

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 10/26/2017 11:58 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 10/26/2017 Time: 11:58 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAKEVIEW SPECIALTY HOSPT & REHAB (52-2005) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	52,080	48	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	52,080	48	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 10/26/2017 11:57 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1701 SHARP ROAD			PO Box:							1.00	
2.00	City: WATERFORD			State: WI		Zip Code: 53185		County: RACINE			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		LAKEVIEW SPECIALTY HOSPITAL & REHAB		522005	39540	2	10/01/1996	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC		CBRF/CCI UNIT									11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2016		12/31/2016		20.00	
21.00	Type of Control (see instructions)						4				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								2		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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.			0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 10/26/2017 11:57 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	N	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					Y	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N	81.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.					N	87.00
				V	XIX		
				1.00	2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
		1.00	2.00	3.00			
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	77,349		0		0	
				1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part I Date/Time Prepared: 10/26/2017 11:57 am	
		1.00	2.00				
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		309000			140.00
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: LAKEVIEW MANAGEMENT INC.	Contractor's Name: WPS		Contractor's Number: 08001			141.00
142.00	Street: 4814 CITY PARK ROAD	PO Box:					142.00
143.00	City: AUSTIN	State: TX		Zip Code: 78730			143.00
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y			144.00
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y					145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N			147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N			148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N			149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.					N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part I Date/Time Prepared: 10/26/2017 11:57 am
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet S-2 Part II Date/Time Prepared: 10/26/2017 11:57 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/23/2017	Y	10/23/2017		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 10/26/2017 11:57 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHUCK		GREEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	S R G L L C			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(972) 381-1150		CHUCK.GREEN@SRGLLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Prepared: 10/26/2017 11:57 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PRINCIPAL		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
10/26/2017 11:57 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	39	14,274	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		39	14,274	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		39	14,274	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	45	16,470			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		84			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
10/26/2017 11:57 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,873	2,019	8,405			1.00
2.00 HMO and other (see instructions)	0	12				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,873	2,019	8,405			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	2,873	2,019	8,405	0.00	152.60	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE			6,565	0.00	49.87	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	202.47	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet S-3
Part I
Date/Time Prepared:
10/26/2017 11:57 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	86	34	210	1.00
2.00 HMO and other (see instructions)				0	1		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	86	34		210	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE	0.00					0	21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A

Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1,684,400	1,684,400	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	136,243	136,243	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	194,503	798,569	993,072	1,006,012	4.00
5.01	00550	DATA PROCESSING	81,271	38,752	120,023	120,023	5.01
5.02	00590	ADMINISTRATIVE	129,836	11,199	141,035	141,035	5.02
5.03	00591	BUSINESS OFFICE	463,637	2,694,554	3,158,191	1,337,148	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	577,537	1,381,525	1,959,062	2,814,490	5.04
6.00	00600	MAINTENANCE & REPAIRS	352,163	414,858	767,021	767,021	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	164,755	164,755	164,755	8.00
9.00	00900	HOUSEKEEPING	137,729	47,002	184,731	184,731	9.00
10.00	01000	DIETARY	345,711	334,034	679,745	679,745	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	39,009	422,334	461,343	40,696	14.00
15.00	01500	PHARMACY	317,282	761,355	1,078,637	1,075,849	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,398	53,988	169,386	169,386	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,654,235	2,598,023	6,252,258	5,357,068	30.00
46.00	04600	OTHER LONG TERM CARE	1,350,278	657,465	2,007,743	1,795,711	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,434	65,434	35,873	54.00
57.00	05700	CT SCAN	0	0	25,425	25,425	57.00
58.00	05800	MRI	0	0	4,136	4,136	58.00
60.00	06000	LABORATORY	19,581	81,167	100,748	109,270	60.00
65.00	06500	RESPIRATORY THERAPY	358,910	106,494	465,404	411,887	65.00
66.00	06600	PHYSICAL THERAPY	0	-184	-184	289,484	66.00
67.00	06700	OCCUPATIONAL THERAPY	739,865	96,769	836,634	324,712	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	188,918	188,918	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	616,325	616,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,488	9,488	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	58,299	58,299	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,876,945	10,728,093	19,605,038	19,548,130	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,392	23,078	182,470	225,376	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	14,002	14,002	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	0	194.02
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	9,036,337	10,751,171	19,787,508	19,787,508	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-147,549	1,536,851	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-3,262	132,981	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-284	1,005,728	4.00
5.01	00550	DATA PROCESSING	0	120,023	5.01
5.02	00590	ADMITTING	0	141,035	5.02
5.03	00591	BUSINESS OFFICE	-548,785	788,363	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	-422,135	2,392,355	5.04
6.00	00600	MAINTENANCE & REPAIRS	-16,523	750,498	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	164,755	8.00
9.00	00900	HOUSEKEEPING	0	184,731	9.00
10.00	01000	DIETARY	-47,512	632,233	10.00
11.00	01100	CAFETERIA	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40,696	14.00
15.00	01500	PHARMACY	0	1,075,849	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,620	161,766	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-588,428	4,768,640	30.00
46.00	04600	OTHER LONG TERM CARE	-5,750	1,789,961	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,873	54.00
57.00	05700	CT SCAN	0	25,425	57.00
58.00	05800	MRI	0	4,136	58.00
60.00	06000	LABORATORY	0	109,270	60.00
65.00	06500	RESPIRATORY THERAPY	0	411,887	65.00
66.00	06600	PHYSICAL THERAPY	0	289,484	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	324,712	67.00
68.00	06800	SPEECH PATHOLOGY	0	188,918	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	616,325	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,488	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	58,299	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,787,848	17,760,282	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	225,376	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	14,002	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	194.02
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-1,787,848	17,999,660	200.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-6
Date/Time Prepared:
10/26/2017 11:57 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - EQUIPMENT DEPRECIATION & AMORTIZATI						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,498	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	52,242	2.00	
	TOTALS		0	94,740		
B - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	612,874	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,488	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
	TOTALS		0	622,362		
C - RECLASS INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	44,652	1.00	
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	120,000	2.00	
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	84,001	3.00	
	TOTALS		0	248,653		
D - RECLASS OUTPATIENT SALARIES						
1.00	PHYSICAL THERAPY	66.00	278,170	0	1.00	
2.00	SPEECH PATHOLOGY	68.00	181,499	0	2.00	
	TOTALS		459,669	0		
E - RECLASS PURCHASED SERVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,451	1.00	
2.00	RENAL DIALYSIS	74.00	0	58,299	2.00	
	TOTALS		0	61,750		
F - MED DIRECTOR TO CLINIC						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	50,000	3,574	1.00	
	TOTALS		50,000	3,574		
G - LAB						
1.00	LABORATORY	60.00	0	8,608	1.00	
	TOTALS		0	8,608		
H - HOSPITAL SPECIFIC SALARY & BENEFITS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	14,544	0	1.00	
	TOTALS		14,544	0		
I - RECLASS CT SCAN AND MRI COST						
1.00	CT SCAN	57.00	0	25,425	1.00	
2.00	MRI	58.00	0	4,136	2.00	
	TOTALS		0	29,561		
K - MANAGEMENT FEES						
1.00	ADMINISTRATIVE AND GENERAL	5.04	0	869,430	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	869,430		
L - RECLASS THERAPY ADMIN						
1.00	PHYSICAL THERAPY	66.00	11,498	0	1.00	
2.00	SPEECH PATHOLOGY	68.00	7,419	0	2.00	
	TOTALS		18,917	0		
M - EMPLOYEE HEALTH						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18,823	2,725	1.00	
	TOTALS		18,823	2,725		
N - MARKETING DEPARTMENT						
1.00	MARKETING DEPARTMENT	194.01	8,452	5,550	1.00	
	TOTALS		8,452	5,550		
O - RENTAL RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,477,250	1.00	
	TOTALS		0	1,477,250		
500.00	Grand Total: Increases		570,405	3,424,203	500.00	

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-6
Date/Time Prepared:
10/26/2017 11:57 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - EQUIPMENT DEPRECIATION & AMORTIZATI							
1.00	BUSINESS OFFICE	5.03	0	94,740	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	94,740			
B - RECLASS CHARGEABLE MEDICAL SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	420,647	0		1.00
2.00	PHARMACY	15.00	0	2,788	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	111,829	0		3.00
4.00	OTHER LONG TERM CARE	46.00	0	25,954	0		4.00
5.00	LABORATORY	60.00	0	86	0		5.00
6.00	RESPIRATORY THERAPY	65.00	0	53,517	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	3,877	0		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,664	0		8.00
	TOTALS		0	622,362			
C - RECLASS INSURANCE							
1.00	BUSINESS OFFICE	5.03	0	248,653	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	248,653			
D - RECLASS OUTPATIENT SALARIES							
1.00	OCCUPATIONAL THERAPY	67.00	459,669	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		459,669	0			
E - RECLASS PURCHASED SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	0	61,750	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	61,750			
F - MED DIRECTOR TO CLINIC							
1.00	ADULTS & PEDIATRICS	30.00	50,000	3,574	0		1.00
	TOTALS		50,000	3,574			
G - LAB							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,608	0		1.00
	TOTALS		0	8,608			
H - HOSPITAL SPECIFIC SALARY & BENEFITS							
1.00	ADULTS & PEDIATRICS	30.00	14,544	0	0		1.00
	TOTALS		14,544	0			
I - RECLASS CT SCAN AND MRI COST							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	29,561	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	29,561			
K - MANAGEMENT FEES							
1.00	BUSINESS OFFICE	5.03	0	400	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	653,493	0		2.00
3.00	OTHER LONG TERM CARE	46.00	0	186,078	0		3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	29,459	0		4.00
	TOTALS		0	869,430			
L - RECLASS THERAPY ADMIN							
1.00	OCCUPATIONAL THERAPY	67.00	18,917	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		18,917	0			
M - EMPLOYEE HEALTH							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	18,823	2,725	0		1.00
	TOTALS		18,823	2,725			
N - MARKETING DEPARTMENT							
1.00	ADMINISTRATIVE AND GENERAL	5.04	8,452	5,550	0		1.00
	TOTALS		8,452	5,550			
O - RENTAL RECLASS							
1.00	BUSINESS OFFICE	5.03	0	1,477,250	10		1.00
	TOTALS		0	1,477,250			
500.00	Grand Total: Decreases		570,405	3,424,203			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-7
Part I
Date/Time Prepared:
10/26/2017 11:57 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	656,103	0	0	0	2.00
3.00	Buildings and Fixtures	278,465	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	1,180,642	0	124,491	124,491	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	2,115,210	0	124,491	124,491	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	2,115,210	0	124,491	124,491	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	656,103	0			2.00
3.00	Buildings and Fixtures	278,465	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	1,270,810	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	2,205,378	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	2,205,378	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-7
Part II
Date/Time Prepared:
10/26/2017 11:57 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Prepared: 10/26/2017 11:57 am
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	934,568	0	934,568	0.423768	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,270,810	0	1,270,810	0.576232	0	2.00
3.00	Total (sum of lines 1-2)	2,205,378	0	2,205,378	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	42,498	1,329,701	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	48,980	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	91,478	1,329,701	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	44,652	120,000	0	1,536,851	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	84,001	0	0	132,981	2.00
3.00	Total (sum of lines 1-2)	0	128,653	120,000	0	1,669,832	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-8

Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)			0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-3,453		ADMINISTRATIVE AND GENERAL	5.04		0	7.00
8.00 Television and radio service (chapter 21)	A	-16,523		MAINTENANCE & REPAIRS	6.00		0	8.00
9.00 Parking lot (chapter 21)			0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-228,723					0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-948,738					0	12.00
13.00 Laundry and linen service			0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-42,030		DIETARY	10.00		0	14.00
15.00 Rental of quarters to employee and others			0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00		0	16.00
17.00 Sale of drugs to other than patients			0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-7,620		MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00		0	19.00
20.00 Vending machines	B	-5,482		DIETARY	10.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00		0	32.00
33.00 REFUND OF TRADE PAYABLES	B	-32,959		ADMINISTRATIVE AND GENERAL	5.04		0	33.00
33.01 AMBULANCE INCOME	B	-91,284		ADULTS & PEDIATRICS	30.00		0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-8

Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
33.02 NONALLOWABLE DEPRECIATION	A	-23,947	BUSINESS OFFICE	5.03	0 33.02
34.00 RENTAL INCOME	B	-4,600	ADMINISTRATIVE AND GENERAL	5.04	0 34.00
35.00 NONALLOWABLE INCOME TAX	A	87,030	ADMINISTRATIVE AND GENERAL	5.04	0 35.00
36.00 NONALLOWABLE DONATIONS	A	-40	ADMINISTRATIVE AND GENERAL	5.04	0 36.00
39.00 HOSPITAL ASSESSMENT	A	-268,421	ADULTS & PEDIATRICS	30.00	0 39.00
40.00 NONALLOWABLE PENALTIES	A	-26,941	BUSINESS OFFICE	5.03	0 40.00
41.00 NONALLOWABLE BUSINESS DEVELOPME	A	-4,216	ADMINISTRATIVE AND GENERAL	5.04	0 41.00
44.00 NONALLOWABLE MARKETING	A	-13,309	ADMINISTRATIVE AND GENERAL	5.04	0 44.00
44.01 NONALLOWABLE MARKETING	A	-127	BUSINESS OFFICE	5.03	0 44.01
44.02 NONALLOWABLE PENALTIES	A	-5,750	OTHER LONG TERM CARE	46.00	0 44.02
44.03 PATIENT TELEPHONE SALARY	A	-9,399	ADMINISTRATIVE AND GENERAL	5.04	0 44.03
44.04 PATIENT TELEPHONE BENEFITS	A	-284	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 44.04
44.05 PATIENT TV DEPRECIATION	A	-3,262	CAP REL COSTS-MVBLE EQUIP	2.00	9 44.05
44.06 NONALLOWABLE INTEREST	A	-137,770	BUSINESS OFFICE	5.03	0 44.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,787,848			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS
 Provider CCN: 52-2005
 Period: From 01/01/2016 To 12/31/2016
 Worksheet A-8-1
 Date/Time Prepared: 10/26/2017 11:57 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.04	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	453,293	894,482 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING RENT	1,329,701	1,477,250 2.00
3.00	5.04	ADMINISTRATIVE AND GENERAL	HOME OFFICE COST	12,306	12,306 3.00
4.00	5.04	ADMINISTRATIVE AND GENERAL	PROFESSIONAL FEES	1,114,345	1,114,345 4.00
4.01	5.03	BUSINESS OFFICE		0	360,000 4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,909,645	3,858,383 5.00

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

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

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

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

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

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

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

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

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-8-1

Date/Time Prepared:
10/26/2017 11:57 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-441,189	0		1.00
2.00	-147,549	10		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	-360,000	0		4.01
5.00	-948,738			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet A-8-2

Date/Time Prepared:
10/26/2017 11:57 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	384,704	174,223	210,480	211,500	1,534	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			384,704	174,223	210,480		1,534	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	155,981	7,799	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			155,981	7,799	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	155,981	54,499	228,723	1.00
2.00	0.00		0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	155,981	54,499	228,723	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet B
Part I
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,536,851	1,536,851			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	132,981		132,981		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,005,728	9,090	0	1,014,818	4.00
5.01 00550	DATA PROCESSING	120,023	0	0	9,348	129,371 5.01
5.02 00590	ADMINISTRATIVE	141,035	10,025	0	14,934	2,875 5.02
5.03 00591	BUSINESS OFFICE	788,363	31,215	211	53,327	13,416 5.03
5.04 00592	ADMINISTRATIVE AND GENERAL	2,392,355	510,456	55,155	65,456	31,623 5.04
6.00 00600	MAINTENANCE & REPAIRS	750,498	191,326	9,315	40,505	10,541 6.00
8.00 00800	LAUNDRY & LINEN SERVICE	164,755	30,884	298	0	0 8.00
9.00 00900	HOUSEKEEPING	184,731	18,643	0	15,841	958 9.00
10.00 01000	DIETARY	632,233	110,104	4,449	39,763	3,833 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
14.00 01400	CENTRAL SERVICES & SUPPLY	40,696	14,094	0	4,487	1,917 14.00
15.00 01500	PHARMACY	1,075,849	14,301	0	36,493	4,792 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	161,766	10,967	0	13,273	2,875 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,768,640	164,304	34,575	412,888	26,833 30.00
46.00 04600	OTHER LONG TERM CARE	1,789,961	179,829	10,837	155,308	6,708 46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	35,873	0	368	0	0 54.00
57.00 05700	CT SCAN	25,425	0	0	0	0 57.00
58.00 05800	MRI	4,136	0	0	0	0 58.00
60.00 06000	LABORATORY	109,270	5,178	5,399	2,252	958 60.00
65.00 06500	RESPIRATORY THERAPY	411,887	5,426	1,868	41,281	1,917 65.00
66.00 06600	PHYSICAL THERAPY	289,484	48,774	434	33,317	2,875 66.00
67.00 06700	OCCUPATIONAL THERAPY	324,712	63,009	0	30,052	1,917 67.00
68.00 06800	SPEECH PATHOLOGY	188,918	4,946	0	21,729	958 68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	616,325	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	9,488	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	1,759	0	0 73.00
74.00 07400	RENAL DIALYSIS	58,299	2,167	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,760,282	1,424,738	124,668	990,254	114,996 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	225,376	38,981	8,313	23,592	12,458 192.00
194.00 07950	OTHER NONREIMBURSABLE	0	0	0	0	0 194.00
194.01 07951	MARKETING DEPARTMENT	14,002	0	0	972	0 194.01
194.02 07952	OTHER NONALLOWABLE	0	36,417	0	0	0 194.02
194.03 07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	36,715	0	0	1,917 194.03
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	TOTAL (sum lines 118-201)	17,999,660	1,536,851	132,981	1,014,818	129,371 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet B
Part I
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description			ADMINISTRATIVE	BUSINESS OFFICE	Subtotal	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMINISTRATIVE	168,869					5.02
5.03	00591	BUSINESS OFFICE	0	886,532				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	0	3,055,045	3,055,045		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,002,185	204,871	1,207,056	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	195,937	40,054	47,505	8.00
9.00	00900	HOUSEKEEPING	0	0	220,173	45,009	28,676	9.00
10.00	01000	DIETARY	0	0	790,382	161,573	169,358	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	61,194	12,510	21,679	14.00
15.00	01500	PHARMACY	0	0	1,131,435	231,292	21,997	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	188,881	38,612	16,870	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,546	281,180	5,741,966	1,173,803	252,726	30.00
46.00	04600	OTHER LONG TERM CARE	27,662	145,202	2,315,507	473,345	276,603	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,508	13,167	51,916	10,613	0	54.00
57.00	05700	CT SCAN	400	2,097	27,922	5,708	0	57.00
58.00	05800	MRI	65	341	4,542	928	0	58.00
60.00	06000	LABORATORY	7,840	41,152	172,049	35,171	7,964	60.00
65.00	06500	RESPIRATORY THERAPY	15,458	81,145	558,982	114,269	8,346	65.00
66.00	06600	PHYSICAL THERAPY	7,580	39,790	422,254	86,319	75,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,214	32,617	458,521	93,733	96,918	67.00
68.00	06800	SPEECH PATHOLOGY	4,891	25,674	247,116	50,516	7,608	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,783	72,351	702,459	143,599	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	190	995	10,673	2,182	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,848	140,930	169,537	34,657	0	73.00
74.00	07400	RENAL DIALYSIS	1,884	9,891	72,241	14,768	3,333	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,869	886,532	17,600,917	2,973,532	1,034,606	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	308,720	63,110	59,960	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	14,974	3,061	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	36,417	7,445	56,016	194.02
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	0	38,632	7,897	56,474	194.03
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	168,869	886,532	17,999,660	3,055,045	1,207,056	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prepared: 10/26/2017 11:57 am
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	
		8.00	9.00	10.00	11.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00590	ADMITTING					5.02
5.03	00591	BUSINESS OFFICE					5.03
5.04	00592	ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	283,496				8.00
9.00	00900	HOUSEKEEPING	126	293,984			9.00
10.00	01000	DIETARY	0	44,026	1,165,339		10.00
11.00	01100	CAFETERIA	0	0	341,442	341,442	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,636	0	0	101,019
15.00	01500	PHARMACY	0	5,718	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,385	0	0	22
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	201,192	65,699	409,487	169,701	1
46.00	04600	OTHER LONG TERM CARE	80,153	71,907	414,410	171,741	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
60.00	06000	LABORATORY	0	2,070	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	2,170	0	0	0
66.00	06600	PHYSICAL THERAPY	0	19,503	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	1,859	25,195	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	1,978	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	99,456
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,540
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	867	0	0	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	283,330	249,154	1,165,339	341,442	101,019
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	166	15,587	0	0	0
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0
194.02	07952	OTHER NONALLOWABLE	0	14,562	0	0	0
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	14,681	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	283,496	293,984	1,165,339	341,442	101,019

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet B
Part I
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00590	ADMINITTING					5.02
5.03	00591	BUSINESS OFFICE					5.03
5.04	00592	ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	1,390,442				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	248,770			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	78,904	8,093,479	0	8,093,479
46.00	04600	OTHER LONG TERM CARE	0	40,745	3,844,411	0	3,844,411
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,695	66,224	0	66,224
57.00	05700	CT SCAN	0	589	34,219	0	34,219
58.00	05800	MRI	0	96	5,566	0	5,566
60.00	06000	LABORATORY	0	11,547	228,801	0	228,801
65.00	06500	RESPIRATORY THERAPY	0	22,770	706,537	0	706,537
66.00	06600	PHYSICAL THERAPY	0	11,165	614,264	0	614,264
67.00	06700	OCCUPATIONAL THERAPY	0	9,153	685,379	0	685,379
68.00	06800	SPEECH PATHOLOGY	0	7,204	314,422	0	314,422
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,302	965,816	0	965,816
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	279	14,674	0	14,674
73.00	07300	DRUGS CHARGED TO PATIENTS	1,390,442	39,546	1,634,182	0	1,634,182
74.00	07400	RENAL DIALYSIS	0	2,775	93,984	0	93,984
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,390,442	248,770	17,301,958	0	17,301,958
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	447,543	0	447,543
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0
194.01	07951	MARKETING DEPARTMENT	0	0	18,035	0	18,035
194.02	07952	OTHER NONALLOWABLE	0	0	114,440	0	114,440
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	0	117,684	0	117,684
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,390,442	248,770	17,999,660	0	17,999,660

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet B
Part II
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,090	0	9,090	4.00
5.01 00550	DATA PROCESSING	0	0	0	0	5.01
5.02 00590	ADMINISTRATIVE	0	10,025	0	10,025	5.02
5.03 00591	BUSINESS OFFICE	0	31,215	211	31,426	5.03
5.04 00592	ADMINISTRATIVE AND GENERAL	27,739	510,456	55,155	593,350	5.04
6.00 00600	MAINTENANCE & REPAIRS	0	191,326	9,315	200,641	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	30,884	298	31,182	8.00
9.00 00900	HOUSEKEEPING	0	18,643	0	18,643	9.00
10.00 01000	DIETARY	0	110,104	4,449	114,553	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	14,094	0	14,094	14.00
15.00 01500	PHARMACY	0	14,301	0	14,301	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	10,967	0	10,967	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	164,304	34,575	198,879	30.00
46.00 04600	OTHER LONG TERM CARE	0	179,829	10,837	190,666	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	368	368	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
60.00 06000	LABORATORY	0	5,178	5,399	10,577	60.00
65.00 06500	RESPIRATORY THERAPY	0	5,426	1,868	7,294	65.00
66.00 06600	PHYSICAL THERAPY	0	48,774	434	49,208	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	63,009	0	63,009	67.00
68.00 06800	SPEECH PATHOLOGY	0	4,946	0	4,946	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	1,759	1,759	73.00
74.00 07400	RENAL DIALYSIS	0	2,167	0	2,167	74.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	27,739	1,424,738	124,668	1,577,145	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	38,981	8,313	47,294	192.00
194.00 07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01 07951	MARKETING DEPARTMENT	0	0	0	0	194.01
194.02 07952	OTHER NONALLOWABLE	0	36,417	0	36,417	194.02
194.03 07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	36,715	0	36,715	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	27,739	1,536,851	132,981	1,697,571	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 10/26/2017 11:57 am	
Cost Center Description			DATA PROCESSING	ADMINISTRATIVE	BUSINESS OFFICE	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	84					5.01
5.02	00590	ADMINISTRATIVE	2	10,161				5.02
5.03	00591	BUSINESS OFFICE	9	0	31,913			5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	21	0	0	593,957		5.04
6.00	00600	MAINTENANCE & REPAIRS	7	0	0	39,831	240,842	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	7,787	9,479	8.00
9.00	00900	HOUSEKEEPING	1	0	0	8,751	5,722	9.00
10.00	01000	DIETARY	2	0	0	31,413	33,792	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1	0	0	2,432	4,326	14.00
15.00	01500	PHARMACY	3	0	0	44,968	4,389	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2	0	0	7,507	3,366	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17	3,236	10,125	228,207	50,426	30.00
46.00	04600	OTHER LONG TERM CARE	4	1,661	5,226	92,028	55,189	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	151	474	2,063	0	54.00
57.00	05700	CT SCAN	0	24	75	1,110	0	57.00
58.00	05800	MRI	0	4	12	181	0	58.00
60.00	06000	LABORATORY	1	471	1,481	6,838	1,589	60.00
65.00	06500	RESPIRATORY THERAPY	1	928	2,921	22,216	1,665	65.00
66.00	06600	PHYSICAL THERAPY	2	455	1,432	16,782	14,969	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	373	1,174	18,223	19,338	67.00
68.00	06800	SPEECH PATHOLOGY	1	294	924	9,821	1,518	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	828	2,604	27,919	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11	36	424	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,612	5,073	6,738	0	73.00
74.00	07400	RENAL DIALYSIS	0	113	356	2,871	665	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	75	10,161	31,913	578,110	206,433	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8	0	0	12,270	11,964	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	595	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	1,447	11,177	194.02
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	1	0	0	1,535	11,268	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	84	10,161	31,913	593,957	240,842	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet B Part II Date/Time Prepared: 10/26/2017 11:57 am	
Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	
			8.00	9.00	10.00	11.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,448					8.00
9.00	00900	HOUSEKEEPING	22	33,281				9.00
10.00	01000	DIETARY	0	4,984	185,100			10.00
11.00	01100	CAFETERIA	0	0	54,234	54,234		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	638	0	0	21,531	14.00
15.00	01500	PHARMACY	0	647	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	496	0	0	5	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,382	7,438	65,042	26,955	0	30.00
46.00	04600	OTHER LONG TERM CARE	13,698	8,140	65,824	27,279	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	234	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	246	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,208	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	318	2,852	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	224	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	21,198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	328	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	98	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,420	28,205	185,100	54,234	21,531	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28	1,765	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	1,649	0	0	0	194.02
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	1,662	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	48,448	33,281	185,100	54,234	21,531	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 10/26/2017 11:57 am
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00590	ADMINISTRATIVE					5.02
5.03	00591	BUSINESS OFFICE					5.03
5.04	00592	ADMINISTRATIVE AND GENERAL					5.04
6.00	00600	MAINTENANCE & REPAIRS					6.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	64,635				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,462			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	7,137	635,542	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	3,676	464,782	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	333	3,389	0	54.00
57.00	05700	CT SCAN	0	53	1,262	0	57.00
58.00	05800	MRI	0	9	206	0	58.00
60.00	06000	LABORATORY	0	1,042	22,253	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,054	37,695	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,007	86,361	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	826	106,383	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	650	18,573	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,832	54,381	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25	824	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	64,635	3,568	83,385	0	73.00
74.00	07400	RENAL DIALYSIS	0	250	6,520	0	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,635	22,462	1,521,556	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	73,540	0	192.00
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	604	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	50,690	0	194.02
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	0	51,181	0	194.03
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	64,635	22,462	1,697,571	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet B-1
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (COMPUTER TIME)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (EQUIPMENT COST)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	185,811				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,459,107			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,099	0	8,823,011		4.00
5.01 00550	DATA PROCESSING	0	0	81,271	135	5.01
5.02 00590	ADMITTING	1,212	0	129,836	3	42,263,661
5.03 00591	BUSINESS OFFICE	3,774	2,318	463,637	14	0
5.04 00592	ADMINISTRATIVE AND GENERAL	61,716	605,172	569,085	33	0
6.00 00600	MAINTENANCE & REPAIRS	23,132	102,206	352,163	11	0
8.00 00800	LAUNDRY & LINEN SERVICE	3,734	3,274	0	0	0
9.00 00900	HOUSEKEEPING	2,254	0	137,729	1	0
10.00 01000	DIETARY	13,312	48,812	345,711	4	0
11.00 01100	CAFETERIA	0	0	0	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	1,704	0	39,009	2	0
15.00 01500	PHARMACY	1,729	0	317,282	5	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,326	0	115,398	3	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	19,865	379,366	3,589,691	28	13,404,340
46.00 04600	OTHER LONG TERM CARE	21,742	118,901	1,350,278	7	6,922,304
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	4,042	0	0	627,741
57.00 05700	CT SCAN	0	0	0	0	99,991
58.00 05800	MRI	0	0	0	0	16,267
60.00 06000	LABORATORY	626	59,244	19,581	1	1,961,846
65.00 06500	RESPIRATORY THERAPY	656	20,500	358,910	2	3,868,482
66.00 06600	PHYSICAL THERAPY	5,897	4,763	289,668	3	1,896,935
67.00 06700	OCCUPATIONAL THERAPY	7,618	0	261,279	2	1,554,973
68.00 06800	SPEECH PATHOLOGY	598	0	188,918	1	1,223,967
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,449,245
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	47,439
73.00 07300	DRUGS CHARGED TO PATIENTS	0	19,301	0	0	6,718,611
74.00 07400	RENAL DIALYSIS	262	0	0	0	471,520
OUTPATIENT SERVICE COST CENTERS						
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	172,256	1,367,899	8,609,446	120	42,263,661
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	4,713	91,208	205,113	13	0
194.00 07950	OTHER NONREIMBURSABLE	0	0	0	0	0
194.01 07951	MARKETING DEPARTMENT	0	0	8,452	0	0
194.02 07952	OTHER NONALLOWABLE	4,403	0	0	0	0
194.03 07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	4,439	0	0	2	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,536,851	132,981	1,014,818	129,371	168,869
203.00	Unit cost multiplier (Wkst. B, Part I)	8.271044	0.091139	0.115019	958.303704	0.003996
204.00	Cost to be allocated (per Wkst. B, Part II)			9,090	84	10,161
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001030	0.622222	0.000240

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet B-1

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Cost Center Description		BUSINESS OFFICE (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.03	5A.04	5.04	6.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	DATA PROCESSING					5.01
5.02	00590	ADMITTING					5.02
5.03	00591	BUSINESS OFFICE	42,263,661				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	-3,055,045	14,944,615		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,002,185	94,878	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	195,937	3,734	224,913
9.00	00900	HOUSEKEEPING	0	0	220,173	2,254	100
10.00	01000	DIETARY	0	0	790,382	13,312	0
11.00	01100	CAFETERIA	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	61,194	1,704	0
15.00	01500	PHARMACY	0	0	1,131,435	1,729	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	188,881	1,326	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,404,340	0	5,741,966	19,865	159,616
46.00	04600	OTHER LONG TERM CARE	6,922,304	0	2,315,507	21,742	63,590
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,741	0	51,916	0	0
57.00	05700	CT SCAN	99,991	0	27,922	0	0
58.00	05800	MRI	16,267	0	4,542	0	0
60.00	06000	LABORATORY	1,961,846	0	172,049	626	0
65.00	06500	RESPIRATORY THERAPY	3,868,482	0	558,982	656	0
66.00	06600	PHYSICAL THERAPY	1,896,935	0	422,254	5,897	0
67.00	06700	OCCUPATIONAL THERAPY	1,554,973	0	458,521	7,618	1,475
68.00	06800	SPEECH PATHOLOGY	1,223,967	0	247,116	598	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,449,245	0	702,459	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,439	0	10,673	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,718,611	0	169,537	0	0
74.00	07400	RENAL DIALYSIS	471,520	0	72,241	262	0
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,263,661	-3,055,045	14,545,872	81,323	224,781
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	308,720	4,713	132
194.00	07950	OTHER NONREIMBURSABLE	0	0	0	0	0
194.01	07951	MARKETING DEPARTMENT	0	0	14,974	0	0
194.02	07952	OTHER NONALLOWABLE	0	0	36,417	4,403	0
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0	0	38,632	4,439	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	886,532		3,055,045	1,207,056	283,496
203.00		Unit cost multiplier (Wkst. B, Part I)	0.020976		0.204424	12.722191	1.260470
204.00		Cost to be allocated (per Wkst. B, Part II)	31,913		593,957	240,842	48,448
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000755		0.039744	2.538439	0.215408

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

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Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		9.00	10.00	11.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00550						5.01
5.02	00590						5.02
5.03	00591						5.03
5.04	00592						5.04
6.00	00600						6.00
8.00	00800						8.00
9.00	00900	88,890					9.00
10.00	01000	13,312	71,724				10.00
11.00	01100	0	21,015	50,709			11.00
14.00	01400	1,704	0	0	622,503		14.00
15.00	01500	1,729	0	0	0	687,330	15.00
16.00	01600	1,326	0	0	136	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	19,865	25,203	25,203	5	0	30.00
46.00	04600	21,742	25,506	25,506	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
60.00	06000	626	0	0	0	0	60.00
65.00	06500	656	0	0	0	0	65.00
66.00	06600	5,897	0	0	0	0	66.00
67.00	06700	7,618	0	0	0	0	67.00
68.00	06800	598	0	0	0	0	68.00
71.00	07100	0	0	0	612,874	0	71.00
72.00	07200	0	0	0	9,488	0	72.00
73.00	07300	0	0	0	0	687,330	73.00
74.00	07400	262	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		75,335	71,724	50,709	622,503	687,330	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	4,713	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	4,403	0	0	0	0	194.02
194.03	07953	4,439	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		293,984	1,165,339	341,442	101,019	1,390,442	202.00
203.00		3.307279	16.247546	6.733361	0.162279	2.022961	203.00
204.00		33,281	185,100	54,234	21,531	64,635	204.00
205.00		0.374407	2.580726	1.069514	0.034588	0.094038	205.00

COST ALLOCATION - STATISTICAL BASIS

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Period:
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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00550	DATA PROCESSING	5.01
5.02	00590	ADMITTING	5.02
5.03	00591	BUSINESS OFFICE	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	5.04
6.00	00600	MAINTENANCE & REPAIRS	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,263,661
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	13,404,340
46.00	04600	OTHER LONG TERM CARE	6,922,304
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,741
57.00	05700	CT SCAN	99,991
58.00	05800	MRI	16,267
60.00	06000	LABORATORY	1,961,846
65.00	06500	RESPIRATORY THERAPY	3,868,482
66.00	06600	PHYSICAL THERAPY	1,896,935
67.00	06700	OCCUPATIONAL THERAPY	1,554,973
68.00	06800	SPEECH PATHOLOGY	1,223,967
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,449,245
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,439
73.00	07300	DRUGS CHARGED TO PATIENTS	6,718,611
74.00	07400	RENAL DIALYSIS	471,520
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,263,661
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0
194.00	07950	OTHER NONREIMBURSABLE	0
194.01	07951	MARKETING DEPARTMENT	0
194.02	07952	OTHER NONALLOWABLE	0
194.03	07953	LAKEVIEW CAPITAL PARTNERS (CBRF)	0
200.00		Cross Foot Adjustments	
201.00		Negative Cost Centers	
202.00		Cost to be allocated (per Wkst. B, Part I)	248,770
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005886
204.00		Cost to be allocated (per Wkst. B, Part II)	22,462
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000531

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet C
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		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	8,093,479		8,093,479	54,499	8,147,978	30.00
46.00	04600 OTHER LONG TERM CARE	3,844,411		3,844,411	0	3,844,411	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	66,224		66,224	0	66,224	54.00
57.00	05700 CT SCAN	34,219		34,219	0	34,219	57.00
58.00	05800 MRI	5,566		5,566	0	5,566	58.00
60.00	06000 LABORATORY	228,801		228,801	0	228,801	60.00
65.00	06500 RESPIRATORY THERAPY	706,537	0	706,537	0	706,537	65.00
66.00	06600 PHYSICAL THERAPY	614,264	0	614,264	0	614,264	66.00
67.00	06700 OCCUPATIONAL THERAPY	685,379	0	685,379	0	685,379	67.00
68.00	06800 SPEECH PATHOLOGY	314,422	0	314,422	0	314,422	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	965,816		965,816	0	965,816	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14,674		14,674	0	14,674	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,634,182		1,634,182	0	1,634,182	73.00
74.00	07400 RENAL DIALYSIS	93,984		93,984	0	93,984	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0		0	0	0	95.00
200.00	Subtotal (see instructions)	17,301,958	0	17,301,958	54,499	17,356,457	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	17,301,958	0	17,301,958	54,499	17,356,457	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

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		Title XVIII			Hospital	PPS		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	13,404,340		13,404,340			30.00
46.00	04600	OTHER LONG TERM CARE	6,922,304		6,922,304			46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	620,124	7,617	627,741	0.105496	0.000000	54.00
57.00	05700	CT SCAN	99,991	0	99,991	0.342221	0.000000	57.00
58.00	05800	MRI	16,267	0	16,267	0.342165	0.000000	58.00
60.00	06000	LABORATORY	1,672,539	289,307	1,961,846	0.116625	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	3,868,482	0	3,868,482	0.182639	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,724,683	172,252	1,896,935	0.323819	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,420,271	134,702	1,554,973	0.440766	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,150,189	73,778	1,223,967	0.256888	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,432,143	17,102	3,449,245	0.280008	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,439	0	47,439	0.309324	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,717,477	1,134	6,718,611	0.243232	0.000000	73.00
74.00	07400	RENAL DIALYSIS	471,520	0	471,520	0.199321	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	41,567,769	695,892	42,263,661			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	41,567,769	695,892	42,263,661			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 10/26/2017 11:57 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.105496		54.00
57.00	05700 CT SCAN	0.342221		57.00
58.00	05800 MRI	0.342165		58.00
60.00	06000 LABORATORY	0.116625		60.00
65.00	06500 RESPIRATORY THERAPY	0.182639		65.00
66.00	06600 PHYSICAL THERAPY	0.323819		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.440766		67.00
68.00	06800 SPEECH PATHOLOGY	0.256888		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.280008		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.309324		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.243232		73.00
74.00	07400 RENAL DIALYSIS	0.199321		74.00
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2016
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		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		8,093,479		8,147,978	30.00
46.00	04600 OTHER LONG TERM CARE		3,844,411		3,844,411	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADIOLOGY-DIAGNOSTIC		66,224	0	66,224	54.00
57.00	05700 CT SCAN		34,219	0	34,219	57.00
58.00	05800 MRI		5,566	0	5,566	58.00
60.00	06000 LABORATORY		228,801	0	228,801	60.00
65.00	06500 RESPIRATORY THERAPY	0	706,537	0	706,537	65.00
66.00	06600 PHYSICAL THERAPY	0	614,264	0	614,264	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	685,379	0	685,379	67.00
68.00	06800 SPEECH PATHOLOGY	0	314,422	0	314,422	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		965,816	0	965,816	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		14,674	0	14,674	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,634,182	0	1,634,182	73.00
74.00	07400 RENAL DIALYSIS		93,984	0	93,984	74.00
OUTPATIENT SERVICE COST CENTERS						
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0		0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
200.00	Subtotal (see instructions)		17,301,958	54,499	17,356,457	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		17,301,958	54,499	17,356,457	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

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		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	13,404,340		13,404,340		30.00
46.00	04600	OTHER LONG TERM CARE	6,922,304		6,922,304		46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	620,124	7,617	627,741	0.105496	54.00
57.00	05700	CT SCAN	99,991	0	99,991	0.342221	57.00
58.00	05800	MRI	16,267	0	16,267	0.342165	58.00
60.00	06000	LABORATORY	1,672,539	289,307	1,961,846	0.116625	60.00
65.00	06500	RESPIRATORY THERAPY	3,868,482	0	3,868,482	0.182639	65.00
66.00	06600	PHYSICAL THERAPY	1,724,683	172,252	1,896,935	0.323819	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,420,271	134,702	1,554,973	0.440766	67.00
68.00	06800	SPEECH PATHOLOGY	1,150,189	73,778	1,223,967	0.256888	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,432,143	17,102	3,449,245	0.280008	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,439	0	47,439	0.309324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,717,477	1,134	6,718,611	0.243232	73.00
74.00	07400	RENAL DIALYSIS	471,520	0	471,520	0.199321	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
200.00		Subtotal (see instructions)	41,567,769	695,892	42,263,661		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	41,567,769	695,892	42,263,661		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 10/26/2017 11:57 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part I Date/Time Prepared: 10/26/2017 11:57 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	635,542	0	635,542	8,405	75.61	
200.00	Total (Lines 30-199)	635,542		635,542	8,405	200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,873	217,228				
200.00	Total (Lines 30-199)	2,873	217,228				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Prepared: 10/26/2017 11:57 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,389	627,741	0.005399	64,497	348	54.00
57.00	05700 CT SCAN	1,262	99,991	0.012621	69,017	871	57.00
58.00	05800 MRI	206	16,267	0.012664	0	0	58.00
60.00	06000 LABORATORY	22,253	1,961,846	0.011343	669,432	7,593	60.00
65.00	06500 RESPIRATORY THERAPY	37,695	3,868,482	0.009744	1,453,427	14,162	65.00
66.00	06600 PHYSICAL THERAPY	86,361	1,896,935	0.045527	465,682	21,201	66.00
67.00	06700 OCCUPATIONAL THERAPY	106,383	1,554,973	0.068415	462,453	31,639	67.00
68.00	06800 SPEECH PATHOLOGY	18,573	1,223,967	0.015174	257,352	3,905	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	54,381	3,449,245	0.015766	1,337,271	21,083	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	824	47,439	0.017370	19,330	336	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	83,385	6,718,611	0.012411	2,400,253	29,790	73.00
74.00	07400 RENAL DIALYSIS	6,520	471,520	0.013828	297,582	4,115	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	421,232	21,937,017		7,496,296	135,043	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet D Part III Date/Time Prepared: 10/26/2017 11:57 am	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,405	0.00	2,873	0		30.00
200.00		Total (lines 30-199)	8,405		2,873	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet D
Part IV
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description		Title XVIII			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet D
Part IV
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	627,741	0.000000	0.000000	64,497	54.00
57.00	05700	CT SCAN	0	99,991	0.000000	0.000000	69,017	57.00
58.00	05800	MRI	0	16,267	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	1,961,846	0.000000	0.000000	669,432	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,868,482	0.000000	0.000000	1,453,427	65.00
66.00	06600	PHYSICAL THERAPY	0	1,896,935	0.000000	0.000000	465,682	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,554,973	0.000000	0.000000	462,453	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,223,967	0.000000	0.000000	257,352	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,449,245	0.000000	0.000000	1,337,271	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	47,439	0.000000	0.000000	19,330	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,718,611	0.000000	0.000000	2,400,253	73.00
74.00	07400	RENAL DIALYSIS	0	471,520	0.000000	0.000000	297,582	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	21,937,017			7,496,296	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII						
					Hospital	PPS
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,560	0	54.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
60.00	06000	LABORATORY	0	1,055	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (Lines 50-199)	0	5,615	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 10/26/2017 11:57 am
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		Title XVIII		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105496	4,560	0	0	481	54.00
57.00	05700	CT SCAN	0.342221	0	0	0	0	57.00
58.00	05800	MRI	0.342165	0	0	0	0	58.00
60.00	06000	LABORATORY	0.116625	1,055	0	0	123	60.00
65.00	06500	RESPIRATORY THERAPY	0.182639	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323819	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.440766	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.256888	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.280008	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.309324	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243232	0	0	1,134	0	73.00
74.00	07400	RENAL DIALYSIS	0.199321	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		5,615	0	1,134	604	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		5,615	0	1,134	604	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 10/26/2017 11:57 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	276	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	276	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	276	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 10/26/2017 11:57 am
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		Title XIX		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.105496	0	2,876	0	0	54.00
57.00	05700	CT SCAN	0.342221	0	0	0	0	57.00
58.00	05800	MRI	0.342165	0	0	0	0	58.00
60.00	06000	LABORATORY	0.116625	0	60,618	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.182639	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323819	0	8,285	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.440766	0	14,781	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.256888	0	20,602	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.280008	0	1,708	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.309324	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.243232	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.199321	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00		Subtotal (see instructions)		0	108,870	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	108,870	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Prepared: 10/26/2017 11:57 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	303	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	7,070	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,683	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,515	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,292	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	478	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	22,341	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	22,341	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 10/26/2017 11:57 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,405	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,405	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		8,405	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,873	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		8,147,978	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		8,147,978	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		8,147,978	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		969.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,785,144	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,785,144	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 10/26/2017 11:57 am	
Cost Center Description			Title XVIII	Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)				42.00	
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT				43.00	
44.00	CORONARY CARE UNIT				44.00	
45.00	BURN INTENSIVE CARE UNIT				45.00	
46.00	SURGICAL INTENSIVE CARE UNIT				46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00	
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,818,248	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				4,603,392	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				217,228	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				135,043	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				352,271	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				4,251,121	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 10/26/2017 11:57 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	635,542	8,147,978	0.078000	0	0	90.00
91.00	Nursing School cost	0	8,147,978	0.000000	0	0	91.00
92.00	Allied health cost	0	8,147,978	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,147,978	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 10/26/2017 11:57 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			8,405 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			8,405 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			8,405 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			2,019 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			8,093,479 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			8,093,479 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			8,093,479 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			962.94 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,944,176 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,944,176 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prepared: 10/26/2017 11:57 am
Cost Center Description			Title XIX	Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				1,033,456
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,977,632
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0
52.00	Total Program excludable cost (sum of lines 50 and 51)				0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005		Period: From 01/01/2016 To 12/31/2016		Worksheet D-1 Date/Time Prepared: 10/26/2017 11:57 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	635,542	8,093,479	0.078525	0	0	90.00
91.00	Nursing School cost	0	8,093,479	0.000000	0	0	91.00
92.00	Allied health cost	0	8,093,479	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,093,479	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 10/26/2017 11:57 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		4,842,303		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.105496	64,497	6,804	54.00
57.00	05700 CT SCAN	0.342221	69,017	23,619	57.00
58.00	05800 MRI	0.342165	0	0	58.00
60.00	06000 LABORATORY	0.116625	669,432	78,073	60.00
65.00	06500 RESPIRATORY THERAPY	0.182639	1,453,427	265,452	65.00
66.00	06600 PHYSICAL THERAPY	0.323819	465,682	150,797	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.440766	462,453	203,834	67.00
68.00	06800 SPEECH PATHOLOGY	0.256888	257,352	66,111	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.280008	1,337,271	374,447	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.309324	19,330	5,979	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.243232	2,400,253	583,818	73.00
74.00	07400 RENAL DIALYSIS	0.199321	297,582	59,314	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,496,296	1,818,248	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		7,496,296		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Prepared: 10/26/2017 11:57 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,304,944		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.105496	29,353	3,097	54.00
57.00	05700 CT SCAN	0.342221	19,660	6,728	57.00
58.00	05800 MRI	0.342165	16,267	5,566	58.00
60.00	06000 LABORATORY	0.116625	235,934	27,516	60.00
65.00	06500 RESPIRATORY THERAPY	0.182639	433,162	79,112	65.00
66.00	06600 PHYSICAL THERAPY	0.323819	349,046	113,028	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.440766	357,276	157,475	67.00
68.00	06800 SPEECH PATHOLOGY	0.256888	290,655	74,666	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.280008	688,740	192,853	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.309324	7,486	2,316	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.243232	1,503,250	365,639	73.00
74.00	07400 RENAL DIALYSIS	0.199321	27,392	5,460	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,958,221	1,033,456	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		3,958,221		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 10/26/2017 11:57 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		276	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		604	2.00
3.00	PPS payments		817	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		276	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,134	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		1,134	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,134	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		858	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		276	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		817	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		163	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		930	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		930	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		930	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		930	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		930	40.00
40.01	Sequestration adjustment (see instructions)		19	40.01
41.00	Interim payments		863	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		48	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet E-1
Part I
Date/Time Prepared:
10/26/2017 11:57 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,827,151		863	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	12/07/2016	22,470		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		22,470		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,849,621		863	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		52,080		48	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,901,701		911	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part IV Date/Time Prepared: 10/26/2017 11:57 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		2,396,518	1.00
1.01	Full standard payment amount		1,843,279	1.01
1.02	Short stay outlier standard payment amount		319,952	1.02
1.03	Site neutral payment amount - Cost		6,082	1.03
1.04	Site neutral payment amount - IPPS comparable		227,205	1.04
2.00	Outlier Payments		1,075,679	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		3,472,197	3.00
4.00	Nursing and Allied Health Managed Care payments (see instructions)		0	4.00
5.00	Organ acquisition (DO NOT USE THIS LINE)		0	5.00
6.00	Cost of physicians' services in a teaching hospital (see instructions)		0	6.00
7.00	Subtotal (see instructions)		3,472,197	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8)		3,472,197	9.00
10.00	Deductibles		6,440	10.00
11.00	Subtotal (line 9 minus line 10)		3,465,757	11.00
12.00	Coinsurance		528,353	12.00
13.00	Subtotal (line 11 minus line 12)		2,937,404	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		36,177	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		23,515	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		29,233	16.00
17.00	Subtotal (sum of lines 13 and 15)		2,960,919	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Recovery of Accelerated Depreciation		0	21.99
22.00	Total amount payable to the provider (see instructions)		2,960,919	22.00
22.01	Sequestration adjustment (see instructions)		59,218	22.01
23.00	Interim payments		2,849,621	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)		52,080	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 3 (see instructions)		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money (see instructions)		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part VII Date/Time Prepared: 10/26/2017 11:57 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,977,632		1.00
2.00	Medical and other services			22,341	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,977,632	22,341	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,977,632	22,341	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		3,958,221	108,870	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		3,958,221	108,870	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		3,958,221	108,870	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		980,589	86,529	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		2,977,632	22,341	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		2,977,632	22,341	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		2,977,632	22,341	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		2,977,632	22,341	36.00
37.00	ELIMINATE COST SETTLEMENT		-2,977,632	-22,341	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet G

Date/Time Prepared:
10/26/2017 11:57 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-16,306	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,207,400	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,104,032	0	0	0	6.00
7.00	Inventory	257,138	0	0	0	7.00
8.00	Prepaid expenses	87,339	0	0	0	8.00
9.00	Other current assets	841,853	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,273,392	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	656,103	0	0	0	17.00
18.00	Accumulated depreciation	-574,597	0	0	0	18.00
19.00	Fixed equipment	278,465	0	0	0	19.00
20.00	Accumulated depreciation	-271,159	0	0	0	20.00
21.00	Automobiles and trucks	150,232	0	0	0	21.00
22.00	Accumulated depreciation	-132,624	0	0	0	22.00
23.00	Major movable equipment	761,800	0	0	0	23.00
24.00	Accumulated depreciation	-637,443	0	0	0	24.00
25.00	Minor equipment depreciable	358,779	0	0	0	25.00
26.00	Accumulated depreciation	-352,212	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	237,344	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	4,510,736	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,274,282	0	0	0	37.00
38.00	Salaries, wages, and fees payable	286,808	0	0	0	38.00
39.00	Payroll taxes payable	229,210	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	-3,074,371	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,568,662	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,284,591	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	10,284,591	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-5,773,855	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-5,773,855	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	4,510,736	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet G-1

Date/Time Prepared:
10/26/2017 11:57 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-1,929,791		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-3,369,468				2.00
3.00	Total (sum of line 1 and line 2)		-5,299,259		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-5,299,259		0		11.00
12.00	RECONCILING ITEM	474,596		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		474,596		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-5,773,855		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	RECONCILING ITEM		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2016
To 12/31/2016

Worksheet G-2
Parts I & II
Date/Time Prepared:
10/26/2017 11:57 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	13,922,830		13,922,830	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	6,922,304		6,922,304	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	20,845,134		20,845,134	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,845,134		20,845,134	17.00
18.00	Ancillary services	21,418,527	0	21,418,527	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN CHARGES	92,255	0	92,255	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	42,355,916	0	42,355,916	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,787,508		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,787,508		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 52-2005	Period: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prepared: 10/26/2017 11:57 am
				1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		42,355,916	1.00
2.00	Less contractual allowances and discounts on patients' accounts		27,103,055	2.00
3.00	Net patient revenues (line 1 minus line 2)		15,252,861	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		19,787,508	4.00
5.00	Net income from service to patients (line 3 minus line 4)		-4,534,647	5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc		0	6.00
7.00	Income from investments		0	7.00
8.00	Revenues from telephone and other miscellaneous communication services		0	8.00
9.00	Revenue from television and radio service		0	9.00
10.00	Purchase discounts		0	10.00
11.00	Rebates and refunds of expenses		32,959	11.00
12.00	Parking lot receipts		0	12.00
13.00	Revenue from laundry and linen service		0	13.00
14.00	Revenue from meals sold to employees and guests		42,030	14.00
15.00	Revenue from rental of living quarters		4,600	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients		0	17.00
18.00	Revenue from sale of medical records and abstracts		7,620	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen		0	20.00
21.00	Rental of vending machines		5,482	21.00
22.00	Rental of hospital space		0	22.00
23.00	Governmental appropriations		0	23.00
24.00	OTHER INCOME		94,047	24.00
24.01	LAKEVIEW CARE PARTNERS INCOME		978,441	24.01
24.02			0	24.02
25.00	Total other income (sum of lines 6-24)		1,165,179	25.00
26.00	Total (line 5 plus line 25)		-3,369,468	26.00
27.00	OTHER EXPENSES (SPECIFY)		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)		0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		-3,369,468	29.00