subtotal (sum of lines 1-7)</td>
<td>2,115,210</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Reconciling Items</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total (line 8 minus line 9)</td>
<td>2,115,210</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Part II - Reconciliation of Amounts from Worksheet A, Column 2, Lines 1 and 2

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Depreciation</th>
<th>Lease</th>
<th>Interest</th>
<th>Insurance (see instructions)</th>
<th>Taxes (see instructions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 CAP REL COSTS-BLDG &amp; FI XT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2.00 CAP REL COSTS-M/BLE EQUIP</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3.00 Total (sum of lines 1-2)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Other Capital-Related Costs (see instructions)</th>
<th>Total (1) (sum of cols. 9 through 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 CAP REL COSTS-BLDG &amp; FI XT</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>2.00 CAP REL COSTS-M/BLE EQUIP</td>
<td>0</td>
<td>2.00</td>
</tr>
<tr>
<td>3.00 Total (sum of lines 1-2)</td>
<td>0</td>
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</table>
## COMPUTATION OF RATIOS

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Gross Assets</th>
<th>Capitalized Leases</th>
<th>Ratio (see instructions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
</tr>
</tbody>
</table>

### PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Gross Assets</th>
<th>Capitalized Leases</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAP REL COSTS-BLDG &amp; FI XT</td>
<td>278,465</td>
<td>0</td>
<td>0.190846</td>
</tr>
<tr>
<td>CAP REL COSTS-MVBLE EQUIP</td>
<td>1,180,642</td>
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<td>0.809154</td>
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<td>Total (sum of lines 1-2)</td>
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### ALLOCATION OF OTHER CAPITAL

#### SUMMARY OF CAPITAL

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<tr>
<th>Cost Center Description</th>
<th>Taxes</th>
<th>Other Capital-Related Costs</th>
<th>Total (sum of cols. 5 through 7)</th>
<th>Depreciation</th>
<th>Lease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.00</td>
<td>7.00</td>
<td>8.00</td>
<td>9.00</td>
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### PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Interest</th>
<th>Insurance (see instructions)</th>
<th>Taxes (see instructions)</th>
<th>Other Capital-Related Costs (see instructions)</th>
<th>Total (sum of cols. 9 through 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.00</td>
<td>12.00</td>
<td>13.00</td>
<td>14.00</td>
<td>15.00</td>
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</table>

### PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Interest</th>
<th>Insurance (see instructions)</th>
<th>Taxes (see instructions)</th>
<th>Other Capital-Related Costs (see instructions)</th>
<th>Total (sum of cols. 9 through 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.00</td>
<td>12.00</td>
<td>13.00</td>
<td>14.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Line #</td>
<td>Cost Center Description</td>
<td>Basis/Code (2)</td>
<td>Amount</td>
<td>Worksheet A-7 Ref.</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------</td>
<td>----------------</td>
<td>---------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>1.00</td>
<td>Investment income - CAP REL COSTS-BLDG &amp; FIXT (chapter 2)</td>
<td>0</td>
<td>CAP REL COSTS-BLDG &amp; FIXT</td>
<td>1.00</td>
<td>0</td>
</tr>
<tr>
<td>2.00</td>
<td>Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)</td>
<td>0</td>
<td>CAP REL COSTS-MVBLE EQUIP</td>
<td>2.00</td>
<td>0</td>
</tr>
<tr>
<td>3.00</td>
<td>Investment income - other (chapter 2)</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>3.00</td>
</tr>
<tr>
<td>4.00</td>
<td>Trade, quantity, and time discounts (chapter 8)</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>4.00</td>
</tr>
<tr>
<td>5.00</td>
<td>Refunds and rebates of expenses (chapter 8)</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>5.00</td>
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<tr>
<td>6.00</td>
<td>Rental of provider space by suppliers (chapter 8)</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>6.00</td>
</tr>
<tr>
<td>7.00</td>
<td>Telephone services (pay stations excluded) (chapter 21)</td>
<td>A</td>
<td>-21,859</td>
<td>MAINTENANCE &amp; REPAIR RS</td>
<td>6.00</td>
</tr>
<tr>
<td>8.00</td>
<td>Television and radio service (chapter 21)</td>
<td>A</td>
<td>-16,168</td>
<td>MAINTENANCE &amp; REPAIR RS</td>
<td>6.00</td>
</tr>
<tr>
<td>9.00</td>
<td>Parking lot (chapter 21)</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>9.00</td>
</tr>
<tr>
<td>10.00</td>
<td>Provider-based physician adjustment</td>
<td>A-8-2</td>
<td>-433,986</td>
<td></td>
<td>10.00</td>
</tr>
<tr>
<td>11.00</td>
<td>Sale of scrap, waste, etc.</td>
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<td>0</td>
<td>0.00</td>
<td>11.00</td>
</tr>
<tr>
<td>12.00</td>
<td>Related organization transactions (chapter 10)</td>
<td>A-8-1</td>
<td>-1,657,505</td>
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<tr>
<td>13.00</td>
<td>Laundry and linen service</td>
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<td>0</td>
<td>0.00</td>
<td>13.00</td>
</tr>
<tr>
<td>14.00</td>
<td>Cafeteria employees and guests</td>
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<td>-48,252</td>
<td>DIETARY</td>
<td>14.00</td>
</tr>
<tr>
<td>15.00</td>
<td>Rental of quarters to employee and others</td>
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<td>0</td>
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<td>15.00</td>
</tr>
<tr>
<td>16.00</td>
<td>Sale of medical and surgical supplies to other than patients</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>16.00</td>
</tr>
<tr>
<td>17.00</td>
<td>Sale of drugs to other than patients</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>17.00</td>
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<tr>
<td>18.00</td>
<td>Sale of medical records and abstracts</td>
<td>B</td>
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<td>MEDICAL RECORDS &amp; LIBRARY</td>
<td>18.00</td>
</tr>
<tr>
<td>19.00</td>
<td>Nursing school (tuition, fees, books, etc.)</td>
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<td>0</td>
<td>0.00</td>
<td>19.00</td>
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<tr>
<td>20.00</td>
<td>Vending machines</td>
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<td>-8,027</td>
<td>DIETARY</td>
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<td>21.00</td>
<td>Income from imposition of interest, finance or penalty charges (chapter 21)</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>21.00</td>
</tr>
<tr>
<td>22.00</td>
<td>Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>22.00</td>
</tr>
<tr>
<td>23.00</td>
<td>Adjustment for respiratory therapy costs in excess of limitation (chapter 14)</td>
<td>A-8-3</td>
<td>0</td>
<td>RESPIRATORY THERAPY</td>
<td>23.00</td>
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<tr>
<td>24.00</td>
<td>Adjustment for physical therapy costs in excess of limitation (chapter 14)</td>
<td>A-8-3</td>
<td>0</td>
<td>PHYSICAL THERAPY</td>
<td>24.00</td>
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<tr>
<td>25.00</td>
<td>Utilization review - physicians' compensation (chapter 21)</td>
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<td>0</td>
<td>0.00</td>
<td>25.00</td>
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<td>26.00</td>
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<td>0</td>
</tr>
<tr>
<td>27.00</td>
<td>Depreciation - CAP REL COSTS-MVBLE EQUIP (chapter 21)</td>
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<td>CAP REL COSTS-MVBLE EQUIP</td>
<td>2.00</td>
<td>0</td>
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<tr>
<td>28.00</td>
<td>Non-physician Anesthetist</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>28.00</td>
</tr>
<tr>
<td>29.00</td>
<td>Physicians' assistant</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
<td>29.00</td>
</tr>
<tr>
<td>30.00</td>
<td>Adjustment for occupational therapy costs in excess of limitation (chapter 14)</td>
<td>A-8-3</td>
<td>0</td>
<td>OCCUPATIONAL THERAPY</td>
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<tr>
<td>30.99</td>
<td>Hospice (non-distinct) (see instructions)</td>
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<td>0</td>
<td>0.00</td>
<td>30.99</td>
</tr>
<tr>
<td>31.00</td>
<td>Adjustment for speech pathology costs in excess of limitation (chapter 14)</td>
<td>A-8-3</td>
<td>0</td>
<td>SPEECH PATHOLOGY</td>
<td>31.00</td>
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<tr>
<td>32.00</td>
<td>CAH HIT Adjustment for Depreciation and Interest</td>
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<td>0.00</td>
<td>32.00</td>
</tr>
<tr>
<td>33.00</td>
<td>MISC INCOME</td>
<td>B</td>
<td>-4</td>
<td>ADMN STRAT VE AND GENERAL</td>
<td>33.00</td>
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<tr>
<td>34.00</td>
<td>RENTAL INCOME</td>
<td>B</td>
<td>-5</td>
<td>ADMN STRAT VE AND GENERAL</td>
<td>34.00</td>
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## Adjustments to Expenses

### Expense Classification on Worksheet A

<table>
<thead>
<tr>
<th>Line</th>
<th>Cost Center Description</th>
<th>Basis/Code (2)</th>
<th>Amount</th>
<th>Cost Center Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.00</td>
<td>Non-Allowable Marketing</td>
<td>A - 42</td>
<td>-35.00</td>
<td>Pharmacotherapeutic and General</td>
<td>15.00</td>
</tr>
<tr>
<td>36.00</td>
<td>Non-Allowable Donations</td>
<td>A - 1,250</td>
<td>-36.00</td>
<td>Administrative and General</td>
<td>5.04</td>
</tr>
<tr>
<td>39.00</td>
<td>Hospital Assessment</td>
<td>A - 97,520</td>
<td>-39.00</td>
<td>Adult &amp; Pediatric Structures</td>
<td>30.00</td>
</tr>
<tr>
<td>40.00</td>
<td>Non-Allowable Penalties</td>
<td>A - 21,400</td>
<td>-40.00</td>
<td>Business Office</td>
<td>5.04</td>
</tr>
<tr>
<td>41.00</td>
<td>Non-Allowable Business Development</td>
<td>A - 35,531</td>
<td>-41.00</td>
<td>Administrative and General</td>
<td>5.04</td>
</tr>
<tr>
<td>42.00</td>
<td>Non-Allowable Marketing</td>
<td>A - 30,669</td>
<td>-42.00</td>
<td>Administrative and General</td>
<td>5.04</td>
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<tr>
<td>43.00</td>
<td>Non-Allowable Marketing</td>
<td>A - 186</td>
<td>-43.00</td>
<td>Respiratory Therapy</td>
<td>65.00</td>
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<tr>
<td>44.02</td>
<td>Non-Allowable Penalties</td>
<td>A - 4,125</td>
<td>-44.02</td>
<td>Other Long-Term Care</td>
<td>46.00</td>
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<tr>
<td>44.03</td>
<td>Patient Telephone Salary</td>
<td>A - 14,651</td>
<td>-44.03</td>
<td>Administrative and General</td>
<td>5.04</td>
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<tr>
<td>44.04</td>
<td>Patient Telephone Benefits</td>
<td>A - 2,603</td>
<td>-44.04</td>
<td>Employee Benefits Department</td>
<td>4.00</td>
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<td>44.05</td>
<td>Employee Benefits Refund</td>
<td>B - 416</td>
<td>-44.05</td>
<td>Employee Benefits Department</td>
<td>4.00</td>
</tr>
<tr>
<td>50.00</td>
<td>Total (sum of lines 1 thru 49)</td>
<td>Transfer to Worksheet A, column 6, line 200</td>
<td>-50.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Notes

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.
<table>
<thead>
<tr>
<th>Line No.</th>
<th>Expense Items</th>
<th>Amount of Allowable Cost</th>
<th>Amount Included in Wks. A, column 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>ADM N STRAT VE AND GENERAL MANAGEMENT FEES</td>
<td>179,759</td>
<td>1,167,316</td>
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<tr>
<td>2.00</td>
<td>CAP REL COSTS-BLDG &amp; FI XT BUILDING RENT</td>
<td>1,208,809</td>
<td>1,878,832</td>
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<tr>
<td>3.00</td>
<td>ADM N STRAT VE AND GENERAL HOME OFFICE COST</td>
<td>12,863</td>
<td>12,788</td>
</tr>
<tr>
<td>4.00</td>
<td>ADM N STRAT VE AND GENERAL PROFESSIONAL FEES</td>
<td>767,292</td>
<td>767,292</td>
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<tr>
<td>5.00</td>
<td>TOTALS (sum of lines 1-4).</td>
<td>2,168,723</td>
<td>3,826,228</td>
</tr>
</tbody>
</table>

*The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A-8, column 2, line 12. 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.*

**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.

<table>
<thead>
<tr>
<th>Symbol (1)</th>
<th>Name</th>
<th>Percentage of Ownership</th>
<th>Related Organization(s) and/or Home Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

G. Other (financial or non-financial) specify:

(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.
<table>
<thead>
<tr>
<th>Related Organization(s) and/or Home Office</th>
<th>Type of Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.00</td>
<td>MANAGEMENT COMP</td>
</tr>
</tbody>
</table>

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and 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

**Worksheet A-8-2**

**Date/Time Prepared:** 5/31/2016 11:36 am

**Period:** From 01/01/2015 To 12/31/2015

**Provider CCN:** 522005

<table>
<thead>
<tr>
<th>Wkst. A Line #</th>
<th>Cost Center/Physician Identifier</th>
<th>Total Remuneration</th>
<th>Professional Component</th>
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### General Service Costs

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<tr>
<th>Cost Center Description</th>
<th>Net Expenses for Cost Allocation (from Wkst A col. 7)</th>
<th>BLDG &amp; Fixt</th>
<th>MVBLE EQUIP</th>
<th>EMPLOYEE BENEFITS DEPARTMENT</th>
<th>DATA PROCESSING</th>
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<tbody>
<tr>
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<td>1,451,694</td>
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#### General Service Cost Centers

- **1.00** CAP REL COSTS - BLDG & FT XT
  - Net Expenses for Cost Allocation: 1,451,694
  - BLDG & Fixt: 1,451,694
  - MVBLE EQUIP: 149,266

- **2.00** CAP REL COSTS - MVBLE EQUIP
  - Net Expenses for Cost Allocation: 149,266
  - BLDG & Fixt: 149,266
  - MVBLE EQUIP: 149,266

#### Capital Related Costs

- **5.01** DATA PROCESS NG
  - Net Expenses for Cost Allocation: 121,869
  - BLDG & Fixt: 362,296
  - MVBLE EQUIP: 11,011

- **5.02** ADM TTI NG
  - Net Expenses for Cost Allocation: 145,900
  - BLDG & Fixt: 1,404,482
  - MVBLE EQUIP: 11,022

#### Employee Benefits Department

- **4.00** EMPLOYEE BENEFITS DEPARTMENT
  - Net Expenses for Cost Allocation: 1,393,471
  - BLDG & Fixt: 11,011
  - MVBLE EQUIP: 1,404,482

#### Data Processing

- **5.03** DATA PROCESSING
  - Net Expenses for Cost Allocation: 121,869
  - BLDG & Fixt: 362,296
  - MVBLE EQUIP: 11,011

### Inpatient Routine Service Cost Centers

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Net Expenses for Cost Allocation (from Wkst A col. 7)</th>
<th>BLDG &amp; Fixt</th>
<th>MVBLE EQUIP</th>
<th>EMPLOYEE BENEFITS DEPARTMENT</th>
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### Ancillary Service Cost Centers

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<th>MVBLE EQUIP</th>
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### Outpatient Service Cost Centers

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<th>Net Expenses for Cost Allocation (from Wkst A col. 7)</th>
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<th>MVBLE EQUIP</th>
<th>EMPLOYEE BENEFITS DEPARTMENT</th>
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<td>73.00 DRUGS CHARGED TO PATIENTS</td>
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### Ambulance Service Cost Centers

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<th>MVBLE EQUIP</th>
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### Subtotals (Sum of Lines 1-117)

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<th>Net Expenses for Cost Allocation (from Wkst A col. 7)</th>
<th>BLDG &amp; Fixt</th>
<th>MVBLE EQUIP</th>
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### Nonreimbursable Costs Centers

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<th>BLDG &amp; Fixt</th>
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<th>EMPLOYEE BENEFITS DEPARTMENT</th>
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### Other Reimbursement Cost Centers

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<td>118.00 SUBTOTALS (SUM OF LINES 1-117)</td>
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### Total (Sum of Lines 118-201)

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### Cost Allocation - General Service Costs

#### Provider CCN: 522005

**Worksheet B**

**Part I**

**Date/Time Prepared:** 5/31/2016 11:36 am

**Period:** From 01/01/2015 To 12/31/2015

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| Lakeview Specialty Hospt & Rehab | MCRIF32 - 8.8.159.0 |
**COST ALLOCATION - GENERAL SERVICE COSTS**

**Provider**: CCN 522005  
**Period**: From 01/01/2015 To 12/31/2015  
**Worksheet B**  
**Part I**  

**Date/Time Prepared**: 5/31/2016 11:36 am

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**LAKEVIEW SPECIALTY HOSPITAL & REHAB**

**MCN F32 - 8:8:159.0**
### ALLOCATION OF CAPITAL RELATED COSTS

**Part II**

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**Provider CCN:** 522005

**Worksheet:** B

**Worksheet B**

#### Provider: LAKEVI EW SPEC ALTY HOSPITAL & REHABILITATION

**LAKEVI EW SPEC ALTY HOSPITAL & REHABILITATION**

**Provider CCN:** 522005

**Date/Time Prepared:** 5/31/2016 11:36 am

**Worksheet B**

### Period: 01/01/2015 to 12/31/2015

**Provider CCN:** 522005

**Worksheet B**

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#### Ancillary Service Cost Centers

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<th>Directly Assigned New Capital Related Costs</th>
<th>BLDG &amp; FIXT</th>
<th>MOBLE EQUIP</th>
<th>Subtotal</th>
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#### Outpatient Service Cost Centers

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#### Other Nonreimbursable Cost Centers

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<th>Subtotal</th>
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#### Subtotals (Sum of lines 1-117)

| Subtotal | 15,427 | 1,411,976 | 139,935 | 1,567,338 | 10,814 | 118.00 |

#### Nonreimbursable Cost Centers

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## Allocation of Capital Related Costs

**Provider CCN:** 522005  
**Worksheet B**  
**Part II**  
**Date/Time Prepared:** 05/31/2016 11:36 AM

### General Service Cost Centers

<table>
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<th>ADMIN NI STRATI VE AND GENERAL</th>
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### Inpatient Routine Service Cost Centers

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<th>ADMIN NI STRATI VE AND GENERAL</th>
<th>MINI NTENACE &amp; REPAI RS</th>
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### Ancillary Service Cost Centers

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<th>ADMIN NI STRATI VE AND GENERAL</th>
<th>MINI NTENACE &amp; REPAI RS</th>
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### Outpatient Service Cost Centers

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<th>ADMIN NI STRATI VE AND GENERAL</th>
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### Special Purpose Cost Centers

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### Nonreimbursable Cost Centers

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**MCN F32**  8.8.159.0
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<th>HOUSEKEEPING</th>
<th>DIETARY</th>
<th>CAFETERIA</th>
<th>CENTRAL SERVICES &amp; SUPPLY</th>
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<td>8.00</td>
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<td>10.00</td>
<td>11.00</td>
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### GENERAL SERVICE COST CENTERS

1. **00100** CAP REL COSTS-BLDG & FIXT 1.00
2. **00200** CAP REL COSTS-MABLE EQUIP 2.00
3. **00400** EMPLOYEE BENEFITS DEPARTMENT 4.00
4. **00550** DATA PROCESSING 5.01
5. **00590** BUSI NESS OFFICE 5.02
6. **00600** MNTNANCE & REPAIRS 6.00
7. **00800** LAUNDRY & LINEN SERVICE 8.00
8. **00900** HOUSEKEEPING 9.00
9. **01000** DIETARY 10.00
10. **01100** CAFETERIA A 11.00
11. **01400** CENTRAL SERVICES & SUPPLY 14.00
12. **01500** PHARMACY 15.00
13. **01600** MEDI CAL RECORDS & LI BRARY 16.00

### INPATIENT ROUTINE SERVICE COST CENTERS

26. **03000** ADULTS & PEDiatrics 30.00

### OUTPATIENT ROUTINE SERVICE COST CENTERS

26. **04600** OTHER LONG TERM CARE 46.00

### ANTHOLOGY SERVICE COST CENTERS

54. **05400** RADI OLOGY- DI AGNOSTIC 54.00
57. **05700** CT SCAN 57.00
58. **05800** MAGNETIC RESONANCE IMAGING (MRI) 58.00
60. **06000** LABORATORY 60.00
65. **06500** RESPI RATORY THERAPY 65.00
66. **06600** PHYSI CAL THERAPY 66.00
67. **06700** OCCUPATI ONAL THERAPY 67.00
68. **06800** SPEECH PATHOLOGY 68.00
71. **07100** MEDI CAL SUPPLIES CHARGED TO PATIENTS 71.00
72. **07200** IMPLANTABLE DEVICES CHARGED TO PATIENTS 72.00
73. **07300** DRUGS CHARGED TO PATIENTS 73.00
74. **07400** RENAL DIALYSIS 74.00

### OUTPATIENT SERVICE COST CENTERS

92. **09200** OBSERVATION BEDS NON-DISTINCT 92.00

### OTHER NONREIMBURSABLE COST CENTERS

95. **09500** AMBULANCE SERVICES 95.00

### SPECIFIC PURPOSE COST CENTERS

118. **01180** SUBTOTALS (SUM OF LINES 1-117) 118.00

### NONREIMBURSABLE COST CENTERS

192. **01920** PHYSICIAN PRIVATE OFFICES 192.00
194. **01940** OTHER NONREIMBURSABLE 194.00
194. **01941** MARKETING DEPARTMENT 194.01
200. **02000** Cross Foot Adjustments 200.00
201. **02010** Negative Cost Centers 201.00
202. **02020** TOTAL (SUM LINES 118-201) 202.00
## ALLOCATION OF CAPITAL RELATED COSTS

**Provider CCN:** 522005  
**Date/Time Prepared:** 5/31/2016 11:36 am  
**Worksheet B**  
**Part II**

### GENERAL SERVICE COST CENTERS

<table>
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<th>Cost Center Description</th>
<th>Pharmac</th>
<th>Med/Cal</th>
<th>Subtotal</th>
<th>Intern &amp; Resident Cost</th>
<th>Post Stepdown Adjustments</th>
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### INPATIENT ROUTINE SERVICE COST CENTERS

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<tr>
<th>Cost Center Description</th>
<th>Pharmac</th>
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<th>Subtotal</th>
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<th>Post Stepdown Adjustments</th>
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### ANCILLARY SERVICE COST CENTERS

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### OUTPATIENT SERVICE COST CENTERS

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### OTHER NON-REIMBURSABLE COST CENTERS

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### SPECIAL PURPOSE COST CENTERS

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### NONREIMBURSABLE COST CENTERS

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## General Service Cost Centers

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<th>EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)</th>
<th>DATA PROCESSING (COMPUTER TIME)</th>
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## Inpatient Routine Service Cost Centers

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<th>DATA PROCESSING (COMPUTER TIME)</th>
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## Outpatient Service Cost Centers

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## Other Reimbursable Cost Centers

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<th>EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)</th>
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## Nonreimbursable Cost Centers

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**MCN F32 - 8.8.159.0**
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<th>BUSINESS OFFICE (GROSS CHARGES)</th>
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<td>PHARMACY (COSTED REQ S.)</td>
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**Period:**
- From: 01/01/2015
- To: 12/31/2015

**Date/Time Prepared:**
- 5/31/2016 11:36 am

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### COMPUTATION OF RATIO OF COSTS TO CHARGES

**Title XVIII**

#### Hospital PPS

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#### Part I

**Period:**
- **To:** 12/31/2015
- **From:** 01/01/2015

**Date/Time Prepared:** 5/31/2016 11:36 am

**Worksheet C**

**Part I**

**5/31/2016 11:36 am**

**Worksheet C**

**Part I**

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**Subtotal (see instructions):**

**Total (see instructions):**

**TOTAL:**

19,702,923

**RCE Disallowance:**

47,293

**Total Costs:**

19,750,216

**LaVieew Specialty Hospit & Rehab**

**MCRIF32 - 8.8.159.0**
| Provider CCN: 522005 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C | Date/Time Prepared: 5/31/2016 11:36 am | Title XVII Hospital | PPS |

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### INPATIENT ROUTINE SERVICE COST CENTERS

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<td>179,852</td>
<td>1,627,029</td>
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### OUTPATIENT SERVICE COST CENTERS

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<th>Total (col. 6 + col. 7)</th>
<th>Cost or Other Ratio</th>
<th>TEFRA Inpatient Ratio</th>
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### OTHER REIMBURSABLE COST CENTERS

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<th>Total (col. 6 + col. 7)</th>
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Subtotal (see instructions) 52,098,975 759,190 52,858,165 201.00 |

Less Observation Beds | 0 | 0 | 0 | 0.000000 | 0.000000 |

Total (see instructions) 52,098,975 759,190 52,858,165 202.00
### Title XVII: Hospital PPS

#### Part I: Computation of Ratio of Costs to Charges

**Period:** From 01/01/2015 To 12/31/2015

**Worksheet C**

**Date/Time Prepared:** 5/31/2016 11:36 am

**Provider CCN:** 522005

#### INPATIENT ROUTINE SERVICE COST CENTERS

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<td>68.00 SPEECH PATHOLOGY</td>
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#### OUTPATIENT SERVICE COST CENTERS

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#### Subtotal (see instructions) | 200.00 |
#### Less Observation Beds | 201.00 |
#### Total (see instructions) | 202.00 |

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MCN F32 - 8.8.159.0
### COMPUTATION OF RATIO OF COSTS TO CHARGES

**Patient: LAKEVIEW SPECIALTY HOSPT & REHAB**  
**Provider CCN: 522005**  
**Period: From 01/01/2015 To 12/31/2015**  
**Worksheet C**  
**Date/Time Prepared: 5/31/2016 11:36 am**

#### Title XIX Hospital

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### APPOINTMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

<table>
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<tr>
<th>Cost Center Description</th>
<th>Capital Related Cost (from Wkst. B, Part II, col. 26)</th>
<th>Swing Bed Adjustment</th>
<th>Reduced Capital Related Cost (col. 1 - col. 2)</th>
<th>Total Patient Days</th>
<th>Per Diem (col. 3 / col. 4)</th>
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#### INPATIENT ROUTINE SERVICE COST CENTERS

**ADULTS & PEDIATRICS**

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<th>Cost Center Description</th>
<th>Inpatient Program days</th>
<th>Inpatient Program Capital Cost (col. 5 x col. 6)</th>
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**Total (lines 30 - 199)**

- **Total Patient Days:** 9,154
- **Total Per Diem:** 200.00
- **Total Inpatient Program Cost:** 215,686

**LAKEVIEW SPECIALTY HOSPITAL & REHAB**

Provider CCN: 522005

Worksheet D

Date/Time Prepared: 5/31/2016 11:36 am

Period: From 01/01/2015 To 12/31/2015

Title XVIII Hospital PPS
<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Capital Related Cost (from Wkst. B, Part II, col. 26)</th>
<th>Total Charges from Wkst. C, Part I, col. 8</th>
<th>Ratio of Cost to Charges (col. 1 ÷ col. 2)</th>
<th>Inpatient Program Charges</th>
<th>Cost (column 3 x column 4)</th>
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Total (lines 50-199): 366,878, 23,869,834, 10,740,946, 159,727, 200.00
### APPOINTMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

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<th>Part III</th>
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<th>Allied Health Cost</th>
<th>All Other Medical Education Cost</th>
<th>Swing-Bed Adjustment Amount (see instructions)</th>
<th>Total Costs (sum of cols. 1 through 3, minus col. 4)</th>
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#### INPATIENT ROUTINE SERVICE COST CENTERS

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<th>Total Patient Days</th>
<th>Per Diem (col. 5 ÷ col. 6)</th>
<th>Inpatient Program Days</th>
<th>Inpatient Program Pass-Through Cost (col. 7 x col. 8)</th>
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS**

**Health Financial Systems**

**Date/Time Prepared:** 5/31/2016 11:36 am

**Worksheet D**

**Part IV**

**Provider CCN:** 522005

**Period:** From 01/01/2015 To 12/31/2015

**Title XVII**

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**LAKEVIEW SPECI ALTY HOSP & REHAB**

**MCN F32 - 8.8.159.0**
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<th>Ratio of Cost to Charges (col. 5 ÷ col. 7)</th>
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### APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

**Title XVIII**

**Hospital PPS**

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<th>Cost Reimbursed Services Not Subject To Ded. &amp; Coins. (see inst.)</th>
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<td><strong>OUTPATIENT SERVICE COST CENTERS</strong></td>
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<td>Cost Reimbursed Services Not Subject To Ded. &amp; Coins. (see inst.)</td>
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<tr>
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<td>60.00 06000 LABORATORY</td>
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<td>73.00 07300 DRUGS CHARGED TO PATIENTS</td>
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<tr>
<td>74.00 07400 RENAL DIALYSIS</td>
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<tr>
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<td><strong>OTHER REIMBURSABLE COST CENTERS</strong></td>
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<tr>
<td>95.00 09500 AMBULANCE SERVICES</td>
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<td>201.00 00 Less PBP Clinic Lab. Services-Program Only Charges</td>
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<td>202.00 00 Net Charges (line 200 - line 201)</td>
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</table>
# APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

## Title XIX

### Hospital

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Charges</th>
<th>Costs</th>
</tr>
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<tbody>
<tr>
<td><strong>ANCILLARY SERVICE COST CENTERS</strong></td>
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<tr>
<td>54.00 05400 RADIOLOGY-DIAGNOSTIC</td>
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<td>57.00 05700 CT SCAN</td>
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<td>58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)</td>
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<td>11,104</td>
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<td>74.00 07400 RENAL DIALYSIS</td>
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<td><strong>OUTPATIENT SERVICE COST CENTERS</strong></td>
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<tr>
<td>92.00 09200 OBSERVATION BEDS (NON-DISTINCT)</td>
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<td><strong>OTHER REIMBURSABLE COST CENTERS</strong></td>
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<td>202.00 Net Charges (line 200 +/- line 201)</td>
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<td>52,174</td>
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### Title XIX

#### Hospital Costs

**Cost Center Description**

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<tr>
<th>Cost Center</th>
<th>Reimbursed Services Subject To Ded. &amp; Coins.</th>
<th>Reimbursed Services Not Subject To Ded. &amp; Coins.</th>
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<tr>
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<td>Cost Center Description</td>
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<tr>
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</tr>
<tr>
<td><strong>PART I - ALL PROVIDER COMPONENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)</td>
<td>9,154  1.00</td>
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</tr>
<tr>
<td>2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)</td>
<td>9,154  2.00</td>
<td></td>
</tr>
<tr>
<td>3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.</td>
<td>0  3.00</td>
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</tr>
<tr>
<td>4.00 Semi-private room days (excluding swing-bed and observation bed days)</td>
<td>9,154  4.00</td>
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</tr>
<tr>
<td>5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period</td>
<td>0  5.00</td>
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</tr>
<tr>
<td>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)</td>
<td>0  6.00</td>
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</tr>
<tr>
<td>7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period</td>
<td>0  7.00</td>
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</tr>
<tr>
<td>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)</td>
<td>0  8.00</td>
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<tr>
<td>9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)</td>
<td>4,027  9.00</td>
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<tr>
<td>10.00 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)</td>
<td>0  10.00</td>
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</tr>
<tr>
<td>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)</td>
<td>0  11.00</td>
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<tr>
<td>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</td>
<td>0  12.00</td>
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</tr>
<tr>
<td>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)</td>
<td>0  13.00</td>
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<tr>
<td>14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)</td>
<td>0  14.00</td>
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</tr>
<tr>
<td>15.00 Total nursery days (title V or XIX only)</td>
<td>0  15.00</td>
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<tr>
<td>16.00 Nursery days (title V or XIX only)</td>
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<tr>
<td><strong>SWING BED ADJUSTMENT</strong></td>
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<td>17.00 Medically necessary swing-bed SNF services applicable to services through December 31 of the cost reporting period</td>
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<td>18.00 Medically necessary swing-bed SNF services applicable to services after December 31 of the cost reporting period</td>
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<td>19.00 Medically necessary swing-bed NF services applicable to services through December 31 of the cost reporting period</td>
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<tr>
<td>20.00 Medically necessary swing-bed NF services applicable to services after December 31 of the cost reporting period</td>
<td>0.00  20.00</td>
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<tr>
<td>21.00 Total medically necessary inpatient routine service cost (see instructions)</td>
<td>7,875,567  21.00</td>
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<tr>
<td>22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)</td>
<td>0  22.00</td>
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<tr>
<td>23.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)</td>
<td>0  23.00</td>
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<tr>
<td>24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)</td>
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<tr>
<td>25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)</td>
<td>0  25.00</td>
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<tr>
<td>26.00 Total swing-bed cost (see instructions)</td>
<td>0  26.00</td>
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<tr>
<td>27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)</td>
<td>7,875,567  27.00</td>
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<tr>
<td><strong>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</strong></td>
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<tr>
<td>28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)</td>
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<tr>
<td>29.00 Private room charges (excluding swing-bed charges)</td>
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</tr>
<tr>
<td>30.00 Semi-private room charges (excluding swing-bed charges)</td>
<td>0  30.00</td>
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</tr>
<tr>
<td>31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)</td>
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<tr>
<td>32.00 Average private room per diem charge (line 29 + line 3)</td>
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<tr>
<td>33.00 Average semi-private room per diem charge (line 30 + line 4)</td>
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<tr>
<td>34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)</td>
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<tr>
<td>35.00 Average per diem private room cost differential (line 34 x line 31)</td>
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<tr>
<td>36.00 Private room cost differential adjustment (line 3 x line 35)</td>
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<tr>
<td>37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)</td>
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<td><strong>PART II - HOSPITAL AND SUBPROVIDERS ONLY</strong></td>
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<tr>
<td>38.00 Adjusted general inpatient routine service per diem (see instructions)</td>
<td>860.34  38.00</td>
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<tr>
<td>39.00 Program general inpatient routine service cost (line 39 x line 38)</td>
<td>3,464,589  39.00</td>
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<tr>
<td>40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)</td>
<td>0  40.00</td>
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<tr>
<td>41.00 Total Program general inpatient routine service cost (line 39 + line 40)</td>
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### Title XVII - Hospital

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Total Inpatient Cost</th>
<th>Total Inpatient Days</th>
<th>Average Per Diem (col. 1 ÷ col. 2)</th>
<th>Program Days (col. 3 x col. 4)</th>
<th>Program Cost</th>
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<tbody>
<tr>
<td>42.00 NURSERY (title V &amp; XIX only)</td>
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<tr>
<td>44.00 CORONARY CARE UNIT</td>
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<tr>
<td>45.00 BURN INTENSIVE CARE UNIT</td>
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<tr>
<td>46.00 SURGICAL INTENSIVE CARE UNIT</td>
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<tr>
<td>Total Program inpatient costs</td>
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### Title XIX - Hospital

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Total Inpatient Cost</th>
<th>Total Inpatient Days</th>
<th>Average Per Diem (col. 1 ÷ col. 2)</th>
<th>Program Days (col. 3 x col. 4)</th>
<th>Program Cost</th>
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</thead>
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<tr>
<td>48.00 Program inpatient ancillary service cost (Wst. D3, col. 3, line 200)</td>
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<tr>
<td>49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)</td>
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### Target Amount and Limit Computation

<table>
<thead>
<tr>
<th></th>
<th>Total Program inpatient costs (sum of lines 41 through 48)(see instructions)</th>
<th>Total Program inpatient costs (sum of lines 41 through 48)(see instructions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2,505,927</td>
<td>5,970,516</td>
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</tbody>
</table>

### Total Program inpatient costs

| Total Program inpatient costs (sum of lines 41 through 48)(see instructions) | 5,970,516 |

### Program Discharges

|                          | 0                                      |

### Program Inpatient Ancillary Services

|                          | 2,505,927 |

### Program Routine Service Costs

|                          | 375,413 |

### Total Program Inpatient Routine Swinging Bed Cost

|                          | 215,686 |

### Intensive Care Type Inpatient Hospital Units

|                          | 215,686 |

### Other Special Care (Specify)

|                          | 47.00   |

### Skilled Nursing Facility, Other Nursing Facility, and ICF/IID Only

|                          | 47.00   |

### Skilled Nursing Facility/Other Nursing Facility/ICF/IID Routine Service Cost

|                          | 75.00   |

### Utilization Review - Physician Compensation (see instructions)

|                          | 85.00   |

### Total Program Operating Costs

|                          | 86.00   |

### Observation Bed Days

|                          | 87.00   |

### Observation Bed Cost

|                          | 89.00   |
### COMPUTATION OF INPATIENT OPERATING COST

**Title XVIII**

**Hospital PPS**

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Cost</th>
<th>Routine Cost (from line 27)</th>
<th>column 1 + column 2</th>
<th>Total Observation Bed Cost (from line 89)</th>
<th>Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)</th>
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<tr>
<td>90.00  Capital-related cost</td>
<td>490,271</td>
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<td>91.00  Nursing School cost</td>
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<tr>
<td>92.00  Allied health cost</td>
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<tr>
<td>93.00  All other Medical Education</td>
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### Hospital PPS

**Period:** From 01/01/2015 To 12/31/2015

**Provider CCN:** 522005

#### INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Inpatient Program Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
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<tbody>
<tr>
<td><strong>INPATIENT ROUTINE SERVICE COST CENTERS</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>30.00</td>
<td>003000</td>
<td>ADULTS &amp; PEDIATRICS</td>
<td>6,518,985</td>
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<tr>
<td>54.00</td>
<td>054000</td>
<td>RADILOGY- DIAGNOSTIC</td>
<td>0.181391</td>
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<tr>
<td>57.00</td>
<td>057000</td>
<td>CT SCAN</td>
<td>0.308104</td>
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<tr>
<td>58.00</td>
<td>058000</td>
<td>MAGNETIC RESONANCE IMAGING (MRI)</td>
<td>0.184646</td>
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<tr>
<td>60.00</td>
<td>060000</td>
<td>LABORATORY</td>
<td>0.302567</td>
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<td>RESPIRATORY THERAPY</td>
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</tr>
<tr>
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<td>066000</td>
<td>PHYSICAL THERAPY</td>
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<td>67.00</td>
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<td>OCCUPATIONAL THERAPY</td>
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<td>68.00</td>
<td>068000</td>
<td>SPEECH PATHOLOGY</td>
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<td>71.00</td>
<td>071000</td>
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<td>IMPLANTABLE DEVICES CHARGED TO PATIENTS</td>
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<td>DRUGS CHARGED TO PATIENTS</td>
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<td>74.00</td>
<td>074000</td>
<td>RENAL DIALYSIS</td>
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<td>092000</td>
<td>OBSERVATION BEDS (NON-DISTINCT)</td>
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<td><strong>OTHER REIMBURSABLE COST CENTERS</strong></td>
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<tr>
<td>95.00</td>
<td>095000</td>
<td>AMBULANCE SERVICES</td>
<td>0.00000</td>
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</table>

#### Total (sum of lines 50-94 and 96-98) | 10,740,946 | 2,505,927 | 200.00 |

#### Less PBP Clinic Laboratory Services-Program only charges (line 61) | 0 | 0 | 201.00 |

#### Net Charges (line 200 minus line 201) | 10,740,946 | 202.00 |
<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Inpatient Program Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INPATIENT ANCILLARY SERVICE COST CENTERS</strong></td>
<td></td>
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</tr>
<tr>
<td>30.00 030000 ADULTS &amp; PEDIATRICS</td>
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<td><strong>ANCILLARY SERVICE COST CENTERS</strong></td>
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<tr>
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<td>2.00</td>
<td>3.00</td>
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<td><strong>ANCILLARY SERVICE COST CENTERS</strong></td>
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<td>30.00 030000 ADULTS &amp; PEDIATRICS</td>
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<td>54.00 054000 RADIOLOGY DIAGNOSTIC</td>
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<td>0.308104</td>
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<tr>
<td>58.00 058000 MAGNETIC RESONANCE IMAGING (MRI)</td>
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<td>71.00 071000 MEDICAL SUPPLIES CHARGED TO PATIENTS</td>
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<tr>
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<td>0.984478</td>
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<td>8,846</td>
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<tr>
<td>73.00 073000 DRUGS CHARGED TO PATIENTS</td>
<td>0.243015</td>
<td>1,516,812</td>
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<tr>
<td>74.00 074000 RENAL DIALYSIS</td>
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<td><strong>OUTPATIENT SERVICE COST CENTERS</strong></td>
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<td></td>
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<td>92.00 092000 OBSERVATION ON BE DS, NON-DISTINCT MCT</td>
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<td>0</td>
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<tr>
<td><strong>OTHER REIMBURSABLE COST CENTERS</strong></td>
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<td></td>
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<tr>
<td>95.00 095000 AMBULANCE SERVICES</td>
<td>0.300000</td>
<td>1,091,377</td>
<td>301,012</td>
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</table>

**Total (sum of lines 50-94 and 96-98)**                    | 4,903,426                | 1,091,377                 | 200.00                                   |

**Less PBP Clinic Laboratory Services-Program only charges (line 61)** | 0 | | 201.00 |

**Net Charges (line 200 minus line 201)**                  | 4,903,426                | 202.00
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<tr>
<th>Line</th>
<th>Description</th>
<th>Amount</th>
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<td>2.00</td>
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<tr>
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<td>Medical and other services reimbursed under OPPS (see instructions)</td>
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<tr>
<td>3.00</td>
<td>PPS payments</td>
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<tr>
<td>4.00</td>
<td>Outlier payment (see instructions)</td>
<td>4.00</td>
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<tr>
<td>5.00</td>
<td>Enter the hospital specific payment to cost ratio (see instructions)</td>
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</tr>
<tr>
<td>6.00</td>
<td>Line 2 times line 5</td>
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<tr>
<td>7.00</td>
<td>Sum of line 3 plus line 4 divided by line 6</td>
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<td>8.00</td>
<td>Transitional corridor payment (see instructions)</td>
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<td>9.00</td>
<td>Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200</td>
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<td>10.00</td>
<td>Organ acquisitions</td>
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<td>11.00</td>
<td>Total cost (sum of lines 1 and 10) (see instructions)</td>
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<td><strong>COMPUTATION OF LESSER OF COST OR CHARGES</strong></td>
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<td>12.00</td>
<td>Ancillary service charges</td>
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<td>13.00</td>
<td>Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)</td>
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<td>14.00</td>
<td>Total reasonable charges (sum of lines 12 and 13)</td>
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<td><strong>CUSTOMARY CHARGES</strong></td>
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<tr>
<td>15.00</td>
<td>Aggregate amount actually collected from patients liable for payment for services on a charge basis</td>
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<tr>
<td>16.00</td>
<td>Amounts that would have been realized from patients liable for payment for services on a charge basis</td>
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<td>17.00</td>
<td>Ratio of line 15 to line 16 (not to exceed 1.000000)</td>
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<td>18.00</td>
<td>Total customary charges (see instructions)</td>
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<td>19.00</td>
<td>Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</td>
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<tr>
<td>20.00</td>
<td>Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</td>
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<td>Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</td>
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<td>22.00</td>
<td>Interns and residents (see instructions)</td>
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<td>23.00</td>
<td>Cost of physicians' services in a teaching hospital (see instructions)</td>
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<td>24.00</td>
<td>Total prospective payment (sum of lines 3, 4, 8 and 9)</td>
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<td><strong>COMPUTATION OF REIMBURSEMENT SETTLEMENT</strong></td>
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<td>25.00</td>
<td>Deductibles and coinsurance (for CAH, see instructions)</td>
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<td>26.00</td>
<td>Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)</td>
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<td>27.00</td>
<td>Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)</td>
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<td>28.00</td>
<td>Direct graduate medical education payments (from Wkst. E-4, line 50)</td>
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<td>Primary payer payments</td>
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<td>32.00</td>
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<td><strong>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV CES)</strong></td>
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<td>Allowable bad debts (see instructions)</td>
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<tr>
<td>35.00</td>
<td>Adjusted reimbursable bad debts (see instructions)</td>
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<td>Allowable bad debts for dual eligible beneficiaries (see instructions)</td>
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<td>38.00</td>
<td>MIP-LCC reconciliation amount from PS&amp;R</td>
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<td>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</td>
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<td>49.00</td>
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<td>54.00</td>
<td>Total (sum of lines 91 and 93)</td>
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**Notes:**
- All amounts are in USD.
- Calculations are based on specific instructions and conditions outlined in the document.
- The document includes various calculations and adjustments relevant to reimbursement settlement.
<table>
<thead>
<tr>
<th>Inpatient Part A</th>
<th>Provider CCN</th>
<th>522005</th>
<th>Period: From 01/01/2015 To 12/31/2015</th>
<th>Worksheet E-1</th>
<th>Date/Time Prepared: 5/31/2016 11:36 am</th>
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<tr>
<td><strong>Title XVII</strong></td>
<td><strong>Hospital</strong></td>
<td><strong>PPS</strong></td>
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<td><strong>Date/Time Prepared:</strong> 5/31/2016 11:36 am</td>
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<tr>
<td>1.00 Total interim payments paid to provider</td>
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<tr>
<td>2.00 Interim payments payable on individual bills, either</td>
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<td></td>
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</tr>
<tr>
<td>submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write &quot;NONE&quot; or enter a zero</td>
<td></td>
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<tr>
<td>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 &quot;NONE&quot; or enter a zero. (1)</td>
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<td></td>
<td></td>
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<tr>
<td><strong>Program to Provider</strong></td>
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</tr>
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<td>5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write &quot;NONE&quot; or enter a zero. (1)</td>
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<tr>
<td><strong>Program to Provider</strong></td>
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<tr>
<td>5.03 Tentative to Provider</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5.03</td>
<td></td>
</tr>
<tr>
<td><strong>Provider to Program</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.01 Tentative to Program</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5.01</td>
<td></td>
</tr>
<tr>
<td>5.02 Tentative to Program</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5.02</td>
<td></td>
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<tr>
<td>5.03 Tentative to Program</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5.03</td>
<td></td>
</tr>
<tr>
<td><strong>Determination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.00 Determined net settlement amount (balance due) based on the cost report. (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6.01 Settlement to Provider</td>
<td>408,696</td>
<td>0</td>
<td>0</td>
<td>6.01</td>
<td></td>
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<tr>
<td>6.02 Settlement to Program</td>
<td>5,303,299</td>
<td>210</td>
<td>7.00</td>
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<tr>
<td><strong>Total Medicare Program Liability (see instructions)</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Contractor Number</strong></td>
<td>NPR Date Mo/Day/Yr</td>
<td>1.00</td>
<td>2.00</td>
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MCRI F32 - 8.8.159.0
<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Amount</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>Net Federal PPS Payments (see instructions)</td>
<td>4,193,740</td>
<td>1.00</td>
</tr>
<tr>
<td>2.00</td>
<td>Outlier Payments</td>
<td>1,762,047</td>
<td>2.00</td>
</tr>
<tr>
<td>3.00</td>
<td>Total PPS Payments (sum of lines 1 and 2)</td>
<td>5,955,787</td>
<td>3.00</td>
</tr>
<tr>
<td>4.00</td>
<td>Nursing and Allied Health Managed Care payments (see instructions)</td>
<td>0</td>
<td>4.00</td>
</tr>
<tr>
<td>5.00</td>
<td>Organ acquisition (DO NOT USE THIS LINE)</td>
<td>0</td>
<td>5.00</td>
</tr>
<tr>
<td>6.00</td>
<td>Cost of physicians' services in a teaching hospital (see instructions)</td>
<td>0</td>
<td>6.00</td>
</tr>
<tr>
<td>7.00</td>
<td>Subtotal (see instructions)</td>
<td>5,955,787</td>
<td>7.00</td>
</tr>
<tr>
<td>8.00</td>
<td>Primary payer payments</td>
<td>0</td>
<td>8.00</td>
</tr>
<tr>
<td>9.00</td>
<td>Subtotal (line 7 less line 8).</td>
<td>5,955,787</td>
<td>9.00</td>
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<tr>
<td>10.00</td>
<td>Deductibles</td>
<td>12,600</td>
<td>10.00</td>
</tr>
<tr>
<td>11.00</td>
<td>Subtotal (line 9 minus line 10)</td>
<td>5,943,187</td>
<td>11.00</td>
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<tr>
<td>12.00</td>
<td>Coinsurance</td>
<td>545,850</td>
<td>12.00</td>
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<tr>
<td>13.00</td>
<td>Subtotal (line 11 minus line 12)</td>
<td>5,397,337</td>
<td>13.00</td>
</tr>
<tr>
<td>14.00</td>
<td>Allowable bad debts (exclude bad debts for professional services) (see instructions)</td>
<td>21,835</td>
<td>14.00</td>
</tr>
<tr>
<td>15.00</td>
<td>Adjusted reimbursable bad debts (see instructions)</td>
<td>14,193</td>
<td>15.00</td>
</tr>
<tr>
<td>16.00</td>
<td>Allowable bad debts for dual eligible beneficiaries (see instructions)</td>
<td>13,363</td>
<td>16.00</td>
</tr>
<tr>
<td>17.00</td>
<td>Subtotal (sum of lines 13 and 15)</td>
<td>5,411,530</td>
<td>17.00</td>
</tr>
<tr>
<td>18.00</td>
<td>Direct graduate medical education payments (from Wkst. E-4, line 49)</td>
<td>0</td>
<td>18.00</td>
</tr>
<tr>
<td>19.00</td>
<td>Other pass through costs (see instructions)</td>
<td>0</td>
<td>19.00</td>
</tr>
<tr>
<td>20.00</td>
<td>Outlier payments reconciliation</td>
<td>0</td>
<td>20.00</td>
</tr>
<tr>
<td>21.00</td>
<td>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</td>
<td>0</td>
<td>21.00</td>
</tr>
<tr>
<td>21.50</td>
<td>Pioneer ACO demonstration payment adjustment (see instructions)</td>
<td>0</td>
<td>21.50</td>
</tr>
<tr>
<td>22.00</td>
<td>Total amount payable to the provider (see instructions)</td>
<td>5,411,530</td>
<td>22.00</td>
</tr>
<tr>
<td>22.01</td>
<td>Sequestration adjustment (see instructions)</td>
<td>108,231</td>
<td>22.01</td>
</tr>
<tr>
<td>23.00</td>
<td>Interim payments</td>
<td>5,711,995</td>
<td>23.00</td>
</tr>
<tr>
<td>24.00</td>
<td>Tentative settlement (for contractor use only)</td>
<td>0</td>
<td>24.00</td>
</tr>
<tr>
<td>25.00</td>
<td>Balance due provider/program (line 22 minus lines 22.01, 23 and 24)</td>
<td>-408,696</td>
<td>25.00</td>
</tr>
<tr>
<td>26.00</td>
<td>Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2</td>
<td>0</td>
<td>26.00</td>
</tr>
<tr>
<td>50.00</td>
<td>Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)</td>
<td>0</td>
<td>50.00</td>
</tr>
<tr>
<td>51.00</td>
<td>Outlier reconciliation adjustment amount (see instructions)</td>
<td>0</td>
<td>51.00</td>
</tr>
<tr>
<td>52.00</td>
<td>The rate used to calculate the Time Value of Money (see instructions)</td>
<td>0.00</td>
<td>52.00</td>
</tr>
<tr>
<td>53.00</td>
<td>Time Value of Money (see instructions)</td>
<td>0</td>
<td>53.00</td>
</tr>
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</table>
**Health Financial Systems**  
**LAKESIDE SPECIALTY HOSP & REHAB**

**CALCULATION OF REIMBURSEMENT SETTLEMENT**

<table>
<thead>
<tr>
<th>Part VII</th>
<th>Worksheet E-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/31/2016</td>
<td>11:36 am</td>
</tr>
</tbody>
</table>

**Title XIX**

**Hospital**

**Cost**

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
</tr>
</tbody>
</table>

**Calculation of Reimbursement Settlement**

<table>
<thead>
<tr>
<th>Title V or XI</th>
<th>Services for</th>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital/SNF/NF services</td>
<td>1.00</td>
<td>0</td>
</tr>
<tr>
<td>Medical and other services</td>
<td>2.00</td>
<td>0</td>
</tr>
<tr>
<td>Organ acquisition (certified transplant centers only)</td>
<td>3.00</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal (sum of lines 1, 2 and 3)</td>
<td>4.00</td>
<td>0</td>
</tr>
<tr>
<td>Inpatient primary payer payments</td>
<td>5.00</td>
<td>0</td>
</tr>
<tr>
<td>Outpatient primary payer payments</td>
<td>6.00</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal (line 4 less sum of lines 5 and 6)</td>
<td>7.00</td>
<td>0</td>
</tr>
</tbody>
</table>

**Computation of lesser of cost or charges**

<table>
<thead>
<tr>
<th>Reasonable Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.00 Routine service charges</td>
</tr>
<tr>
<td>9.00 Ancillary service charges</td>
</tr>
<tr>
<td>10.00 Organ acquisition charges, net of revenue</td>
</tr>
<tr>
<td>11.00 Incentive from target amount computation</td>
</tr>
<tr>
<td>12.00 Total reasonable charges (sum of lines 8 through 11)</td>
</tr>
</tbody>
</table>

**Computation of customary charges**

<table>
<thead>
<tr>
<th>Customary Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.00 Amount actually collected from patients liable for payment for services on a charge basis</td>
</tr>
<tr>
<td>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)</td>
</tr>
<tr>
<td>15.00 Ratio of line 13 to line 14 (not to exceed 1.000000)</td>
</tr>
<tr>
<td>16.00 Total customary charges (see instructions)</td>
</tr>
<tr>
<td>17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)</td>
</tr>
<tr>
<td>18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)</td>
</tr>
</tbody>
</table>

**Prospective Payment Amount**

- Lines 22 through 26 must only be completed for PPS providers.

| Costs of physicians' services in a teaching hospital (see instructions) | 0 |

**Calculation of reimbursement settlement**

<p>| Excess of reasonable cost (from line 18) | 0 |
| Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) | 0 |
| Deductibles | 0 |
| Coinsurance | 0 |
| Allowable bad debts (see instructions) | 0 |
| Utilization review | 0 |
| Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) | 0 |
| OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | 0 |
| Subtotal (line 36 ± line 37) | 0 |
| Direct graduate medical education payments (from Wks 4) | 0 |
| Total amount payable to the provider (sum of lines 38 and 39) | 0 |
| Interim payments | 0 |
| Balance due provider program (line 40 minus line 41) | 0 |
| Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2 | 0 |</p>
<table>
<thead>
<tr>
<th>Current Assets</th>
<th>Specific Purpose Fund</th>
<th>Endowment Fund</th>
<th>Plant Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash on hand in banks</td>
<td>81,537</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Temporary investments</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Notes receivable</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>7,755,120</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other receivables</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Allowances for uncollectible notes and accounts receivable</td>
<td>-7,658,372</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Inventory</td>
<td>318,596</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>-21,384</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other current assets</td>
<td>1,355,828</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Due from other funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total current assets (sum of lines 1-10)</td>
<td>6,831,335</td>
<td>0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Fixed Assets</th>
<th>Specific Purpose Fund</th>
<th>Endowment Fund</th>
<th>Plant Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Buildings</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accrued depreciation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Leasedhold improvements</td>
<td>656,103</td>
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<td>0</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>66,523</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Fixed equipment</td>
<td>278,465</td>
<td>0</td>
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<tr>
<td>Accumulated depreciation</td>
<td>-265,622</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Automobiles and trucks</td>
<td>184,554</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Accumulated depreciation</td>
<td>-168,258</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Movable equipment</td>
<td>637,309</td>
<td>0</td>
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<tr>
<td>Accumulated depreciation</td>
<td>5,866,016</td>
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<td>0</td>
</tr>
<tr>
<td>Minor equipment depreciable</td>
<td>358,779</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Accumulated depreciation</td>
<td>-333,814</td>
<td>0</td>
<td>0</td>
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<tr>
<td>HIT designated Assets</td>
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<td>0</td>
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<tr>
<td>Total fixed assets (sum of lines 12-29)</td>
<td>228,626</td>
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<table>
<thead>
<tr>
<th>Other Assets</th>
<th>Specific Purpose Fund</th>
<th>Endowment Fund</th>
<th>Plant Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investments</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Deposits on leases</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Due from owners/officers</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total other assets (sum of lines 31-34)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total assets (sum of lines 11, 30, and 35)</td>
<td>7,059,961</td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Liabilities</th>
<th>Specific Purpose Fund</th>
<th>Endowment Fund</th>
<th>Plant Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts payable</td>
<td>5,217,074</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Salaries, wages, and fees payable</td>
<td>407,245</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Payroll taxes payable</td>
<td>73,909</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Notes and loans payable (short term)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Deferred income</td>
<td>-2,897,328</td>
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<td>0</td>
</tr>
<tr>
<td>Accelerated payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Due to other funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other current liabilities</td>
<td>6,159,838</td>
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<tr>
<td>Total current liabilities (sum of lines 37 thru 44)</td>
<td>8,989,752</td>
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</table>

<table>
<thead>
<tr>
<th>Long-Term Liabilities</th>
<th>Specific Purpose Fund</th>
<th>Endowment Fund</th>
<th>Plant Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage payable</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Notes payable</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unsecured loans</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other long term liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total long term liabilities (sum of lines 46 thru 49)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total liabilities (sum of lines 45 and 50)</td>
<td>8,095,972</td>
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<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capital Accounts</th>
<th>Specific Purpose Fund</th>
<th>Endowment Fund</th>
<th>Plant Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>General fund balance</td>
<td>-1,929,791</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Specific purpose fund balance</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Donor created - endowment fund balance - restricted</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Donor created - endowment fund balance - unrestricted</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Governing body created - endowment fund balance</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plant fund balance - invested in plant</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plant fund balance - reserve for plant improvement, replacement, and expansion</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total fund balances (sum of lines 52 thru 58)</td>
<td>-1,929,791</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total liabilities and fund balances (sum of lines 51 and 59)</td>
<td>7,059,961</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fund Type</td>
<td>General Fund</td>
<td>Special Purpose Fund</td>
<td>Endowment Fund</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------</td>
<td>----------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>1.00 Fund balances at begin</td>
<td>618,498</td>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>ning of period</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.00 Net income (loss)</td>
<td>-894,672</td>
<td>2.00</td>
<td>3.00</td>
</tr>
<tr>
<td>(from Wkst. G-3, line 29)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.00 Total (sum of line 1</td>
<td>-276,174</td>
<td>0</td>
<td>4.00</td>
</tr>
<tr>
<td>and line 2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.00 Additions (credit</td>
<td>0</td>
<td>0</td>
<td>5.00</td>
</tr>
<tr>
<td>adjustments) (specify)</td>
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<tr>
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<td>0</td>
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<td>-276,174</td>
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<tr>
<td>12.00 AUDIT ADJUSTMENTS</td>
<td>1,653,617</td>
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<tr>
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<tr>
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<tr>
<td>18.00 Total deductions (sum</td>
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<tr>
<td>of lines 12-17)</td>
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<td>19.00 Fund balance at end</td>
<td>-1,929,791</td>
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<td>of period per balance</td>
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<tr>
<td>sheet (line 11 minus line 18)</td>
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<td>begin 999999</td>
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<tr>
<td>period</td>
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<td>2.00 Net</td>
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<td>(from Wkst.</td>
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<tr>
<td>(sum of line</td>
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</tr>
<tr>
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<td>4.00 Additions</td>
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<td>(specify)</td>
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<td>10.00 Total</td>
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<td>(line 3 plus</td>
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<td>18.00 Total</td>
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<td>deductions (sum</td>
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<td>of lines 12-17)</td>
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<tr>
<td>19.00 Fund</td>
<td>0</td>
</tr>
<tr>
<td>balance at</td>
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</tr>
<tr>
<td>end of period</td>
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<td>per balance</td>
<td></td>
</tr>
<tr>
<td>sheet (line 11</td>
<td></td>
</tr>
<tr>
<td>minus line 18)</td>
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</table>
## STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**Provider CCN:** 522005  
**Period:** From 01/01/2015 to 12/31/2015  
**Worksheet:** G-2  
**Date Prepared:** 05/31/2016 11:36 am

### PART I - PATIENT REVENUES

**Cost Center Description**  
<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>Hospital</td>
<td>14,970,739</td>
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<tr>
<td>2.00</td>
<td>SUBPROVIDER - IPF</td>
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</tr>
<tr>
<td>3.00</td>
<td>SUBPROVIDER - IRF</td>
<td></td>
</tr>
<tr>
<td>4.00</td>
<td>SUBPROVIDER</td>
<td></td>
</tr>
<tr>
<td>5.00</td>
<td>Sw ng bed - SNF</td>
<td>0</td>
</tr>
<tr>
<td>6.00</td>
<td>Sw ng bed - NF</td>
<td>0</td>
</tr>
<tr>
<td>7.00</td>
<td>SKI LLED NURSING FACILITY</td>
<td></td>
</tr>
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<td>8.00</td>
<td>NURSING FACILITY</td>
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</tr>
<tr>
<td>9.00</td>
<td>OTHER LONG TERM CARE</td>
<td>14,017,592</td>
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<tr>
<td>10.00</td>
<td>Total general inpatient care services (sum of lines 1-9)</td>
<td>28,988,331</td>
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<tr>
<td>11.00</td>
<td>INTENSIVE CARE UNIT</td>
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</tr>
<tr>
<td>12.00</td>
<td>CORONARY CARE UNIT</td>
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</tr>
<tr>
<td>13.00</td>
<td>BURN INTENSIVE CARE UNIT</td>
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</tr>
<tr>
<td>14.00</td>
<td>SURGICAL INTENSIVE CARE UNIT</td>
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<tr>
<td>15.00</td>
<td>OTHER SPEC. CARE (SPECIFY)</td>
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<tr>
<td>16.00</td>
<td>Total intensive care type inpatient hospital services (sum of lines 11-15)</td>
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</tr>
<tr>
<td>17.00</td>
<td>Total inpatient routine care services (sum of lines 10 and 16)</td>
<td>28,988,331</td>
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<tr>
<td>18.00</td>
<td>Ancillary services</td>
<td>23,110,643</td>
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<td>Outpatient services</td>
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<td>20.00</td>
<td>RURAL HEALTH CLINIC</td>
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<td>21.00</td>
<td>FEDERALLY QUALIFIED HEALTH CENTER</td>
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<tr>
<td>22.00</td>
<td>HOME HEALTH AGENCY</td>
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<tr>
<td>23.00</td>
<td>AMBULANCE SERVICES</td>
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<tr>
<td>24.00</td>
<td>CMHC</td>
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<td>25.00</td>
<td>AMBULATORY SURGICAL CENTER (D.P.)</td>
<td>0</td>
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<tr>
<td>26.00</td>
<td>HOSPICE</td>
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<td>27.00</td>
<td>PHYSICIAN CHARGES</td>
<td>0</td>
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<td>28.00</td>
<td>Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1)</td>
<td>52,120,372</td>
</tr>
</tbody>
</table>

### PART II - OPERATING EXPENSES

| Operating expenses (per Wkst. A, column 3, line 200) | 23,075,210 | 29.00 |
| ADD (SPECIFY) | 0 | 30.00 |
| DEDUCT (SPECIFY) | 0 | 31.00 |
| Total additions (sum of lines 30-35) | 0 | 36.00 |
| Total deductions (sum of lines 37-41) | 0 | 42.00 |
| Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Wkst. G-3, line 4) | 23,075,210 | 43.00 |
## Statement of Revenues and Expenses

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)</td>
<td>53,504,480</td>
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<tr>
<td>2.00</td>
<td>Less contractual allowances and discounts on patients' accounts</td>
<td>31,434,563</td>
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<tr>
<td>3.00</td>
<td>Net patient revenues (line 1 minus line 2)</td>
<td>22,069,917</td>
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<tr>
<td>4.00</td>
<td>Less total operating expenses (from Wkst. G-2, Part II, line 43)</td>
<td>23,075,210</td>
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<tr>
<td>5.00</td>
<td>Net income from service to patients (line 3 minus line 4)</td>
<td>-1,005,293</td>
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### Other Income

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.00</td>
<td>Contributions, donations, bequests, etc</td>
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<tr>
<td>7.00</td>
<td>Income from investments</td>
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<td>8.00</td>
<td>Revenues from telephone and other miscellaneous communication services</td>
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<td>9.00</td>
<td>Revenue from television and radio service</td>
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<tr>
<td>10.00</td>
<td>Purchase discounts</td>
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<tr>
<td>11.00</td>
<td>Rebates and refunds of expenses</td>
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<td>12.00</td>
<td>Parking lot receipts</td>
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<tr>
<td>13.00</td>
<td>Revenue from laundry and linen service</td>
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<tr>
<td>14.00</td>
<td>Revenue from meals sold to employees and guests</td>
<td>48,252</td>
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<tr>
<td>15.00</td>
<td>Revenue from rental of living quarters</td>
<td>5,530</td>
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<tr>
<td>16.00</td>
<td>Revenue from sale of medical and surgical supplies to other than patients</td>
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<tr>
<td>17.00</td>
<td>Revenue from sale of drugs to other than patients</td>
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<tr>
<td>18.00</td>
<td>Revenue from sale of medical records and abstracts</td>
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<tr>
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<td>Tuition (fees, sale of textbooks, uniforms, etc.)</td>
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<td>20.00</td>
<td>Revenue from gifts, flowers, coffee shops, and canteen</td>
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<tr>
<td>21.00</td>
<td>Rental of vending machines</td>
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<td>Rental of hospital space</td>
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<td>Interest income</td>
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<td>Other miscellaneous income</td>
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<td>Total other income (sum of lines 6-24)</td>
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<td>Total (line 5 plus line 25)</td>
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<td>Other expenses (specify)</td>
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<td>28.00</td>
<td>Total other expenses (sum of line 27 and subscripts)</td>
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<td>29.00</td>
<td>Net income (or loss) for the period (line 26 minus line 28)</td>
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