LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: Time: 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] 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: ___ 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 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) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2014 and ending 12/31/2014, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-426,295	-1		3,299,591	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-426,295	-1		3,299,591	200

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 resopnd 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 this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence 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

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1701 SHARP ROAD	P.O. Box:			1
2	City: WATERFORD	State: WI	ZIP Code: 53185	County: RACINE	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	LAKEVIEW SPECIALTY HOSPT & REHAB	52-2005	39540	2	10 / 01 / 1996	N	P	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC	CBRF/CCI UNIT								11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 01 / 01 / 2014	To: 12 / 31 / 2014	20
21	Type of control (see instructions)	4		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments 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§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
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	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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	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.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, 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.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	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
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.			37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	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

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
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 baseline 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 osteopathci 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

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	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.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	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 oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	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)				66

Enter in lines 67-67.49, column 1 the program name. 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)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	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
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed 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 and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a 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 and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	Y		80
81	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

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	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
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers		1	2	
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108

		Physical	Occupational	Speech	Respiratory	
109	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 each therapy.		N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	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-I, Section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	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

		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	126,948			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	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
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	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
127	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
128	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
129	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
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	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
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	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
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	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

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	Name: LAKEVIEW MANAGEMENT INC.	Contractor's Name: WPS	Contractor's Number: 52280	141
142	Street: 2011 RUTLAND DRIVE	P.O. Box:		142
143	City: AUSTIN	State: TX	ZIP Code: 78758	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

		Y/N	Date		
Provider Organization and Operation		1	2		
1	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
		Y/N	Date	V/I	
		1	2	3	
2	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
3	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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? 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
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	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)	Y	05/18/2015	Y	05/18/2015	16
17	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)	N		N		17
18	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 the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	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.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	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.		35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	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.			38
39	If line 36 is yes, did the provider render servcies to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: THOMAS	Last name: STITT	Title: VP, FINANCE AND REIMBURSEM	41
42	Employer: HEALTH DIMENSIONS GROUP			42
43	Phone number: 763-225-8639	E-mail Address: TOMS@HDGI1.COM		43

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	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	39	14,235			4,377	2,345	9,041	1
2	HMO and other (see instructions)						102	33		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		39	14,235			4,377	2,345	9,041	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		39	14,235			4,377	2,345	9,041	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46	45	16,425					12,736	21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		84							27
28	Observation Bed Days									28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	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)					129	54	244	1
2	HMO and other (see instructions)					7			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		170.61			129	54	244	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care		103.59					47	21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)		274.20						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif-ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	10,399,867			554,688.00		1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		3,019,021	31,390		215,474.00		10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		335,220			7,315.00		11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		1,371,023					17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		569,047					19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		168,053	4,590		7,229.00		26
27	Administrative & General		1,527,930	-238,351		60,236.00		27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs		318,730	43,834		16,872.00		29
30	Operation of Plant							30
31	Laundry & Linen Service							31
32	Housekeeping		209,619	14,611		20,988.00		32
33	Housekeeping under contract (see instructions)							33
34	Dietary		353,927			26,664.00		34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration							38
39	Central Services and Supply		67,060			4,633.00		39
40	Pharmacy		357,757			11,306.00		40
41	Medical Records & Medical Records Library		109,332			6,061.00		41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

							1
1	Net salaries (see instructions)	10,399,867		10,399,867	554,688.00	18.75	1
2	Excluded area salaries (see instructions)	3,019,021	31,390	3,050,411	215,474.00	14.16	2
3	Subtotal salarles (line 1 minus line 2)	7,380,846	-31,390	7,349,456	339,214.00	21.67	3
4	Subtotal other wages & related costs (see instructions)	335,220		335,220	7,315.00	45.83	4
5	Subtotal wage-related costs (see instructions)	1,371,023		1,371,023		18.65%	5
6	Total (sum of lines 3 through 5)	9,087,089	-31,390	9,055,699	346,529.00	26.13	6
7	Total overhead cost (see instructions)	3,112,408	-175,316	2,937,092	153,989.00	19.07	7

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	70,000	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	486,787	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	1,486	10
11	Life Insurance (If employee is owner or beneficiary)	10,521	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	-2,610	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	386,958	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	770,668	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	185,308	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	30,952	23
24	Total Wage Related cost (Sum of lines 1-23)	1,940,070	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

	STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	Wage Index Fiscal Year Ending Date			1
2	Provider's Cost Reporting Period Used for Wage Index Year on Line 1 (FYB in Col. 1, FYE in Col. 2)			2
3	Midpoint of Provider's Cost Reporting Period Shown on Line 2, Adjusted to First of Month			3
4	Date Beginning the 3-Year Averaging Period (subtract 18 months from midpoint shown on Line 3)			4
5	Date Ending the 3-Year Averaging Period (add 18 months to midpoint shown on Line 3)			5
	STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	Effective Date of Pension Plan			6
7	First Day of the Provider Cost Reporting Period Containing the Pension Plan Effective Date			7
8	Starting Date of the Adjusted Averaging Period (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

	STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	Beginning Date of Averaging Period from Line 4 or Line 8, as Applicable			9
10	Ending Date of Averaging Period from Line 5			10
11	Enter Provider Contributions Made During Averaging Period on Lines 9 & 10	**DEPOSIT DATE(S)**	**CONTRIB-UTION(S)**	11
12	Total Calendar Months Included in Averaging Period (36 unless Step 2 completed)			12
13	Total Contributions Made During Averaging Period			13
14	Average Monthly Contribution (Line 13 divided by Line 12)			14
15	Number of MOnths in Provider Cost Reporting Period on Line 2			15
16	Average Pension Contributions (Line 14 times Line 15)			16
	STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	Annual Prefunding Installment (see instructions)			17
18	Reportable Prefunding Installment ((Line 17 times Line 15) divided by 12)			18
19	Total Pension Cost for Wage Index (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	335,220	1,376,089	1
2	Hospital	335,220	1,376,089	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,664,592	1,664,592	-46,230	1,618,362	-330,456	1,287,906	1
2	00200	Cap Rel Costs-Mvble Equip				124,221	124,221	9,834	134,055	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	168,053	1,097,072	1,265,125	-1,862	1,263,263		1,263,263	4
5.01	00592	ADMINISTRATIVE AND GENERAL	950,571	1,493,393	2,443,964	902,850	3,346,814	-1,373,845	1,972,969	5.01
5.02	00590	ADMITTING	157,560	14,084	171,644	-6,572	165,072	-41,389	123,683	5.02
5.03	00591	BUSINESS OFFICE	419,799	592,743	1,012,542	-127,169	885,373	-14,479	870,894	5.03
6	00600	Maintenance & Repairs	318,730	626,007	944,737	47,389	992,126		992,126	6
7	00700	Operation of Plant								7
8	00800	Laundry & Linen Service		89,410	89,410		89,410		89,410	8
9	00900	Housekeeping	209,619	66,826	276,445	9,085	285,530		285,530	9
10	01000	Dietary	353,927	451,043	804,970	-2,871	802,099	-57,198	744,901	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration								13
14	01400	Central Services & Supply	67,060	276,281	343,341	-258,907	84,434		84,434	14
15	01500	Pharmacy	357,757	957,450	1,315,207	-7,376	1,307,831		1,307,831	15
16	01600	Medical Records & Library	109,332	54,137	163,469	-61	163,408	-5,748	157,660	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	3,102,916	2,889,966	5,992,882	-1,029,181	4,963,701	-347,494	4,616,207	30
46	04600	Other Long Term Care	2,738,543	1,104,138	3,842,681	-486,127	3,356,554	-16,475	3,340,079	46
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic		78,298	78,298	15,401	93,699		93,699	54
60	06000	Laboratory	33,574	128,774	162,348	17,634	179,982		179,982	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	348,855	238,821	587,676	-99,437	488,239		488,239	65
66	06600	Physical Therapy		2,396	2,396	334,905	337,301		337,301	66
67	06700	Occupational Therapy	783,093	97,305	880,398	-586,652	293,746		293,746	67
68	06800	Speech Pathology				226,691	226,691		226,691	68
71	07100	Medical Supplies Charged to Patients				795,865	795,865		795,865	71
73	07300	Drugs Charged to Patients				13,506	13,506		13,506	73
74	07400	Renal Dialysis				163,077	163,077		163,077	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	137,046	13,554	150,600	-125	150,475	-966	149,509	95
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	10,256,435	11,936,290	22,192,725	-1,946	22,190,779	-2,178,216	20,012,563	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices	143,432	66,008	209,440	1,946	211,386		211,386	192
200		TOTAL (sum of lines 118-199)	10,399,867	12,002,298	22,402,165		22,402,165	-2,178,216	20,223,949	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	EQUIPMENT DEPRECIATION & AMORTIZATI	A	Cap Rel Costs-Mvble Equip	2		124,221	1
500	Total reclassifications					124,221	500
	Code Letter - A						
1	RECLASS CHARGEABLE MEDICAL SUPPLIES	B	Medical Supplies Charged to P	71		765,188	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
500	Total reclassifications					765,188	500
	Code Letter - B						
1	RECLASS INSURANCE	C	Cap Rel Costs-Bldg & Fixt	1		77,991	1
500	Total reclassifications					77,991	500
	Code Letter - C						
1	RECLASS OUTPATIENT SALARIES	D	Physical Therapy	66	297,688	24,139	1
2			Speech Pathology	68	201,396	16,331	2
500	Total reclassifications				499,084	40,470	500
	Code Letter - D						
1	RECLASS PURCHASED SERVICES	E	Radiology-Diagnostic	54		15,401	1
2			Laboratory	60		9,954	2
3			Respiratory Therapy	65		6,331	3
4			Physical Therapy	66		1,035	4
5			Medical Supplies Charged to P	71		30,677	5
6			Drugs Charged to Patients	73		13,506	6
7			Renal Dialysis	74		163,077	7
500	Total reclassifications					239,981	500
	Code Letter - E						
1	MED DIRECTOR TO CLINIC	F	Physicians' Private Offices	192	10,403	979	1
500	Total reclassifications				10,403	979	500
	Code Letter - F						
1	LAB	G	Laboratory	60		8,463	1
500	Total reclassifications					8,463	500
	Code Letter - G						
1	HOSPITAL SPECIFIC SALARY & BENEFITS	H	Adults & Pediatrics	30	154,329	13,478	1
2							2
3							3
500	Total reclassifications				154,329	13,478	500
	Code Letter - H						
1	RCC ADMINISTRATOR	I	Other Long Term Care	46	25,577	2,254	1
500	Total reclassifications				25,577	2,254	500
	Code Letter - I						
1	EOC DIRECTOR	J	Maintenance & Repairs	6	43,834	3,863	1
2			Housekeeping	9	14,611	1,288	2
500	Total reclassifications				58,445	5,151	500
	Code Letter - J						
1	MANAGEMENT FEES	K	ADMINISTRATIVE AND GENERAL	5.01		1,106,715	1
2							2
3							3
500	Total reclassifications					1,106,715	500
	Code Letter - K						
1	RECLASS THERAPY ADMIN	L	Physical Therapy	66	11,140	903	1
2			Speech Pathology	68	8,292	672	2
500	Total reclassifications				19,432	1,575	500
	Code Letter - L						

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	EMPLOYEE HEALTH	M	Employee Benefits Department	4	4,590	2,022	1
500	Total reclassifications				4,590	2,022	500
	Code Letter - M						
	GRAND TOTAL (Increases)				771,860	2,388,488	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	EQUIPMENT DEPRECIATION & AMORTIZATI	A	Cap Rel Costs-Bldg & Fixt	1		124,221	9	1
500	Total reclassifications					124,221		500
	Code letter - A							
1	RECLASS CHARGEABLE MEDICAL SUPPLIES	B	Employee Benefits Department	4		11		1
2			ADMINISTRATIVE AND GENERAL	5.01		326		2
3			BUSINESS OFFICE	5.03		55		3
4			Maintenance & Repairs	6		308		4
5			Housekeeping	9		6,814		5
6			Dietary	10		2,871		6
7			Central Services & Supply	14		258,907		7
8			Pharmacy	15		7,376		8
9			Medical Records & Library	16		61		9
10			Adults & Pediatrics	30		316,697		10
11			Other Long Term Care	46		51,537		11
12			Laboratory	60		783		12
13			Respiratory Therapy	65		105,768		13
14			Occupational Therapy	67		10,725		14
15			Ambulance Services	95		125		15
16			Physicians' Private Offices	192		2,824		16
500	Total reclassifications					765,188		500
	Code letter - B							
1	RECLASS INSURANCE	C	BUSINESS OFFICE	5.03		77,991	12	1
500	Total reclassifications					77,991		500
	Code letter - C							
1	RECLASS OUTPATIENT SALARIES	D	Occupational Therapy	67	499,084	40,470		1
2								2
500	Total reclassifications				499,084	40,470		500
	Code letter - D							
1	RECLASS PURCHASED SERVICES	E	Adults & Pediatrics	30		239,981		1
2								2
3								3
4								4
5								5
6								6
7								7
500	Total reclassifications					239,981		500
	Code letter - E							
1	MED DIRECTOR TO CLINIC	F	Adults & Pediatrics	30	10,403	979		1
500	Total reclassifications				10,403	979		500
	Code letter - F							
1	LAB	G	Employee Benefits Department	4		8,463		1
500	Total reclassifications					8,463		500
	Code letter - G							
1	HOSPITAL SPECIFIC SALARY & BENEFITS	H	ADMITTING	5.02	6,049	523		1
2			ADMINISTRATIVE AND GENERAL	5.01	103,135	8,977		2
3			BUSINESS OFFICE	5.03	45,145	3,978		3
500	Total reclassifications				154,329	13,478		500
	Code letter - H							
1	RCC ADMINISTRATOR	I	ADMINISTRATIVE AND GENERAL	5.01	25,577	2,254		1
500	Total reclassifications				25,577	2,254		500
	Code letter - I							
1	EOC DIRECTOR	J	ADMINISTRATIVE AND GENERAL	5.01	58,445	5,151		1
2								2
500	Total reclassifications				58,445	5,151		500
	Code letter - J							
1	MANAGEMENT FEES	K	Adults & Pediatrics	30		628,928		1
2			Other Long Term Care	46		462,421		2
3			Occupational Therapy	67		15,366		3
500	Total reclassifications					1,106,715		500
	Code letter - K							
1	RECLASS THERAPY ADMIN	L	Occupational Therapy	67	19,432	1,575		1
2								2
500	Total reclassifications				19,432	1,575		500
	Code letter - L							

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	EMPLOYEE HEALTH	M	Physicians' Private Offices	192	4,590	2,022		1
500	Total reclassifications				4,590	2,022		500
	Code letter - M							
	GRAND TOTAL (Decreases)				771,860	2,388,488		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements								2
3	Buildings and Fixtures	656,103					656,103		3
4	Building Improvements								4
5	Fixed Equipment	278,465					278,465		5
6	Movable Equipment	1,144,573	38,522		38,522	10,457	1,172,638		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	2,079,141	38,522		38,522	10,457	2,107,206		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	2,079,141	38,522		38,522	10,457	2,107,206		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	181,205	1,365,814			117,573		1,664,592	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	181,205	1,365,814			117,573		1,664,592	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	656,103		656,103	0.311362					1
2	Cap Rel Costs-Mvble Equ	1,451,103		1,451,103	0.688638					2
3	Total (sum of lines 1-2)	2,107,206		2,107,206	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	56,984	1,035,358		77,991	117,573		1,287,906	1
2	Cap Rel Costs-Mvble Equip	134,055						134,055	2
3	Total (sum of lines 1-2)	191,039	1,035,358		77,991	117,573		1,421,961	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trace, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-172,077				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-1,343,315				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-49,748	Dietary	10		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-5,748	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-7,450	Dietary	10		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-10,429	BUSINESS OFFICE	5.03		21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	MISC INCOME	B	-8,926	ADMINISTRATIVE AND GENERAL	5.01		33
34	RENTAL INCOME	B	-1,200	ADMINISTRATIVE AND GENERAL	5.01		34
35	MARKET INCOME	B	-10,838	ADMINISTRATIVE AND GENERAL	5.01		35
36	INCOME TAX	A	-217,876	ADMINISTRATIVE AND GENERAL	5.01		36
37							37
38							38
39	HOSPITAL ASSESSMENT	A	-172,149	Adults & Pediatrics	30		39
40	GAIN LOSS ON SALE OF ASSETS	B	-4,050	BUSINESS OFFICE	5.03		40
41	NONALLOWABLE BUSINESS DEVELOPMENT	A	-112,312	ADMINISTRATIVE AND GENERAL	5.01		41
42	NONALLOWABLE PATIENT REF SERVICES	A	-41,389	ADMITTING	5.02		42
43	NONALLOWABLE PATIENT REF SERVICES	A	-3,268	Adults & Pediatrics	30		43
44	INTERDEPARTMENT PURCHASED SERVICES	A	-16,475	Other Long Term Care	46		44
44.01	INTERDEPARTMENT PURCHASED SERVICES	A	-966	Ambulance Services	95		44.01
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,178,216				50

(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 **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5.01	ADMINISTRATIVE AND GENERAL	MANAGEMENT FEES	874,415	1,897,108	-1,022,693		1
2	2	Cap Rel Costs-Mvble Equip	EQUIPMENT	9,834		9,834	9	2
3	1	Cap Rel Costs-Bldg & Fixt	BUILDING RENT	1,035,358	1,365,814	-330,456	10	3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			1,919,607	3,262,922	-1,343,315		5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			LAKEVIEW MANAGEMENT INC			6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the 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.
G. Other (financial Or non-financial) specify:

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics INFINITY	173,760		173,760	171,400	3,640	299,950	14,998	1
2	30	Adults & Pediatrics DR. JB	85,500		85,500	171,400	448	36,917	1,846	2
3	30	Adults & Pediatrics DR. AH	126,200	37,860	88,340	171,400	442	36,423	1,821	3
4	30	Adults & Pediatrics DR. SS	45,400		45,400	171,400	227	18,706	935	4
5	30	Adults & Pediatrics DR. MV	7,750		7,750	171,400	39	3,214	161	5
6	30	Adults & Pediatrics DR WFH	4,300		4,300	171,400	22	1,813	91	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	442,910	37,860	405,050		4,818	397,023	19,852	200

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics INFINITY					299,950			1
2	30	Adults & Pediatrics DR. JB					36,917	48,583	48,583	2
3	30	Adults & Pediatrics DR. AH					36,423	51,917	89,777	3
4	30	Adults & Pediatrics DR. SS					18,706	26,694	26,694	4
5	30	Adults & Pediatrics DR. MV					3,214	4,536	4,536	5
6	30	Adults & Pediatrics DR WFH					1,813	2,487	2,487	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					397,023	134,217	172,077	200

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMIN & GENERAL	
		0	1	2	4	4A	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,287,906	1,287,906					1
2	Cap Rel Costs-Mvble Equip	134,055		134,055				2
4	Employee Benefits Department	1,263,263	9,693		1,272,956			4
5.01	ADMINISTRATIVE AND GENERAL	1,972,969	334,628	54,290	95,055	2,456,942	2,456,942	5.01
5.02	ADMITTING	123,683	8,433		18,858	150,974	20,878	5.02
5.03	BUSINESS OFFICE	870,894	26,281	214	46,631	944,020	130,546	5.03
6	Maintenance & Repairs	992,126	160,659	8,837	45,126	1,206,748	166,878	6
7	Operation of Plant							7
8	Laundry & Linen Service	89,410	29,273	302		118,985	16,454	8
9	Housekeeping	285,530	16,922		27,909	330,361	45,685	9
10	Dietary	744,901	109,697	5,031	44,051	903,680	124,967	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	84,434	2,811		8,347	95,592	13,219	14
15	Pharmacy	1,307,831	14,717	2,505	44,528	1,369,581	189,395	15
16	Medical Records & Library	157,660	9,234		13,608	180,502	24,961	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,616,207	127,857	34,221	404,111	5,182,396	716,652	30
46	Other Long Term Care	3,340,079	282,219	11,709	344,033	3,978,040	550,111	46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	93,699		373		94,072	13,009	54
60	Laboratory	179,982	4,585	5,473	4,179	194,219	26,858	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	488,239	4,592	2,234	43,420	538,485	74,465	65
66	Physical Therapy	337,301	41,033	440	38,438	417,212	57,695	66
67	Occupational Therapy	293,746	53,864		32,930	380,540	52,624	67
68	Speech Pathology	226,691	3,674		26,099	256,464	35,466	68
71	Medical Supplies Charged to Patients	795,865				795,865	110,058	71
73	Drugs Charged to Patients	13,506				13,506	1,868	73
74	Renal Dialysis	163,077	3,660			166,737	23,058	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	149,509	9,060		17,057	175,626	24,287	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,012,563	1,252,892	125,629	1,254,380	19,950,547	2,419,134	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	211,386	35,014	8,426	18,576	273,402	37,808	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	20,223,949	1,287,906	134,055	1,272,956	20,223,949	2,456,942	202

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	ADMITTING	BUSINESS OFFICE	MAIN-TENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.02	5.03	6	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE AND GENERAL							5.01
5.02	ADMITTING	171,852						5.02
5.03	BUSINESS OFFICE		1,074,566					5.03
6	Maintenance & Repairs			1,373,626				6
7	Operation of Plant							7
8	Laundry & Linen Service			53,742	189,181			8
9	Housekeeping			31,068		407,114		9
10	Dietary			201,390	75	63,615	1,293,727	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply			5,161		1,630		14
15	Pharmacy			27,018		8,535		15
16	Medical Records & Library			16,952		5,355		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	45,502	280,251	234,731	119,214	74,147	537,107	30
46	Other Long Term Care	55,049	339,022	518,120	68,776	163,664	756,620	46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	931	5,737					54
60	Laboratory	2,618	16,127	8,418		2,659		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,051	111,177	8,431		2,663		65
66	Physical Therapy	5,451	33,573	75,331	400	23,796		66
67	Occupational Therapy	5,533	34,081	98,887	406	31,237		67
68	Speech Pathology	4,057	24,989	6,745	297	2,131		68
71	Medical Supplies Charged to Patients	12,953	79,777					71
73	Drugs Charged to Patients	20,482	126,150					73
74	Renal Dialysis	1,225	7,545	6,719		2,123		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services			16,632		5,254		95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	171,852	1,058,429	1,309,345	189,168	386,809	1,293,727	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		16,137	64,281	13	20,305		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	171,852	1,074,566	1,373,626	189,181	407,114	1,293,727	202

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE AND GENERAL							5.01
5.02	ADMITTING							5.02
5.03	BUSINESS OFFICE							5.03
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	115,602						14
15	Pharmacy		1,594,529					15
16	Medical Records & Library			227,770				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			79,933	7,269,933		7,269,933	30
46	Other Long Term Care			22,573	6,451,975		6,451,975	46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			1,636	115,385		115,385	54
60	Laboratory			4,600	255,499		255,499	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			31,712	784,984		784,984	65
66	Physical Therapy			9,576	623,034		623,034	66
67	Occupational Therapy			9,721	613,029		613,029	67
68	Speech Pathology			7,128	337,277		337,277	68
71	Medical Supplies Charged to Patients	115,602		22,756	1,137,011		1,137,011	71
73	Drugs Charged to Patients		1,594,529	35,983	1,792,518		1,792,518	73
74	Renal Dialysis			2,152	209,559		209,559	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services				221,799		221,799	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	115,602	1,594,529	227,770	19,812,003		19,812,003	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				411,946		411,946	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	115,602	1,594,529	227,770	20,223,949		20,223,949	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMIN & GENERAL	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	125	9,693		9,818	9,818		4
5.01	ADMINISTRATIVE AND GENERAL		334,628	54,290	388,918	733	389,651	5.01
5.02	ADMITTING		8,433		8,433	145	3,311	5.02
5.03	BUSINESS OFFICE		26,281	214	26,495	360	20,703	5.03
6	Maintenance & Repairs		160,659	8,837	169,496	348	26,465	6
7	Operation of Plant							7
8	Laundry & Linen Service		29,273	302	29,575		2,609	8
9	Housekeeping		16,922		16,922	215	7,245	9
10	Dietary	800	109,697	5,031	115,528	340	19,819	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply		2,811		2,811	64	2,096	14
15	Pharmacy		14,717	2,505	17,222	343	30,036	15
16	Medical Records & Library		9,234		9,234	105	3,959	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		127,857	34,221	162,078	3,118	113,658	30
46	Other Long Term Care	405	282,219	11,709	294,333	2,654	87,242	46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			373	373		2,063	54
60	Laboratory	9,058	4,585	5,473	19,116	32	4,259	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		4,592	2,234	6,826	335	11,810	65
66	Physical Therapy		41,033	440	41,473	296	9,150	66
67	Occupational Therapy	399	53,864		54,263	254	8,346	67
68	Speech Pathology		3,674		3,674	201	5,625	68
71	Medical Supplies Charged to Patients						17,454	71
73	Drugs Charged to Patients						296	73
74	Renal Dialysis		3,660		3,660		3,657	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		9,060		9,060	132	3,852	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,787	1,252,892	125,629	1,389,308	9,675	383,655	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	3,789	35,014	8,426	47,229	143	5,996	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	14,576	1,287,906	134,055	1,436,537	9,818	389,651	202

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ADMITTING	BUSINESS OFFICE	MAIN-TENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.02	5.03	6	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE AND GENERAL							5.01
5.02	ADMITTING	11,889						5.02
5.03	BUSINESS OFFICE		47,558					5.03
6	Maintenance & Repairs			196,309				6
7	Operation of Plant							7
8	Laundry & Linen Service			7,680	39,864			8
9	Housekeeping			4,440		28,822		9
10	Dietary			28,781	16	4,504	168,988	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply			738		115		14
15	Pharmacy			3,861		604		15
16	Medical Records & Library			2,423		379		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,150	12,398	33,546	25,120	5,249	70,158	30
46	Other Long Term Care	3,803	15,019	74,046	14,493	11,587	98,830	46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	64	254					54
60	Laboratory	181	713	1,203		188		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,250	4,918	1,205		189		65
66	Physical Therapy	377	1,485	10,766	84	1,685		66
67	Occupational Therapy	383	1,508	14,132	85	2,211		67
68	Speech Pathology	281	1,105	964	63	151		68
71	Medical Supplies Charged to Patients	897	3,529					71
73	Drugs Charged to Patients	1,418	5,581					73
74	Renal Dialysis	85	334	960		150		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services			2,377		372		95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	11,889	46,844	187,122	39,861	27,384	168,988	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		714	9,187	3	1,438		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	11,889	47,558	196,309	39,864	28,822	168,988	202

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		14	15	16	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE AND GENERAL							5.01
5.02	ADMITTING							5.02
5.03	BUSINESS OFFICE							5.03
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	5,824						14
15	Pharmacy		52,066					15
16	Medical Records & Library			16,100				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			5,648	434,123		434,123	30
46	Other Long Term Care			1,596	603,603		603,603	46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic			116	2,870		2,870	54
60	Laboratory			325	26,017		26,017	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			2,242	28,775		28,775	65
66	Physical Therapy			677	65,993		65,993	66
67	Occupational Therapy			687	81,869		81,869	67
68	Speech Pathology			504	12,568		12,568	68
71	Medical Supplies Charged to Patients	5,824		1,609	29,313		29,313	71
73	Drugs Charged to Patients		52,066	2,544	61,905		61,905	73
74	Renal Dialysis			152	8,998		8,998	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services				15,793		15,793	95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,824	52,066	16,100	1,371,827		1,371,827	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				64,710		64,710	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,824	52,066	16,100	1,436,537		1,436,537	202

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT EQUIPMENT COST	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMIN & GENERAL ACCUM COST	ADMITTING GROSS REVENUE	
		1	2	4	5A.01	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	185,091						1
2	Cap Rel Costs-Mvble Equip		1,451,102					2
4	Employee Benefits Department	1,393		10,227,524				4
5.01	ADMINISTRATIVE AND GENERAL	48,091	587,658	763,714	-2,456,942	17,767,007		5.01
5.02	ADMITTING	1,212		151,511		150,974	47,975,634	5.02
5.03	BUSINESS OFFICE	3,777	2,318	374,654		944,020		5.03
6	Maintenance & Repairs	23,089	95,658	362,564		1,206,748		6
7	Operation of Plant							7
8	Laundry & Linen Service	4,207	3,274			118,985		8
9	Housekeeping	2,432		224,230		330,361		9
10	Dietary	15,765	54,462	353,927		903,680		10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	404		67,060		95,592		14
15	Pharmacy	2,115	27,118	357,757		1,369,581		15
16	Medical Records & Library	1,327		109,332		180,502		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	18,375	370,432	3,246,842		5,182,396	12,702,884	30
46	Other Long Term Care	40,559	126,745	2,764,120		3,978,040	15,367,225	46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		4,042			94,072	260,031	54
60	Laboratory	659	59,244	33,574		194,219	730,990	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	660	24,180	348,855		538,485	5,039,311	65
66	Physical Therapy	5,897	4,763	308,828		417,212	1,521,744	66
67	Occupational Therapy	7,741		264,577		380,540	1,544,783	67
68	Speech Pathology	528		209,688		256,464	1,132,678	68
71	Medical Supplies Charged to Patients					795,865	3,616,018	71
73	Drugs Charged to Patients					13,506	5,717,970	73
74	Renal Dialysis	526				166,737	342,000	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,302		137,046		175,626		95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	180,059	1,359,894	10,078,279	-2,456,942	17,493,605	47,975,634	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	5,032	91,208	149,245		273,402		192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,287,906	134,055	1,272,956		2,456,942	171,852	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.958231	0.092382	0.124464		0.138287	0.003582	203
204	Cost to be allocated (Per Wkst. B, Part II)			9,818		389,651	11,889	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000960		0.021931	0.000248	205

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	BUSINESS OFFICE GROSS REVENUE	MAIN-TENANCE & REPAIRS SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		5.03	6	8	9	10	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE AND GENERAL							5.01
5.02	ADMITTING							5.02
5.03	BUSINESS OFFICE	48,707,095						5.03
6	Maintenance & Repairs		107,529					6
7	Operation of Plant							7
8	Laundry & Linen Service		4,207	253,295				8
9	Housekeeping		2,432		100,890			9
10	Dietary		15,765	100	15,765	21,777		10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply		404		404		100	14
15	Pharmacy		2,115		2,115			15
16	Medical Records & Library		1,327		1,327			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	12,702,884	18,375	159,616	18,375	9,041		30
46	Other Long Term Care	15,367,225	40,559	92,085	40,559	12,736		46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	260,031						54
60	Laboratory	730,990	659		659			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,039,311	660		660			65
66	Physical Therapy	1,521,744	5,897	535	5,897			66
67	Occupational Therapy	1,544,783	7,741	543	7,741			67
68	Speech Pathology	1,132,678	528	398	528			68
71	Medical Supplies Charged to Patients	3,616,018					100	71
73	Drugs Charged to Patients	5,717,970						73
74	Renal Dialysis	342,000	526		526			74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		1,302		1,302			95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	47,975,634	102,497	253,277	95,858	21,777	100	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	731,461	5,032	18	5,032			192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,074,566	1,373,626	189,181	407,114	1,293,727	115,602	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.022062	12.774470	0.746880	4.035226	59.407953	1,156.020000	203
204	Cost to be allocated (Per Wkst. B, Part II)	47,558	196,309	39,864	28,822	168,988	5,824	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000976	1.825638	0.157382	0.285677	7.759930	58.240000	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE					
		15	16					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE AND GENERAL							5.01
5.02	ADMITTING							5.02
5.03	BUSINESS OFFICE							5.03
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	100						15
16	Medical Records & Library		36,195,334					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		12,702,884					30
46	Other Long Term Care		3,586,925					46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		260,031					54
60	Laboratory		730,990					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,039,311					65
66	Physical Therapy		1,521,744					66
67	Occupational Therapy		1,544,783					67
68	Speech Pathology		1,132,678					68
71	Medical Supplies Charged to Patients		3,616,018					71
73	Drugs Charged to Patients	100	5,717,970					73
74	Renal Dialysis		342,000					74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	36,195,334					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,594,529	227,770					202
203	Unit Cost Multiplier (Wkst. B, Part I)	15,945.290000	0.006293					203
204	Cost to be allocated (Per Wkst. B, Part II)	52,066	16,100					204
205	Unit Cost Multiplier (Wkst. B, Part II)	520.660000	0.000445					205

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	7,269,933		7,269,933	134,217	7,404,150	30
46	Other Long Term Care	6,451,975		6,451,975		6,451,975	46
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	115,385		115,385		115,385	54
60	Laboratory	255,499		255,499		255,499	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	784,984		784,984		784,984	65
66	Physical Therapy	623,034		623,034		623,034	66
67	Occupational Therapy	613,029		613,029		613,029	67
68	Speech Pathology	337,277		337,277		337,277	68
71	Medical Supplies Charged to Patients	1,137,011		1,137,011		1,137,011	71
73	Drugs Charged to Patients	1,792,518		1,792,518		1,792,518	73
74	Renal Dialysis	209,559		209,559		209,559	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	221,799		221,799		221,799	95
200	Subtotal (sum of lines 30 thru 199)	19,812,003		19,812,003	134,217	19,946,220	200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)	19,812,003		19,812,003		19,946,220	202

COMPUTATION OF RATIO OF COST TO CHARGES **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	12,702,884		12,702,884				30
46	Other Long Term Care	15,367,225		15,367,225				46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	250,320	9,711	260,031	0.443736	0.443736	0.443736	54
60	Laboratory	616,507	114,483	730,990	0.349525	0.349525	0.349525	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,039,311		5,039,311	0.155772	0.155772	0.155772	65
66	Physical Therapy	1,185,097	336,647	1,521,744	0.409421	0.409421	0.409421	66
67	Occupational Therapy	1,308,043	236,740	1,544,783	0.396838	0.396838	0.396838	67
68	Speech Pathology	896,709	235,969	1,132,678	0.297770	0.297770	0.297770	68
71	Medical Supplies Charged to Patients	3,609,595	6,422	3,616,017	0.314437	0.314437	0.314437	71
73	Drugs Charged to Patients	5,717,970		5,717,970	0.313489	0.313489	0.313489	73
74	Renal Dialysis	342,000		342,000	0.612746	0.612746	0.612746	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Subtotal (sum of lines 30 thru 199)	47,035,661	939,972	47,975,633				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	47,035,661	939,972	47,975,633				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] PPS** **[ ] TEFRA**

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	434,123		434,123	9,041	48.02	4,377	210,184	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	434,123		434,123	9,041		4,377	210,184	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 52-2005** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[ ] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[XX] PPS** **[ ] TEFRA**

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	2,870	260,031	0.011037	136,662	1,508	54
60	Laboratory	26,017	730,990	0.035591	358,468	12,758	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	28,775	5,039,311	0.005710	2,866,060	16,365	65
66	Physical Therapy	65,993	1,521,744	0.043367	589,187	25,551	66
67	Occupational Therapy	81,869	1,544,783	0.052997	686,377	36,376	67
68	Speech Pathology	12,568	1,132,678	0.011096	332,982	3,695	68
71	Medical Supplies Charged to Patients	29,313	3,616,017	0.008106	1,866,375	15,129	71
73	Drugs Charged to Patients	61,905	5,717,970	0.010826	2,905,594	31,456	73
74	Renal Dialysis	8,998	342,000	0.026310	173,594	4,567	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	318,308	19,905,524		9,915,299	147,405	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [XX] PPS
[XX] Title XVIII, Part A [ ] TEFRA
[ ] Title XIX [ ] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	9,041		4,377		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	9,041		4,377		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 52-2005** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V; [XX] Title XVIII, Part A; [ ] Title XIX; [XX] Hospital; [ ] IPF; [ ] IRF; [ ] SUB (Other); [ ] SNF; [ ] NF; [ ] ICF/MR; [XX] PPS; [ ] TEFRA; [ ] Other

(A)	Cost Center Description	1 Non Physician Anesth-etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 52-2005** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/MR | [XX] PPS [ ] TEFRA [ ] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	260,031			136,662		533		54
60	Laboratory	730,990			358,468		912		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,039,311			2,866,060				65
66	Physical Therapy	1,521,744			589,187				66
67	Occupational Therapy	1,544,783			686,377				67
68	Speech Pathology	1,132,678			332,982				68
71	Medical Supplies Charged to Patients	3,616,017			1,866,375				71
73	Drugs Charged to Patients	5,717,970			2,905,594				73
74	Renal Dialysis	342,000			173,594				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	19,905,524			9,915,299		1,445		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 52-2005** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/MR**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.443736	533			237			54
60	Laboratory	0.349525	912			319			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.155772							65
66	Physical Therapy	0.409421							66
67	Occupational Therapy	0.396838							67
68	Speech Pathology	0.297770							68
71	Medical Supplies Charged to Patients	0.314437							71
73	Drugs Charged to Patients	0.313489							73
74	Renal Dialysis	0.612746							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Subtotal (see instructions)		1,445			556			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		1,445			556			202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	434,123		434,123	9,041	48.02	2,345	112,607	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	434,123		434,123	9,041		2,345	112,607	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 52-2005** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	2,870	260,031	0.011037	68,582	757	54
60	Laboratory	26,017	730,990	0.035591	142,412	5,069	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	28,775	5,039,311	0.005710	1,235,054	7,052	65
66	Physical Therapy	65,993	1,521,744	0.043367	298,988	12,966	66
67	Occupational Therapy	81,869	1,544,783	0.052997	289,726	15,355	67
68	Speech Pathology	12,568	1,132,678	0.011096	272,552	3,024	68
71	Medical Supplies Charged to Patients	29,313	3,616,017	0.008106	1,031,686	8,363	71
73	Drugs Charged to Patients	61,905	5,717,970	0.010826	1,589,889	17,212	73
74	Renal Dialysis	8,998	342,000	0.026310			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	318,308	19,905,524		4,928,889	69,798	200

(A) Worksheet A line numbers

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX
[ ] PPS
[ ] TEFRA
[XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	9,041		2,345		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	9,041		2,345		200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 52-2005** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 52-2005** | **WORKSHEET D PART IV**

Check Applicable Boxes:
[ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	260,031			68,582				54
60	Laboratory	730,990			142,412				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,039,311			1,235,054				65
66	Physical Therapy	1,521,744			298,988				66
67	Occupational Therapy	1,544,783			289,726				67
68	Speech Pathology	1,132,678			272,552				68
71	Medical Supplies Charged to Patients	3,616,017			1,031,686				71
73	Drugs Charged to Patients	5,717,970			1,589,889				73
74	Renal Dialysis	342,000							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	19,905,524			4,928,889				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 52-2005** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[ ] Title XVIII, Part B** **[XX] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/MR**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.443736							54
60	Laboratory	0.349525							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.155772							65
66	Physical Therapy	0.409421							66
67	Occupational Therapy	0.396838							67
68	Speech Pathology	0.297770							68
71	Medical Supplies Charged to Patients	0.314437							71
73	Drugs Charged to Patients	0.313489							73
74	Renal Dialysis	0.612746							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
92	Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 52-2005** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/MR	[XX] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[ ] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,041	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,041	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,041	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,377	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,404,150	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,404,150	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,404,150	37

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) | [XX] PPS [ ] TEFRA [ ] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	818.95	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,584,544	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	3,584,544	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,849,244	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	6,433,788	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	210,184	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	147,405	51
52	Total Program excludable cost (sum of lines 50 and 51)	357,589	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	6,076,199	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 52-2005** **WORKSHEET D-1 PARTS III & IV**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[ ] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					818.95	88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 52-2005** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,041	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,041	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	9,041	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,345	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	7,269,933	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,269,933	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	7,269,933	37

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	804.11	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,885,638	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,885,638	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,413,953	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,299,591	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	112,607	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	69,798	51
52	Total Program excludable cost (sum of lines 50 and 51)	182,405	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 52-2005** **WORKSHEET D-1 PARTS III & IV**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[ ] PPS**	
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)						87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 52-2005** **WORKSHEET D-3**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF [XX] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/MR [ ] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		6,405,401		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.443736	136,662	60,642	54
60	Laboratory	0.349525	358,468	125,294	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.155772	2,866,060	446,452	65
66	Physical Therapy	0.409421	589,187	241,226	66
67	Occupational Therapy	0.396838	686,377	272,380	67
68	Speech Pathology	0.297770	332,982	99,152	68
71	Medical Supplies Charged to Patients	0.314437	1,866,375	586,857	71
73	Drugs Charged to Patients	0.313489	2,905,594	910,872	73
74	Renal Dialysis	0.612746	173,594	106,369	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		9,915,299	2,849,244	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		9,915,299		202

(A) Worksheet A line numbers

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 52-2005** **WORKSHEET D-3**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		3,529,892		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.443736	68,582	30,432	54
60	Laboratory	0.349525	142,412	49,777	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.155772	1,235,054	192,387	65
66	Physical Therapy	0.409421	298,988	122,412	66
67	Occupational Therapy	0.396838	289,726	114,974	67
68	Speech Pathology	0.297770	272,552	81,158	68
71	Medical Supplies Charged to Patients	0.314437	1,031,686	324,400	71
73	Drugs Charged to Patients	0.313489	1,589,889	498,413	73
74	Renal Dialysis	0.612746			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		4,928,889	1,413,953	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,928,889		202

(A) Worksheet A line numbers

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCLUATION **EXHIBIT 5**

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
		(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments							1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1							1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1							1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1							1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1							1.04
2	Outlier payments for discharges							2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments							4
	Indirect Medical Education Adjustment							
5	Amount from Worksheet E Part A, line 21							5
6	IME payment adjustment							6
6.01	IME payment adjustment for managed care							6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7	IME payment adjustment factor							7
8	IME add-on adjustment amount							8
8.01	IME payment adjustment add-on for managed care							8.01
9	Total IME payment (sum of lines 6 and 8)							9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)							9.01
	Disproportionate Share Adjustment							
10	Allowable disproportionate share percentage							10
11	Disproportionate share adjustment							11
11.01	Uncompensated care payments							11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal							13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)							14
15	Total payment for inpatient operating costs SCH and MDH only							15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)							16
17	Special add-on payments for new technologies							17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)							17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG							17.02
18	Capital outlier reconciliation adjustment amount							18
19	**SUBTOTAL**							19
20	Capital DRG other than outlier							20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments							21
21.01	Model 4 BPCI Capital DRG outlier payments							21.01
22	Indirect medical education percentage							22
23	Indirect medical education adjustment							23
24	Allowable disproportionate share percentage							24
25	Disproportionate share adjustment							25
26	Total prospective capital payments							26
27								27
28	Low volume adjustment prior to October 1							28
29	Low volume adjustment on or after October 1							29
30	HVBP payment adjustment							30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment							31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment							32

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	556			2
3	PPS payments	164			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	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)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	164			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	33			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	131			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	131			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	131			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	131			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	131			40
40.01	Sequestration adjustment (see instructions)	3			40.01
41	Interim payments	129			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-1			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				4,764,281		129	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	07/16/2014	537,300			3.01
	amount based on subsequent revision of the interim		.02	01/14/2015	392,900			3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		930,200			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				5,694,481		129	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)		1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)		2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	9,041	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)		5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)		6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART IV**

Check applicable box: **[XX] Hospital**

PART IV - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER LTCH PPS

1	Net Federal PPS payment (see instructions)	4,294,295	1
2	Outlier payments	1,388,646	2
3	Total PPS payments (sum of lines 1 and 2)	5,682,941	3
4	Nursing and allied health managed care payments (see instructions)		4
5	Organ acquisition DO NOT USE THIS LINE		5
6	Cost of physicians' services in a teaching hospital (see instructions)		6
7	Subtotal (see instructions)	5,682,941	7
8	Primary payer payments		8
9	Subtotal (line 7 less line 8)	5,682,941	9
10	Deductibles	15,744	10
11	Subtotal (line 9 minus line 10)	5,667,197	11
12	Coinsurance	412,984	12
13	Subtotal (line 11 minus line 12)	5,254,213	13
14	Allowable bad debts (exclude bad debts for professional services) (see instructions)	186,903	14
15	Adjusted reimbursable bad debts (see instructions)	121,487	15
16	Allowable bad debts for dual eligible beneficiaries (see instructions)	103,348	16
17	Subtotal (sum of lines 13 and 15)	5,375,700	17
18	Direct graduate medical education payments (from Wkst. E-4, line 49)		18
19	Other pass through costs (see instructions)		19
20	Outlier payments reconciliation		20
21	Other adjustments (specify) (see instructions)		21
21.50	Pioneer ACO demonstration payment adjustment (see instructions)		21.50
22	Total amount payable to the provider (see instructions)	5,375,700	22
22.01	Sequestration adjustment (see instructions)	107,514	22.01
23	Interim payments	5,694,481	23
24	Tentative settlement (for contractor use only)		24
25	Balance due provider/program (line 22 minus lines 22.01, 23 and 24)	-426,295	25
26	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		26

TO BE COMPLETED BY CONTRACTOR

50	Original PPS payment and outlier amount from Wkst. E-3 Part IV, line 3 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 52-2005** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[ ] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[ ] TEFRA**
		[ ] SNF		**[XX] Other**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	3,299,591		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	3,299,591		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	3,299,591		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	4,928,889		9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	4,928,889		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	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)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	4,928,889		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,629,298		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	3,299,591		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	3,299,591		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	3,299,591		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	3,299,591		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	3,299,591		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	3,299,591		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	3,299,591		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks					1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable					4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets	5,211,133				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	5,211,133				11
	FIXED ASSETS					
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	656,103				17
18	Accumulated depreciation	-477,585				18
19	Fixed equipment	278,465				19
20	Accumulated depreciation	-250,369				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	1,172,637				23
24	Accumulated depreciation	-998,792				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	380,459				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30 and 35)	5,591,592				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable					37
38	Salaries, wages and fees payable					38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	4,973,094				44
45	Total current liabilities (sum of lines 37 thru 44)	4,973,094				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)					50
51	Total liabilities (sum of lines 45 and 50)	4,973,094				51
	CAPITAL ACCOUNTS					
52	General fund balance	618,498				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	618,498				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	5,591,592				60

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	In Lieu of Form **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		1,656,761			1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,038,263			2
3	Total (sum of line 1 and line 2)		618,498			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		618,498			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		618,498			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	12,702,884		12,702,884	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care	15,367,225		15,367,225	9
10	Total general inpatient care services (sum of lines 1-9)	28,070,109		28,070,109	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	28,070,109		28,070,109	17
18	Ancillary services	18,965,560	939,965	19,905,525	18
19	Outpatient services		731,461	731,461	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	47,035,669	1,671,426	48,707,095	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		22,402,165	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		22,402,165	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	48,707,095	1
2	Less contractual allowances and discounts on patients' accounts	27,784,325	2
3	Net patient revenues (line 1 minus line 2)	20,922,770	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	22,402,165	4
5	Net income from service to patients (line 3 minus line 4)	-1,479,395	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	49,748	14
15	Revenue from rental of living quarters	1,200	15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	5,748	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen	10,838	20
21	Rental of vending machines	7,450	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (OTHER (INTEREST INCOME))	10,429	24
24.01	Other (OTHER (MISC INCOME))	351,669	24.01
24.02	Other (GAIN/LOSS ON SALE OF ASSETS)	4,050	24.02
25	Total other income (sum of lines 6-24)	441,132	25
26	Total (line 5 plus line 25)	-1,038,263	26
29	Net income (or loss) for the period (line 26 minus line 28)	-1,038,263	29

LAKEVIEW SPECIALTY HOSPT & REHAB Provider CCN: 52-2005	Non CMS worksheet **CMS-2552-10**	Period : From: 01/01/2014 To: 12/31/2014	Run Date: 06/01/2015 Run Time: 08:57 Version: 2015.03 (05/30/2015)

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V			
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT	TOTAL THIRD PARTY UTIL	
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	48.41		25.94				74.35	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	Radiology-Diagnostic	52.56	0.20	26.37				79.13	54
60	Laboratory	49.04	0.12	19.48				68.64	60
65	Respiratory Therapy	56.87		24.51				81.38	65
66	Physical Therapy	38.72		19.65				58.37	66
67	Occupational Therapy	44.43		18.76				63.19	67
68	Speech Pathology	29.40		24.06				53.46	68
71	Medical Supplies Charged to Pat	51.61		28.53				80.14	71
73	Drugs Charged to Patients	50.82		27.81				78.63	73
74	Renal Dialysis	50.76						50.76	74
200	TOTAL CHARGES	49.81	0.01	24.76				74.58	200

REPORT 98 - COST ALLOCATION SUMMARY

		DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	COST CENTERS	AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,287,906	6.37	-1,287,906	-13.83			1
2	Cap Rel Costs-Mvble Equip	134,055	0.66	-134,055	-1.44			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	1,263,263	6.25	-1,263,263	-13.56			4
5.01	ADMINISTRATIVE AND GENERAL	1,972,969	9.76	-1,972,969	-21.18			5.01
5.02	ADMITTING	123,683	0.61	-123,683	-1.33			5.02
5.03	BUSINESS OFFICE	870,894	4.31	-870,894	-9.35			5.03
6	Maintenance & Repairs	992,126	4.91	-992,126	-10.65			6
7	Operation of Plant							7
8	Laundry & Linen Service	89,410	0.44	-89,410	-0.96			8
9	Housekeeping	285,530	1.41	-285,530	-3.07			9
10	Dietary	744,901	3.68	-744,901	-8.00			10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	84,434	0.42	-84,434	-0.91			14
15	Pharmacy	1,307,831	6.47	-1,307,831	-14.04			15
16	Medical Records & Library	157,660	0.78	-157,660	-1.69			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	4,616,207	22.83	2,653,726	28.49	7,269,933	35.95	30
46	Other Long Term Care	3,340,079	16.52	3,111,896	33.41	6,451,975	31.90	46
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	93,699	0.46	21,686	0.23	115,385	0.57	54
60	Laboratory	179,982	0.89	75,517	0.81	255,499	1.26	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	488,239	2.41	296,745	3.19	784,984	3.88	65
66	Physical Therapy	337,301	1.67	285,733	3.07	623,034	3.08	66
67	Occupational Therapy	293,746	1.45	319,283	3.43	613,029	3.03	67
68	Speech Pathology	226,691	1.12	110,586	1.19	337,277	1.67	68
71	Medical Supplies Charged to Patients	795,865	3.94	341,146	3.66	1,137,011	5.62	71
73	Drugs Charged to Patients	13,506	0.07	1,779,012	19.10	1,792,518	8.86	73
74	Renal Dialysis	163,077	0.81	46,482	0.50	209,559	1.04	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	149,509	0.74	72,290	0.78	221,799	1.10	95
	OUTPATIENT SERVICE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	211,386	1.05	200,560	2.15	411,946	2.04	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	20,223,949	100.00			20,223,949	100.00	202

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	2,870	260,031	0.011037	136,662	1,508	54
60	Laboratory	26,017	730,990	0.035591	358,468	12,758	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	28,775	5,039,311	0.005710	2,866,060	16,365	65
66	Physical Therapy	65,993	1,521,744	0.043367	589,187	25,551	66
67	Occupational Therapy	81,869	1,544,783	0.052997	686,377	36,376	67
68	Speech Pathology	12,568	1,132,678	0.011096	332,982	3,695	68
71	Medical Supplies Charged to Pat	29,313	3,616,017	0.008106	1,866,375	15,129	71
73	Drugs Charged to Patients	61,905	5,717,970	0.010826	2,905,594	31,456	73
74	Renal Dialysis	8,998	342,000	0.026310	173,594	4,567	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
92	Observation Beds (Non-Distinct						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	TOTAL	318,308	19,905,524		9,915,299	147,405	200

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST-MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	434,123		434,123	9,041	48.02	4,377	210,184	30
200	TOTAL	434,123		434,123	9,041		4,377	210,184	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	210,184
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	147,405
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	357,589
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	129
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	4,377
PER DISCHARGE CAPITAL COSTS	2,772.01

I. COST TO CHARGE RATIO FOR LTCH

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, lines 30-35 + Worksheet D, Part IV, column 11, line 200))	6,433,788
2. TOTAL MEDICARE CHARGES (Worksheet D-3, column 2, lines 30-35 + line 202)	16,320,700
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.394

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	357,589
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.022

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	556
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	1,445
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.385