

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 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Prepared: 5/31/2019 9:39 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 5/31/2019	Time: 9:39 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAKEVIEW SPECIALTY HOSPT & REHAB (52-2005) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CHRISTOPHER SLOVER
Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title XVIII			HIT	Title XIX	
		Title V	Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY							
1.00	Hospital	0	-247,881	0	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	-247,881	0	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 52-2005		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 9:39 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	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			LAKEVIEW SPECIALTY HOSPT & REHAB	522005	39540	2	10/01/1996	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2018	12/31/2018	20.00
21.00	Type of Control (see instructions)						4		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 52-2005

Period:
From 01/01/2018
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Part I
Date/Time Prepared:
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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
						Urban/Rural St	Date of Geogra	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part I
Date/Time Prepared:
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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N					63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		64.00

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

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		Y		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N	110.00

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		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	82,160	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 healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	309000		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 52-2005		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part I Date/Time Prepared: 5/31/2019 9:39 am	
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					
142.00	Street: 4814 CITY PARK ROAD	PO Box:							
143.00	City: AUSTIN	State: TX		Zip Code: 78730					
									1.00
144.00	Are provider based physicians' costs included in Worksheet A?								Y
									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
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
									1.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N
				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	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
									1.00
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N
		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
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
168.01	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
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 9:39 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	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					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	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	04/10/2019	Y	04/10/2019
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 52-2005		Period: From 01/01/2018 To 12/31/2018		Worksheet S-2 Part II Date/Time Prepared: 5/31/2019 9:39 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		N		21.00	
					1.00		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)							
Capital Related Cost							
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00	
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00	
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00	
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00	
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00	
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00	
Interest Expense							
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00	
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00	
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00	
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00	
Purchased Services							
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00	
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00	
Provider-Based Physicians							
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00	
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00	
				Y/N	Date		
				1.00	2.00		
Home Office Costs							
36.00	Were home office costs claimed on the cost report?				Y	36.00	
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				Y	37.00	
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				N	38.00	
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				N	39.00	
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				N	40.00	
				1.00	2.00		
Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ADAM			MARCIN		41.00
42.00	Enter the employer/company name of the cost report preparer	H R P L L C					42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(972) 381-1150			AGMARCIN@HRPLLC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet S-2
Part II
Date/Time Prepared:
5/31/2019 9:39 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 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/31/2019 9:39 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	14,235	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		39	14,235	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		39	14,235	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		39			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/31/2019 9:39 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,711	3,223	10,291			1.00
2.00	HMO and other (see instructions)	0	954				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)	2,711	3,223	10,291			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)	2,711	3,223	10,291	0.00	167.86	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	167.86	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	50					33.00
33.01	LTCH site neutral days and discharges	1,779					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet S-3
Part I
Date/Time Prepared:
5/31/2019 9:39 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	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	82	55	244	1.00
2.00 HMO and other (see instructions)			0	27		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	82	55	244	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			8			33.00
33.01 LTCH site neutral days and discharges			49			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet A

Date/Time Prepared:
5/31/2019 9:39 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	0	1,924,211	1,924,211	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	216,969	216,969	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	170,118	654,287	824,405	797,770	4.00
5.01	00550	DATA PROCESSING	63,971	44,534	108,505	108,505	5.01
5.02	00590	ADMITTING	127,135	8,369	135,504	135,504	5.02
5.03	00591	BUSINESS OFFICE	472,240	2,761,877	3,234,117	1,084,447	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	620,877	951,536	1,572,413	1,564,936	5.04
6.00	00600	MAINTENANCE & REPAIRS	244,687	560,694	805,381	805,381	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,995	13,995	13,995	8.00
9.00	00900	HOUSEKEEPING	167,629	67,132	234,761	234,761	9.00
10.00	01000	DIETARY	286,102	305,007	591,109	591,109	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	25,539	410,703	436,242	12,786	14.00
15.00	01500	PHARMACY	291,240	1,020,889	1,312,129	1,310,353	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,666	77,159	108,825	104,373	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,614,916	2,405,144	6,020,060	5,528,127	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,599	52,599	52,599	54.00
57.00	05700	CT SCAN	0	0	0	15,701	57.00
58.00	05800	MRI	0	0	0	25,351	58.00
60.00	06000	LABORATORY	41,689	112,145	153,834	162,822	60.00
65.00	06500	RESPIRATORY THERAPY	369,090	69,877	438,967	405,261	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	346,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	748,175	95,564	843,739	338,069	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	153,714	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	499,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	401,738	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,275,074	9,611,511	16,886,585	16,836,204	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	115,116	11,812	126,928	119,744	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	7,477	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	0	44,647	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	5,441	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	7,390,190	9,623,323	17,013,513	17,013,513	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet A

Date/Time Prepared:
5/31/2019 9:39 am

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-588,030	1,336,181	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-258	216,711	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-182,699	615,071	4.00
5.01	00550	DATA PROCESSING	0	108,505	5.01
5.02	00590	ADMITTING	0	135,504	5.02
5.03	00591	BUSINESS OFFICE	-258,231	826,216	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	781,955	2,346,891	5.04
6.00	00600	MAINTENANCE & REPAIRS	-22,329	783,052	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	13,995	8.00
9.00	00900	HOUSEKEEPING	0	234,761	9.00
10.00	01000	DIETARY	-38,128	552,981	10.00
11.00	01100	CAFETERIA	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,786	14.00
15.00	01500	PHARMACY	0	1,310,353	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-545	103,828	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-514,133	5,013,994	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,599	54.00
57.00	05700	CT SCAN	0	15,701	57.00
58.00	05800	MRI	0	25,351	58.00
60.00	06000	LABORATORY	0	162,822	60.00
65.00	06500	RESPIRATORY THERAPY	0	405,261	65.00
66.00	06600	PHYSICAL THERAPY	0	346,249	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	338,069	67.00
68.00	06800	SPEECH PATHOLOGY	0	153,714	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	499,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	401,738	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-822,398	16,013,806	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	119,744	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	7,477	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	44,647	194.03
194.04	07954	EMS/AMBULANCE	0	5,441	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-822,398	16,191,115	200.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet A-6
Date/Time Prepared:
5/31/2019 9:39 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	16,431		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	50,632		2.00
	0		0	67,063		
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	499,248		1.00
	PATIENT					
2.00	IMPL. DEV. CHARGED TO	72.00	0	2,225		2.00
	PATIENTS					
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	501,473		
	C - RECLASS INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	56,006		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	130,791		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	35,546		3.00
	0		0	222,343		
	D - RECLASS OUTPATIENT SALARIES					
1.00	PHYSICAL THERAPY	66.00	308,895	37,099		1.00
2.00	SPEECH PATHOLOGY	68.00	137,093	16,465		2.00
	0		445,988	53,564		
	E - RECLASS PURCHASED SERVICES					
1.00	RENAL DIALYSIS	74.00	0	401,738		1.00
	0		0	401,738		
	F - MED DIRECTOR TO CLINIC					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	12,500	1,002		1.00
	0		12,500	1,002		
	G - LAB					
1.00	LABORATORY	60.00	0	8,994		1.00
	0		0	8,994		
	H - OVERHEAD COST ALLOCATION					
1.00	LAKEVIEW CARE PARTNERS (CBRF)	194.03	44,647	0		1.00
2.00	EMS/AMBULANCE	194.04	5,441	0		2.00
3.00		0.00	0	0		3.00
	0		50,088	0		
	I - RECLASS CT SCAN AND MRI COST					
1.00	CT SCAN	57.00	0	15,701		1.00
2.00	MRI	58.00	0	25,351		2.00
	0		0	41,052		
	L - RECLASS THERAPY ADMIN					
1.00	PHYSICAL THERAPY	66.00	228	27		1.00
2.00	SPEECH PATHOLOGY	68.00	139	17		2.00
	0		367	44		
	M - EMPLOYEE HEALTH					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	17,690	1,815		1.00
	0		17,690	1,815		
	N - MARKETING DEPARTMENT					
1.00	MARKETING DEPARTMENT	194.01	4,212	3,265		1.00
	0		4,212	3,265		
	O - RENTAL RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,851,774		1.00
	0		0	1,851,774		
500.00	Grand Total: Increases		530,845	3,154,127		500.00

RECLASSIFICATIONS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet A-6
Date/Time Prepared:
5/31/2019 9:39 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	67,063	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	67,063			
	B - RECLASS CHARGEABLE MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	423,456	0		1.00
2.00	PHARMACY	15.00	0	1,776	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	35,641	0		3.00
4.00	LABORATORY	60.00	0	6	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	33,706	0		5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	5,707	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,181	0		7.00
	0		0	501,473			
	C - RECLASS INSURANCE						
1.00	BUSINESS OFFICE	5.03	0	222,343	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	222,343			
	D - RECLASS OUTPATIENT SALARIES						
1.00	OCCUPATIONAL THERAPY	67.00	445,988	53,564	0		1.00
2.00		0.00	0	0	0		2.00
	0		445,988	53,564			
	E - RECLASS PURCHASED SERVICES						
1.00	ADULTS & PEDIATRICS	30.00	0	401,738	0		1.00
	0		0	401,738			
	F - MED DIRECTOR TO CLINIC						
1.00	ADULTS & PEDIATRICS	30.00	12,500	1,002	0		1.00
	0		12,500	1,002			
	G - LAB						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,994	0		1.00
	0		0	8,994			
	H - OVERHEAD COST ALLOCATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	37,146	0	0		1.00
2.00	BUSINESS OFFICE	5.03	8,490	0	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	4,452	0	0		3.00
	0		50,088	0			
	I - RECLASS CT SCAN AND MRI COST						
1.00	ADULTS & PEDIATRICS	30.00	0	41,052	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	41,052			
	L - RECLASS THERAPY ADMIN						
1.00	OCCUPATIONAL THERAPY	67.00	367	44	0		1.00
2.00		0.00	0	0	0		2.00
	0		367	44			
	M - EMPLOYEE HEALTH						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	17,690	1,815	0		1.00
	0		17,690	1,815			
	N - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE AND GENERAL	5.04	4,212	3,265	0		1.00
	0		4,212	3,265			
	O - RENTAL RECLASS						
1.00	BUSINESS OFFICE	5.03	0	1,851,774	10		1.00
	0		0	1,851,774			
500.00	Grand Total: Decreases		530,845	3,154,127			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet A-7
Part I
Date/Time Prepared:
5/31/2019 9:39 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	0	1.00	
2.00	Land Improvements	656,103	0	0	0	0	2.00	
3.00	Buildings and Fixtures	290,159	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	1,257,416	0	0	0	0	6.00	
7.00	HIT designated Assets	0	138,073	0	138,073	36,972	7.00	
8.00	Subtotal (sum of lines 1-7)	2,203,678	138,073	0	138,073	36,972	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	2,203,678	138,073	0	138,073	36,972	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	290,159	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	1,257,416	0				6.00	
7.00	HIT designated Assets	101,101	0				7.00	
8.00	Subtotal (sum of lines 1-7)	2,304,779	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	2,304,779	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet A-7
Part II
Date/Time Prepared:
5/31/2019 9:39 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 01/01/2018
To 12/31/2018Worksheet A-7
Part III
Date/Time Prepared:
5/31/2019 9:39 am

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	946,262	0	946,262	0.410565	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,358,517	0	1,358,517	0.589435	0	2.00
3.00	Total (sum of lines 1-2)	2,304,779	0	2,304,779	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	16,431	1,263,744	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	50,374	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	66,805	1,263,744	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	56,006	0	0	1,336,181	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	35,546	130,791	0	216,711	2.00
3.00	Total (sum of lines 1-2)	0	91,552	130,791	0	1,552,892	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8

Date/Time Prepared:
5/31/2019 9:39 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	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	A	-689	ADMINISTRATIVE AND GENERAL	5.04	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,483	MAINTENANCE & REPAIRS	6.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-14,846	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	-210,913			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	221,233			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-35,363	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	-545	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-2,765	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	A	-37,891	BUSINESS OFFICE	5.03	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 UNEMPLOYMENT INSURANCE	B	-41,907	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8

Date/Time Prepared:
5/31/2019 9:39 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	3.00	4.00	5.00	
33.01	REFUND OF WORKERS COMP INSURANCE	B	-139,760	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	REFUND OF COBRA INSURANCE	B	-63	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02
34.00	MISCELLANEOUS INCOME	B	-136	ADMINISTRATIVE AND GENERAL	5.04	0	34.00
35.00	NONALLOWABLE PENALTIES	A	-220,340	BUSINESS OFFICE	5.03	0	35.00
36.00	NONALLOWABLE DONATIONS	A	-75	ADMINISTRATIVE AND GENERAL	5.04	0	36.00
39.00	HOSPITAL ASSESSMENT	A	-303,144	ADULTS & PEDIATRICS	30.00	0	39.00
41.00	POSTAGE INCOME	B	-259	ADMINISTRATIVE AND GENERAL	5.04	0	41.00
44.00	NONALLOWABLE MARKETING	A	-13,955	ADMINISTRATIVE AND GENERAL	5.04	0	44.00
44.01	NONALLOWABLE MARKETING	A	-76	ADULTS & PEDIATRICS	30.00	0	44.01
44.03	PATIENT TELEPHONE SALARY	A	-12,194	ADMINISTRATIVE AND GENERAL	5.04	0	44.03
44.04	PATIENT TELEPHONE BENEFITS	A	-969	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.04
44.05	PATIENT TELEPHONE DEPRECIATION	A	-258	CAP REL COSTS-MVBLE EQUIP	2.00	9	44.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-822,398				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 01/01/2018
To 12/31/2018

Worksheet A-8-1

Date/Time Prepared:
5/31/2019 9:39 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	809,263	0	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	BUILDING RENT	1,263,744	1,851,774	2.00
3.00	5.04	ADMINISTRATIVE AND GENERAL	HOME OFFICE COST	27,396	27,396	3.00
4.00	5.04	ADMINISTRATIVE AND GENERAL	PROFESSIONAL FEES	633,340	633,340	4.00
4.01	194.03	LAKEVIEW CARE PARTNERS (CBRF	SHARED SERVICES	44,647	44,647	4.01
4.02	194.04	EMS/AMBULANCE	SHARED SERVICES	5,441	5,441	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,783,831	2,562,598	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

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

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8-1

Date/Time Prepared:
5/31/2019 9:39 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	809,263	0		1.00
2.00	-588,030	10		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	221,233			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet A-8-2

Date/Time Prepared:
5/31/2019 9:39 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	364,555	174,941	189,614	211,500	1,511	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			364,555	174,941	189,614		1,511	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	153,642	7,682	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			153,642	7,682	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	153,642	35,972	210,913		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	153,642	35,972	210,913		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
Date/Time Prepared:
5/31/2019 9:39 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	1,336,181	1,336,181			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	216,711	216,711			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	615,071	5,902	1,553	622,526	4.00
5.01	00550	DATA PROCESSING	108,505	0	941	5,501	114,947
5.02	00590	ADMITTING	135,504	8,821	0	10,932	4,365
5.03	00591	BUSINESS OFFICE	826,216	27,725	291	39,878	14,550
5.04	00592	ADMINISTRATIVE AND GENERAL	2,346,891	475,816	87,660	53,027	20,370
6.00	00600	MAINTENANCE & REPAIRS	783,052	175,662	25,422	21,041	13,095
8.00	00800	LAUNDRY & LINEN SERVICE	13,995	24,648	412	0	1,455
9.00	00900	HOUSEKEEPING	234,761	16,259	0	14,414	0
10.00	01000	DIETARY	552,981	82,966	7,234	24,602	4,365
11.00	01100	CAFETERIA	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	12,786	2,876	0	2,196	1,455
15.00	01500	PHARMACY	1,310,353	9,708	0	25,044	2,910
16.00	01600	MEDICAL RECORDS & LIBRARY	103,828	58,715	0	2,340	2,910
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,013,994	211,466	65,481	309,770	24,737
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,599	0	508	0	0
57.00	05700	CT SCAN	15,701	0	0	0	0
58.00	05800	MRI	25,351	0	0	0	0
60.00	06000	LABORATORY	162,822	1,989	10,143	3,585	1,455
65.00	06500	RESPIRATORY THERAPY	405,261	6,984	2,577	31,738	2,910
66.00	06600	PHYSICAL THERAPY	346,249	42,925	599	26,581	7,275
67.00	06700	OCCUPATIONAL THERAPY	338,069	54,679	0	25,954	0
68.00	06800	SPEECH PATHOLOGY	153,714	4,814	0	11,801	1,455
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	499,248	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,225	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,426	0	0
74.00	07400	RENAL DIALYSIS	401,738	0	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 through 117)	16,013,806	1,211,955	205,247	608,404	103,307
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	119,744	24,446	11,464	9,453	1,455
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0
194.01	07951	MARKETING DEPARTMENT	7,477	0	0	362	0
194.02	07952	OTHER NONALLOWABLE	0	1,802	0	0	0
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	44,647	97,978	0	3,839	8,730
194.04	07954	EMS/AMBULANCE	5,441	0	0	468	1,455
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers		0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	16,191,115	1,336,181	216,711	622,526	114,947

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ADMITTING	BUSINESS OFFICE	Subtotal	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.02	5.03	5A.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING	159,622					5.02
5.03	00591	BUSINESS OFFICE	0	908,660				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	0	2,983,764	2,983,764		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,018,272	230,762	1,249,034	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	40,510	9,180	47,934	8.00
9.00	00900	HOUSEKEEPING	0	0	265,434	60,153	31,620	9.00
10.00	01000	DIETARY	0	0	672,148	152,323	161,350	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	19,313	4,377	5,592	14.00
15.00	01500	PHARMACY	0	0	1,348,015	305,489	18,879	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	167,793	38,025	114,187	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	70,870	403,379	6,099,697	1,382,324	411,253	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	510	2,903	56,520	12,809	0	54.00
57.00	05700	CT SCAN	0	0	15,701	0	0	57.00
58.00	05800	MRI	0	0	25,351	0	0	58.00
60.00	06000	LABORATORY	4,265	24,281	208,540	47,260	3,868	60.00
65.00	06500	RESPIRATORY THERAPY	22,204	126,412	598,086	135,539	13,581	65.00
66.00	06600	PHYSICAL THERAPY	5,736	32,658	462,023	104,704	83,478	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,498	31,301	455,501	103,226	106,338	67.00
68.00	06800	SPEECH PATHOLOGY	3,502	19,940	195,226	44,242	9,363	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,685	66,524	577,457	130,864	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38	216	2,479	562	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,567	162,635	193,628	43,880	0	73.00
74.00	07400	RENAL DIALYSIS	6,747	38,411	446,896	101,276	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,622	908,660	15,852,354	2,906,995	1,007,443	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	166,562	37,746	47,542	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	7,839	1,776	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	1,802	408	3,504	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	155,194	35,170	190,545	194.03
194.04	07954	EMS/AMBULANCE	0	0	7,364	1,669	0	194.04
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	159,622	908,660	16,191,115	2,983,764	1,249,034	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part I
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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	97,624					8.00
9.00	00900	HOUSEKEEPING	719	357,926				9.00
10.00	01000	DIETARY	539	49,382	1,035,742			10.00
11.00	01100	CAFETERIA	0	0	314,449	314,449		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,712	0	2,536	33,530	14.00
15.00	01500	PHARMACY	0	5,778	0	10,144	778	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,948	0	2,536	66	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	85,399	125,867	439,177	248,515	1,129	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,184	0	2,536	2,834	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,157	0	12,679	31	65.00
66.00	06600	PHYSICAL THERAPY	0	25,549	0	10,144	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	32,545	0	12,679	120	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,865	0	5,072	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	28,402	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,657	283,987	753,626	306,841	33,487	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,550	0	5,072	43	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	1,072	6,557	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	10,967	58,317	275,559	2,536	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	97,624	357,926	1,035,742	314,449	33,530	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet B
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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	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	1,689,083					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	357,555				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	158,729	8,952,090	0	8,952,090	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,142	70,471	0	70,471	54.00
57.00	05700	CT SCAN	0	0	15,701	0	15,701	57.00
58.00	05800	MRI	0	0	25,351	0	25,351	58.00
60.00	06000	LABORATORY	0	9,555	275,777	0	275,777	60.00
65.00	06500	RESPIRATORY THERAPY	0	49,743	813,816	0	813,816	65.00
66.00	06600	PHYSICAL THERAPY	0	12,851	698,749	0	698,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,317	722,726	0	722,726	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,846	264,614	0	264,614	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	26,177	762,900	0	762,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	85	3,253	0	3,253	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,689,083	63,996	1,990,587	0	1,990,587	73.00
74.00	07400	RENAL DIALYSIS	0	15,114	563,286	0	563,286	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,689,083	357,555	15,159,321	0	15,159,321	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	271,515	0	271,515	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	9,615	0	9,615	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	13,343	0	13,343	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	728,288	0	728,288	194.03
194.04	07954	EMS/AMBULANCE	0	0	9,033	0	9,033	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,689,083	357,555	16,191,115	0	16,191,115	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet B
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,902	1,553	7,455	4.00
5.01	00550	DATA PROCESSING	0	0	941	941	5.01
5.02	00590	ADMITTING	0	8,821	0	8,821	5.02
5.03	00591	BUSINESS OFFICE	0	27,725	291	28,016	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	52,687	475,816	87,660	616,163	5.04
6.00	00600	MAINTENANCE & REPAIRS	0	175,662	25,422	201,084	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,648	412	25,060	8.00
9.00	00900	HOUSEKEEPING	0	16,259	0	16,259	9.00
10.00	01000	DIETARY	0	82,966	7,234	90,200	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,876	0	2,876	14.00
15.00	01500	PHARMACY	0	9,708	0	9,708	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	58,715	0	58,715	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	211,466	65,481	276,947	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	508	508	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	1,989	10,143	12,132	60.00
65.00	06500	RESPIRATORY THERAPY	0	6,984	2,577	9,561	65.00
66.00	06600	PHYSICAL THERAPY	0	42,925	599	43,524	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	54,679	0	54,679	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,814	0	4,814	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,426	2,426	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,687	1,211,955	205,247	1,469,889	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,446	11,464	35,910	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	1,802	0	1,802	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	97,978	0	97,978	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,687	1,336,181	216,711	1,605,579	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet B
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Cost Center Description			DATA PROCESSING	ADMITTING	BUSINESS OFFICE	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
			5.01	5.02	5.03	5.04	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING	1,007					5.01
5.02	00590	ADMITTING	38	8,990				5.02
5.03	00591	BUSINESS OFFICE	127	0	28,621			5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	178	0	0	616,976		5.04
6.00	00600	MAINTENANCE & REPAIRS	115	0	0	47,716	249,167	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	13	0	0	1,898	9,562	8.00
9.00	00900	HOUSEKEEPING	0	0	0	12,438	6,308	9.00
10.00	01000	DIETARY	38	0	0	31,497	32,187	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13	0	0	905	1,116	14.00
15.00	01500	PHARMACY	25	0	0	63,168	3,766	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25	0	0	7,863	22,779	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	218	3,981	12,701	285,837	82,040	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	29	91	2,649	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	13	241	765	9,772	772	60.00
65.00	06500	RESPIRATORY THERAPY	25	1,253	3,983	28,026	2,709	65.00
66.00	06600	PHYSICAL THERAPY	64	324	1,029	21,650	16,653	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	310	986	21,345	21,213	67.00
68.00	06800	SPEECH PATHOLOGY	13	198	628	9,148	1,868	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	659	2,096	27,060	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2	7	116	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,612	5,125	9,073	0	73.00
74.00	07400	RENAL DIALYSIS	0	381	1,210	20,942	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	905	8,990	28,621	601,103	200,973	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13	0	0	7,805	9,484	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	367	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	0	84	699	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	76	0	0	7,272	38,011	194.03
194.04	07954	EMS/AMBULANCE	13	0	0	345	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,007	8,990	28,621	616,976	249,167	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet B
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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	36,533					8.00
9.00	00900	HOUSEKEEPING	269	35,447				9.00
10.00	01000	DIETARY	202	4,891	159,310			10.00
11.00	01100	CAFETERIA	0	0	48,366	48,366		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	170	0	390	5,496	14.00
15.00	01500	PHARMACY	0	572	0	1,560	128	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,461	0	390	11	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,958	12,465	67,552	38,226	185	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	117	0	390	464	60.00
65.00	06500	RESPIRATORY THERAPY	0	412	0	1,950	5	65.00
66.00	06600	PHYSICAL THERAPY	0	2,530	0	1,560	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,223	0	1,950	20	67.00
68.00	06800	SPEECH PATHOLOGY	0	284	0	780	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,655	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	21	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	32,429	28,125	115,918	47,196	5,489	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,441	0	780	7	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	0	106	1,008	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	4,104	5,775	42,384	390	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	36,533	35,447	159,310	48,366	5,496	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet B
Part II
Date/Time Prepared:
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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	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	79,227					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	93,272				16.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	41,400	857,219	0	857,219	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	298	3,575	0	3,575	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,493	27,202	0	27,202	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,978	61,282	0	61,282	65.00
66.00	06600	PHYSICAL THERAPY	0	3,353	91,005	0	91,005	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,213	107,250	0	107,250	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,047	19,921	0	19,921	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,829	41,299	0	41,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22	168	0	168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	79,227	16,696	114,159	0	114,159	73.00
74.00	07400	RENAL DIALYSIS	0	3,943	26,476	0	26,476	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
	SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,227	93,272	1,349,556	0	1,349,556	118.00
	NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	55,553	0	55,553	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	371	0	371	194.01
194.02	07952	OTHER NONALLOWABLE	0	0	3,699	0	3,699	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	196,036	0	196,036	194.03
194.04	07954	EMS/AMBULANCE	0	0	364	0	364	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	79,227	93,272	1,605,579	0	1,605,579	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/31/2019 9:39 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	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	185,402					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,724,092				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	819	12,357	7,239,528			4.00
5.01	00550	DATA PROCESSING	0	7,490	63,971	79		5.01
5.02	00590	ADMITTING	1,224	0	127,135	3	50,587,616	5.02
5.03	00591	BUSINESS OFFICE	3,847	2,318	463,750	10	0	5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	66,022	697,394	616,665	14	0	5.04
6.00	00600	MAINTENANCE & REPAIRS	24,374	202,249	244,687	9	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,420	3,274	0	1	0	8.00
9.00	00900	HOUSEKEEPING	2,256	0	167,629	0	0	9.00
10.00	01000	DIETARY	11,512	57,552	286,102	3	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	399	0	25,539	1	0	14.00
15.00	01500	PHARMACY	1,347	0	291,240	2	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,147	0	27,214	2	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,342	520,948	3,602,416	17	22,457,001	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,042	0	0	161,639	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	276	80,696	41,689	1	1,351,824	60.00
65.00	06500	RESPIRATORY THERAPY	969	20,500	369,090	2	7,037,735	65.00
66.00	06600	PHYSICAL THERAPY	5,956	4,763	309,123	5	1,818,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,587	0	301,820	0	1,742,637	67.00
68.00	06800	SPEECH PATHOLOGY	668	0	137,232	1	1,110,138	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,703,613	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12,019	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,301	0	0	9,054,395	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	2,138,433	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	168,165	1,632,884	7,075,302	71	50,587,616	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,392	91,208	109,926	1	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	4,212	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	250	0	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	13,595	0	44,647	6	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	5,441	1	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,336,181	216,711	622,526	114,947	159,622	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.206940	0.125696	0.085990	1,455.025316	0.003155	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,455	1,007	8,990	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001030	12.746835	0.000178	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/31/2019 9:39 am

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	50,587,616				5.03
5.04	00592	ADMINISTRATIVE AND GENERAL	0	-2,983,764	13,166,299		5.04
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,018,272	89,116	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	40,510	3,420	543 8.00
9.00	00900	HOUSEKEEPING	0	0	265,434	2,256	4 9.00
10.00	01000	DIETARY	0	0	672,148	11,512	3 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	19,313	399	0 14.00
15.00	01500	PHARMACY	0	0	1,348,015	1,347	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	167,793	8,147	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,457,001	0	6,099,697	29,342	475 30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	161,639	0	56,520	0	0 54.00
57.00	05700	CT SCAN	0	-15,701	0	0	0 57.00
58.00	05800	MRI	0	-25,351	0	0	0 58.00
60.00	06000	LABORATORY	1,351,824	0	208,540	276	0 60.00
65.00	06500	RESPIRATORY THERAPY	7,037,735	0	598,086	969	0 65.00
66.00	06600	PHYSICAL THERAPY	1,818,182	0	462,023	5,956	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	1,742,637	0	455,501	7,587	0 67.00
68.00	06800	SPEECH PATHOLOGY	1,110,138	0	195,226	668	0 68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,703,613	0	577,457	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,019	0	2,479	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,054,395	0	193,628	0	0 73.00
74.00	07400	RENAL DIALYSIS	2,138,433	0	446,896	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0 95.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,587,616	-3,024,816	12,827,538	71,879	482 118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	166,562	3,392	0 192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0 194.00
194.01	07951	MARKETING DEPARTMENT	0	0	7,839	0	0 194.01
194.02	07952	OTHER NONALLOWABLE	0	0	1,802	250	0 194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	0	0	155,194	13,595	61 194.03
194.04	07954	EMS/AMBULANCE	0	0	7,364	0	0 194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	908,660		2,983,764	1,249,034	97,624 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.017962		0.226621	14.015822	179.786372 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,621		616,976	249,167	36,533 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000566		0.046860	2.795985	67.279926 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/31/2019 9:39 am

Cost Center Description			HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			9.00	10.00	11.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	DATA PROCESSING						5.01
5.02	00590	ADMITTING						5.02
5.03	00591	BUSINESS OFFICE						5.03
5.04	00592	ADMINISTRATIVE AND GENERAL						5.04
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	83,440					9.00
10.00	01000	DIETARY	11,512	66,980				10.00
11.00	01100	CAFETERIA	0	20,335	124			11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	399	0	1	610,898		14.00
15.00	01500	PHARMACY	1,347	0	4	14,173	970,408	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,147	0	1	1,211	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,342	28,401	98	20,563	0	30.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	276	0	1	51,627	0	60.00
65.00	06500	RESPIRATORY THERAPY	969	0	5	565	0	65.00
66.00	06600	PHYSICAL THERAPY	5,956	0	4	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,587	0	5	2,183	0	67.00
68.00	06800	SPEECH PATHOLOGY	668	0	2	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	517,471	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,321	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	970,408	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,203	48,736	121	610,114	970,408	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,392	0	2	784	0	192.00
194.00	07950	OTHER NONALLOWABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING DEPARTMENT	0	0	0	0	0	194.01
194.02	07952	OTHER NONALLOWABLE	250	424	0	0	0	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	13,595	17,820	1	0	0	194.03
194.04	07954	EMS/AMBULANCE	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	357,926	1,035,742	314,449	33,530	1,689,083	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.289621	15.463452	2,535.879032	0.054886	1.740591	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	35,447	159,310	48,366	5,496	79,227	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.424820	2.378471	390.048387	0.008997	0.081643	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet B-1

Date/Time Prepared:
5/31/2019 9:39 am

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	16.00
		50,587,616	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
		0	
ANCILLARY SERVICE COST CENTERS			
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
		161,639	
		0	
		0	
		1,351,824	
		7,037,735	
		1,818,182	
		1,742,637	
		1,110,138	
		3,703,613	
		12,019	
		9,054,395	
		2,138,433	
OUTPATIENT SERVICE COST CENTERS			
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
		0	
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		50,587,616	
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	OTHER NONALLOWABLE	194.00
194.01	07951	MARKETING DEPARTMENT	194.01
194.02	07952	OTHER NONALLOWABLE	194.02
194.03	07953	LAKEVIEW CARE PARTNERS (CBRF)	194.03
194.04	07954	EMS/AMBULANCE	194.04
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
		357,555	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		93,272	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207.00
		0.007068	
		0.001844	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/31/2019 9:39 am

				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	8,952,090		8,952,090	35,972	8,988,062	30.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,471		70,471	0	70,471	54.00
57.00	05700	CT SCAN	15,701		15,701	0	15,701	57.00
58.00	05800	MRI	25,351		25,351	0	25,351	58.00
60.00	06000	LABORATORY	275,777		275,777	0	275,777	60.00
65.00	06500	RESPIRATORY THERAPY	813,816	0	813,816	0	813,816	65.00
66.00	06600	PHYSICAL THERAPY	698,749	0	698,749	0	698,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	722,726	0	722,726	0	722,726	67.00
68.00	06800	SPEECH PATHOLOGY	264,614	0	264,614	0	264,614	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	762,900		762,900	0	762,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,253		3,253	0	3,253	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,990,587		1,990,587	0	1,990,587	73.00
74.00	07400	RENAL DIALYSIS	563,286		563,286	0	563,286	74.00
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
200.00		Subtotal (see instructions)	15,159,321	0	15,159,321	35,972	15,195,293	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	15,159,321	0	15,159,321	35,972	15,195,293	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
Date/Time Prepared:
5/31/2019 9:39 am

					Title XVIII	Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,457,001		22,457,001			30.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	590,373	19,832	610,205	0.115487	0.000000	54.00
57.00	05700	CT SCAN	15,701	0	15,701	1.000000	0.000000	57.00
58.00	05800	MRI	25,351	0	25,351	1.000000	0.000000	58.00
60.00	06000	LABORATORY	1,242,003	109,821	1,351,824	0.204004	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,588,298	871	6,589,169	0.123508	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,598,949	219,233	1,818,182	0.384312	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,662,320	80,317	1,742,637	0.414731	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,070,569	39,569	1,110,138	0.238361	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,697,850	5,763	3,703,613	0.205988	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,019	0	12,019	0.270655	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,054,395	0	9,054,395	0.219848	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,138,433	0	2,138,433	0.263411	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
200.00		Subtotal (see instructions)	50,153,262	475,406	50,628,668			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	50,153,262	475,406	50,628,668			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 52-2005	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/31/2019 9:39 am
				Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio			
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		30.00		
46.00	04600	OTHER LONG TERM CARE		46.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.115487	54.00		
57.00	05700	CT SCAN	1.000000	57.00		
58.00	05800	MRI	1.000000	58.00		
60.00	06000	LABORATORY	0.204004	60.00		
65.00	06500	RESPIRATORY THERAPY	0.123508	65.00		
66.00	06600	PHYSICAL THERAPY	0.384312	66.00		
67.00	06700	OCCUPATIONAL THERAPY	0.414731	67.00		
68.00	06800	SPEECH PATHOLOGY	0.238361	68.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205988	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.270655	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219848	73.00		
74.00	07400	RENAL DIALYSIS	0.263411	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		

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COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
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				Title XIX		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,457,001		22,457,001			30.00	
46.00	04600	OTHER LONG TERM CARE	0		0			46.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	590,373	19,832	610,205	0.115487	0.000000	54.00	
57.00	05700	CT SCAN	15,701	0	15,701	1.000000	0.000000	57.00	
58.00	05800	MRI	25,351	0	25,351	1.000000	0.000000	58.00	
60.00	06000	LABORATORY	1,242,003	109,821	1,351,824	0.204004	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	6,588,298	871	6,589,169	0.123508	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	1,598,949	219,233	1,818,182	0.384312	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,662,320	80,317	1,742,637	0.414731	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	1,070,569	39,569	1,110,138	0.238361	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,697,850	5,763	3,703,613	0.205988	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,019	0	12,019	0.270655	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	9,054,395	0	9,054,395	0.219848	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	2,138,433	0	2,138,433	0.263411	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00	
200.00		Subtotal (see instructions)	50,153,262	475,406	50,628,668			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	50,153,262	475,406	50,628,668			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet C
Part I
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part I
Date/Time Prepared:
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Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		857,219	0	857,219	10,291	83.30	30.00
200.00	Total (lines 30 through 199)		857,219		857,219	10,291		200.00
Cost Center Description			Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
			6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		2,711	225,826				
200.00	Total (lines 30 through 199)		2,711	225,826				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part II
Date/Time Prepared:
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Cost Center Description		Title XVIII		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,575	610,205	0.005859	176,963	1,037	54.00
57.00	05700 CT SCAN	0	15,701	0.000000	14,043	0	57.00
58.00	05800 MRI	0	25,351	0.000000	0	0	58.00
60.00	06000 LABORATORY	27,202	1,351,824	0.020122	391,029	7,868	60.00
65.00	06500 RESPIRATORY THERAPY	61,282	6,589,169	0.009300	1,266,367	11,777	65.00
66.00	06600 PHYSICAL THERAPY	91,005	1,818,182	0.050053	432,698	21,658	66.00
67.00	06700 OCCUPATIONAL THERAPY	107,250	1,742,637	0.061545	459,445	28,277	67.00
68.00	06800 SPEECH PATHOLOGY	19,921	1,110,138	0.017945	230,683	4,140	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	41,299	3,703,613	0.011151	1,061,751	11,840	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	168	12,019	0.013978	1,243	17	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	114,159	9,054,395	0.012608	2,369,777	29,878	73.00
74.00	07400 RENAL DIALYSIS	26,476	2,138,433	0.012381	505,016	6,253	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	492,337	28,171,667		6,909,015	122,745	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 52-2005		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part III Date/Time Prepared: 5/31/2019 9:39 am		
					Title XVIII		Hospital		PPS		
Cost Center Description				Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
				1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00	
Cost Center Description				Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
				4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	10,291	0.00	2,711			30.00	
200.00		Total (lines 30 through 199)	0	0	10,291		2,711			200.00	
Cost Center Description				Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
				9.00							
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part IV
Date/Time Prepared:
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				Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
			4.00	5.00	6.00	7.00	8.00		
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	610,205	0.000000	54.00	
57.00	05700	CT SCAN	0	0	0	15,701	0.000000	57.00	
58.00	05800	MRI	0	0	0	25,351	0.000000	58.00	
60.00	06000	LABORATORY	0	0	0	1,351,824	0.000000	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,589,169	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	1,818,182	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,742,637	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,110,138	0.000000	68.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,703,613	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	12,019	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,054,395	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	0	2,138,433	0.000000	74.00	
	OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	0	0	0	28,171,667		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 52-2005

Period:
From 01/01/2018
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	176,963	0	4,173	0	54.00
57.00	05700 CT SCAN	0.000000	14,043	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
60.00	06000 LABORATORY	0.000000	391,029	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,266,367	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	432,698	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	459,445	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	230,683	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,061,751	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,243	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2,369,777	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	505,016	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		6,909,015	0	4,173	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part V
Date/Time Prepared:
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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 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	0.115487	4,173	0	0	482	54.00
57.00	05700	CT SCAN	1.000000	0	0	0	0	57.00
58.00	05800	MRI	1.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.204004	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.123508	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.384312	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.414731	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.238361	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205988	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.270655	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219848	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.263411	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)		4,173	0	0	482	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		4,173	0	0	482	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 52-2005		Period: From 01/01/2018 To 12/31/2018		Worksheet D Part V Date/Time Prepared: 5/31/2019 9:39 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	0					73.00
74.00	07400	RENAL DIALYSIS	0	0					74.00
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0						95.00
200.00		Subtotal (see instructions)	0	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	0	0					202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part V
Date/Time Prepared:
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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	0.115487	0	2,589	0	0	54.00
57.00	05700	CT SCAN	1.000000	0	0	0	0	57.00
58.00	05800	MRI	1.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.204004	0	32,116	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.123508	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.384312	0	38,514	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.414731	0	29,280	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.238361	0	17,257	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.205988	0	7	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.270655	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219848	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.263411	0	0	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000	0	0			95.00
200.00		Subtotal (see instructions)		0	119,763	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	119,763	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet D
Part V
Date/Time Prepared:
5/31/2019 9:39 am

				Title XIX	Hospital	Cost
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	299	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	6,552	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	14,801	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	12,143	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,113	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1	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)	37,909	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	37,909	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/31/2019 9:39 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,291	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,291	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		10,291	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)		2,711	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)		8,988,062	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)		8,988,062	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)		8,988,062	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)		873.39	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,367,760	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)		2,367,760	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/31/2019 9:39 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)					1,555,542 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,923,302 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)					225,826 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					122,745 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					348,571 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,574,731 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 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/31/2019 9:39 am

Cost Center Description		Title XVIII		Hospital	PPS	
		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	857,219	8,988,062	0.095373	0	0 90.00
91.00	Nursing School cost	0	8,988,062	0.000000	0	0 91.00
92.00	Allied health cost	0	8,988,062	0.000000	0	0 92.00
93.00	All other Medical Education	0	8,988,062	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 52-2005	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/31/2019 9:39 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)			10,291 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			10,291 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			10,291 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			3,223 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)			8,952,090 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)			8,952,090 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)			8,952,090 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)			869.90 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,803,688 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)			2,803,688 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/31/2019 9:39 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)					1,611,632	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,415,320	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet D-1

Date/Time Prepared:
5/31/2019 9:39 am

Cost Center Description		Title XIX		Hospital		Cost	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	857,219	8,952,090	0.095756	0	0	90.00
91.00	Nursing School cost	0	8,952,090	0.000000	0	0	91.00
92.00	Allied health cost	0	8,952,090	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,952,090	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/31/2019 9:39 am	
		Title XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,053,306		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.115487	176,963	20,437	54.00
57.00	05700 CT SCAN	1.000000	14,043	14,043	57.00
58.00	05800 MRI	1.000000	0	0	58.00
60.00	06000 LABORATORY	0.204004	391,029	79,771	60.00
65.00	06500 RESPIRATORY THERAPY	0.123508	1,266,367	156,406	65.00
66.00	06600 PHYSICAL THERAPY	0.384312	432,698	166,291	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.414731	459,445	190,546	67.00
68.00	06800 SPEECH PATHOLOGY	0.238361	230,683	54,986	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.205988	1,061,751	218,708	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.270655	1,243	336	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.219848	2,369,777	520,991	73.00
74.00	07400 RENAL DIALYSIS	0.263411	505,016	133,027	74.00
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,909,015	1,555,542	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		6,909,015		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 52-2005	Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Prepared: 5/31/2019 9:39 am	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,356,787		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.115487	129,334	14,936	54.00
57.00	05700 CT SCAN	1.000000	0	0	57.00
58.00	05800 MRI	1.000000	0	0	58.00
60.00	06000 LABORATORY	0.204004	281,835	57,495	60.00
65.00	06500 RESPIRATORY THERAPY	0.123508	1,393,251	172,078	65.00
66.00	06600 PHYSICAL THERAPY	0.384312	510,235	196,089	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.414731	502,918	208,576	67.00
68.00	06800 SPEECH PATHOLOGY	0.238361	325,942	77,692	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.205988	913,580	188,187	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.270655	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.219848	2,494,397	548,388	73.00
74.00	07400 RENAL DIALYSIS	0.263411	562,584	148,191	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)		7,114,076	1,611,632	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		7,114,076		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 52-2005	Period: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 5/31/2019 9:39 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		482	2.00
3.00	OPPS payments		457	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		457	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		92	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)		365	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)		365	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		365	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)		365	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		365	40.00
40.01	Sequestration adjustment (see instructions)		7	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		358	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	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 01/01/2018
To 12/31/2018Worksheet E-1
Part I
Date/Time Prepared:
5/31/2019 9:39 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		2,935,956		358	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	08/08/2018	206,700		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)		206,700		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)		3,142,656		358	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		247,881		0	6.02
7.00	Total Medicare program liability (see instructions)		2,894,775		358	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 01/01/2018 To 12/31/2018	Worksheet E-3 Part IV Date/Time Prepared: 5/31/2019 9:39 am
		Title XVIII	Hospital	PPS
		1.00		
PART IV - MEDICARE PART A SERVICES - LTCH PPS				
1.00	Net Federal PPS Payments (see instructions)		1,958,039	1.00
1.01	Full standard payment amount		1,516,404	1.01
1.02	Short stay outlier standard payment amount		253,311	1.02
1.03	Site neutral payment amount - Cost		2,102	1.03
1.04	Site neutral payment amount - IPPS comparable		186,222	1.04
2.00	Outlier Payments		1,241,763	2.00
3.00	Total PPS Payments (sum of lines 1 and 2)		3,199,802	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)		3,199,802	7.00
8.00	Primary payer payments		0	8.00
9.00	Subtotal (line 7 less line 8).		3,199,802	9.00
10.00	Deductibles		6,700	10.00
11.00	Subtotal (line 9 minus line 10)		3,193,102	11.00
12.00	Coinsurance		376,693	12.00
13.00	Subtotal (line 11 minus line 12)		2,816,409	13.00
14.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		211,451	14.00
15.00	Adjusted reimbursable bad debts (see instructions)		137,443	15.00
16.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		88,382	16.00
17.00	Subtotal (sum of lines 13 and 15)		2,953,852	17.00
18.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	18.00
19.00	Other pass through costs (see instructions)		0	19.00
20.00	Outlier payments reconciliation		0	20.00
21.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	21.00
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	21.50
21.99	Demonstration payment adjustment amount before sequestration		0	21.99
22.00	Total amount payable to the provider (see instructions)		2,953,852	22.00
22.01	Sequestration adjustment (see instructions)		59,077	22.01
22.02	Demonstration payment adjustment amount after sequestration		0	22.02
23.00	Interim payments		3,142,656	23.00
24.00	Tentative settlement (for contractor use only)		0	24.00
25.00	Balance due provider/program (line 22 minus lines 22.01, 22.02, 23 and 24)		-247,881	25.00
26.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	26.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt IV, line 2 (see instructions)		1,241,763	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 01/01/2018
To 12/31/2018Worksheet E-3
Part VII
Date/Time Prepared:
5/31/2019 9:39 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		4,415,320		1.00
2.00	Medical and other services			37,909	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		4,415,320	37,909	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		4,415,320	37,909	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		6,356,787		8.00
9.00	Ancillary service charges		7,114,076	119,763	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)		13,470,863	119,763	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)		13,470,863	119,763	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		9,055,543	81,854	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		4,415,320	37,909	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		4,415,320	37,909	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4,415,320	37,909	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		4,415,320	37,909	36.00
37.00	ELIMINATE COST SETTLEMENT		-4,415,320	-37,909	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet G

Date/Time Prepared:
5/31/2019 9:39 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	36,504	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,276,495	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-526,997	0	0	0	6.00
7.00	Inventory	223,467	0	0	0	7.00
8.00	Prepaid expenses	128,880	0	0	0	8.00
9.00	Other current assets	121,284	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,259,633	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	-611,338	0	0	0	18.00
19.00	Fixed equipment	290,159	0	0	0	19.00
20.00	Accumulated depreciation	-279,135	0	0	0	20.00
21.00	Automobiles and trucks	84,480	0	0	0	21.00
22.00	Accumulated depreciation	-34,610	0	0	0	22.00
23.00	Major movable equipment	911,672	0	0	0	23.00
24.00	Accumulated depreciation	-714,331	0	0	0	24.00
25.00	Minor equipment depreciable	362,365	0	0	0	25.00
26.00	Accumulated depreciation	-359,143	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)	306,222	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	6,565,855	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,264,374	0	0	0	37.00
38.00	Salaries, wages, and fees payable	463,955	0	0	0	38.00
39.00	Payroll taxes payable	277,492	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,324,730	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,330,551	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)	9,330,551	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-2,764,696	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-2,764,696	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	6,565,855	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet G-1

Date/Time Prepared:
5/31/2019 9:39 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		-2,542,500		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-222,196				2.00
3.00	Total (sum of line 1 and line 2)		-2,764,696		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-2,764,696		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-2,764,696		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
5/31/2019 9:39 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,223,752		19,223,752	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19,223,752		19,223,752	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)	19,223,752		19,223,752	17.00
18.00	Ancillary services	31,723,187	0	31,723,187	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	103,145	0	103,145	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	51,050,084	0	51,050,084	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		17,013,513		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		17,013,513		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 52-2005

Period:
From 01/01/2018
To 12/31/2018

Worksheet G-3

Date/Time Prepared:
5/31/2019 9:39 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	51,050,084	1.00
2.00	Less contractual allowances and discounts on patients' accounts	35,623,279	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,426,805	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	17,013,513	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,586,708	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	182,420	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	35,363	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	545	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	2,765	21.00
22.00	Rental of hospital space	303,640	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	351,127	24.00
24.01	LAKEVIEW CARE PARTNERS INCOME	436,716	24.01
24.02	EMS INCOME	51,936	24.02
25.00	Total other income (sum of lines 6-24)	1,364,512	25.00
26.00	Total (line 5 plus line 25)	-222,196	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)	-222,196	29.00