

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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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. ☒ Electronically filed cost report Date: 12/03/2019 Time: 16:08 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WESTLAKE COMMUNITY HOSPITAL (14-0240) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2018 and ending 01/27/2019, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) CAROL BAILEY
Chief Financial Officer or Administrator of Provider(s)

V.P. OF OPERATIONS REIMBURSEMENT
Title

12/03/2019 16:08
Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		105,252	76,843			1
2	SUBPROVIDER - IPF			103			2
3	SUBPROVIDER - IRF		19,814				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		125,066	76,946			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 respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete 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 applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 1225 SUPERIOR STREET	P.O. Box:		1
2	City: MELROSE PARK	State: IL	ZIP Code: 60160	County: COOK

Hospital and Hospital-Based Component Identification:

Component		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
0	1	2	3	4	5	6	7	8	
3	Hospital	WESTLAKE COMMUNITY HOSPITAL	14-0240	16974	1	07 / 01 / 1966	N	P	O
4	Subprovider - IPF	PSYCH	14-S240	16974	4	01 / 01 / 1984	N	P	O
5	Subprovider - IRF	REHAB	14-T240	16974	5	01 / 01 / 1984	N	P	O
6	Subprovider - (OTHER)								
7	Swing Beds - SNF								
8	Swing Beds - NF								
9	Hospital-Based SNF								
10	Hospital-Based NF								
11	Hospital-Based OLTC								
12	Hospital-Based HHA								
13	Separately Certified ASC								
14	Hospital-Based Hospice								
15	Hospital-Based Health Clinic - RHC								
16	Hospital-Based Health Clinic - FQHC								
17	Hospital-Based (CMHC)								
18	Renal Dialysis								
19	Other								

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2018	To: 01 / 27 / 2019		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.	Y	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)	Y	Y		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.	3	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.	592	704	21	2	3,250	37	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.	50	152			377		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 is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)			37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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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)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
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	Y	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	Y	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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
56	Teaching Hospitals 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 as defined in CMS Pub 15-1, chapter 21, 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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
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 osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

	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. Enter in column 4 direct the 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 received 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 through 67. (see instructions)	N			63
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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 column 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					1.27		67

Inpatient Psychiatric Facility 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.	Y			70
71	If line 70 is 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, indicate which program year began during this cost reporting period. (see instructions)	N	N		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.	Y			75
76	If line 75 is 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, indicate which program year began during this cost reporting period. (see instructions)	N	N		76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		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
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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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	N	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/IID 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06

Rural Providers

Rural Providers				1	2	
105	Does this hospital qualify as a 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 elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.					107
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
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.	Physical	Occupational	Speech	Respiratory	109
				1		
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N	110
				1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.					111

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-L, chapter 22, 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.	N			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
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance	
		1,528,338			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.	Y			121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

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 in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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

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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	HB0557	140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name: TENET HEALTHCARE CORPORATION	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number: 04011	141
142	Street: 1445 ROSS AVE., STE 1400	P.O. Box:		142
143	City: DALLAS, TX	State: TX	ZIP Code: 75202-2703	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	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, chapter 40, §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	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N	N	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.	Y			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
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01 / 01 / 2018	03 / 31 / 2018		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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171

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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)	N		3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/25/2019	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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	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

		Y/N	
Bad Debts		Y	
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

		Y/N	
Bed Complement		N	
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	11/13/2019	Y	11/13/2019	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 Report 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

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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 relined 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 services 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: BETH	Last name: SLOAN	Title: DIRECTOR OF OPERATIONS REI
42	Employer: TENET EMPLOYMENT INC.		
43	Phone number: 606-451-1228	E-mail Address: BETH1.SLOAN@TENETHEALTH.COM	

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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	109	22,999			2,762	1,054	8,705	1
2	HMO and other (see instructions)						748	3,250		2
3	HMO IPF Subprovider						414	2,129		3
4	HMO IRF Subprovider						284	377		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)		109	22,999			2,762	1,054	8,705	7
8	Intensive Care Unit	31	12	2,532			245	55	955	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						210	1,000	13
14	Total (see instructions)		121	25,531			3,007	1,319	10,660	14
15	CAH Visits									15
16	Subprovider - IPF	40	17	3,587			450	697	1,697	16
17	Subprovider - IRF	41	20	4,220			607	202	1,795	17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								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)		158							27
28	Observation Bed Days								1,060	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							37	59	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		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)					480	195	1,972	1
2	HMO and other (see instructions)					159	547		2
3	HMO IPF Subprovider						178		3
4	HMO IRF Subprovider						27		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)		419.57			480	195	1,972	14
15	CAH Visits								15
16	Subprovider - IPF		16.06			41	5	183	16
17	Subprovider - IRF		15.65			41	8	103	17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								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)		451.28						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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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	18,198,194		18,198,194	545,198.00	33.38	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 and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		1,504,282	28,315	1,532,597	40,337.00	37.99	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		68,485		68,485	946.00	72.39	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		1,168,807		1,168,807	31,862.00	36.68	14.01
14.02	Related organization salaries							14.02
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)		3,074,395		3,074,395			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		284,928		284,928			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
25.50	Home office wage-related		314,702		314,702			25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		221,243	19,093	240,336	4,236.00	56.74	26
27	Administrative & General		1,119,036	-211,736	907,300	56,791.00	15.98	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		709,359		709,359	25,882.00	27.41	30
31	Laundry & Linen Service							31
32	Housekeeping		459,231		459,231	30,522.00	15.05	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		464,541		464,541	26,934.00	17.25	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		359,990		359,990	7,678.00	46.89	38
39	Central Services and Supply		63,424		63,424	4,368.00	14.52	39
40	Pharmacy		654,839	7,396	662,235	13,481.00	49.12	40
41	Medical Records & Medical Records Library		950,049	156,932	1,106,981	11,803.00	93.79	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		18,198,194		18,198,194	545,198.00	33.38	1
2	Excluded area salaries (see instructions)		1,504,282	28,315	1,532,597	40,337.00	37.99	2
3	Subtotal salaries (line 1 minus line 2)		16,693,912	-28,315	16,665,597	504,861.00	33.01	3
4	Subtotal other wages & related costs (see instructions)		1,237,292		1,237,292	32,808.00	37.71	4
5	Subtotal wage-related costs (see instructions)		3,389,097		3,389,097		20.34%	5
6	Total (sum of lines 3 through 5)		21,320,301	-28,315	21,291,986	537,669.00	39.60	6
7	Total overhead cost (see instructions)		5,001,712	-28,315	4,973,397	181,695.00	27.37	7

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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	193,414	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)	1,497,335	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	-37,122	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	345,886	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	1,309,737	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	-235,127	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	272	23
24	Total Wage Related cost (Sum of lines 1-23)	3,074,395	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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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	68,485	3,074,395	1
2	Hospital	68,485	3,074,395	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

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA**WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.174732	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	6,528,726	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	3,322,944	5
6	Medicaid charges	78,607,136	6
7	Medicaid cost (line 1 times line 6)	13,735,182	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	3,883,512	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,883,512	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	12,135,810	982,675	13,118,485	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,120,514	982,675	3,103,189	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	2,120,514	982,675	3,103,189	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,929,861	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	334,373	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	514,420	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,415,441	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	602,102	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,705,291	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,588,803	31

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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				2,403,832	2,403,832	400,484	2,804,316	1
2	00200	Cap Rel Costs-Mvble Equip				628,429	628,429	507,702	1,136,131	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	221,243	3,439,997	3,661,240	12,659	3,673,899	286,991	3,960,890	4
5	00500	Administrative & General	1,119,036	6,545,316	7,664,352	-3,020,816	4,643,536	-58,700	4,584,836	5
7	00700	Operation of Plant	709,359	2,765,019	3,474,378	-22,696	3,451,682	680	3,452,362	7
8	00800	Laundry & Linen Service		239,873	239,873	5,566	245,439		245,439	8
9	00900	Housekeeping	459,231	225,915	685,146	-66	685,080		685,080	9
10	01000	Dietary	464,541	222,347	686,888	-186	686,702	-82,841	603,861	10
11	01100	Cafeteria								11
13	01300	Nursing Administration	359,990	1,407	361,397		361,397		361,397	13
14	01400	Central Services & Supply	63,424	154,152	217,576	-90,002	127,574		127,574	14
15	01500	Pharmacy	654,839	1,034,609	1,689,448	-825,936	863,512	-1,045	862,467	15
16	01600	Medical Records & Library	950,049	135,301	1,085,350	158,278	1,243,628	-6,262	1,237,366	16
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	4,076,504	378,855	4,455,359	-606,983	3,848,376	-11,197	3,837,179	30
31	03100	Intensive Care Unit	681,641	58,362	740,003	-11,521	728,482		728,482	31
40	04000	Subprovider - IPF	633,340	51,582	684,922	-2,135	682,787	-11,197	671,590	40
41	04100	Subprovider - IRF	699,317	74,599	773,916	-6,460	767,456	-49,183	718,273	41
43	04300	Nursery	245,188	278,669	523,857	497,609	1,021,466	-268,097	753,369	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,062,557	2,355,251	3,417,808	-1,051,266	2,366,542	-34,633	2,331,909	50
50.01	03340	GASTRO INTESTINAL SERVICES	105,795	86,452	192,247	-7,703	184,544		184,544	50.01
51	05100	Recovery Room	191,292	8,136	199,428	-770	198,658		198,658	51
52	05200	Delivery Room & Labor Room	765,543	394,911	1,160,454		1,160,454	-347,418	813,036	52
53	05300	Anesthesiology	108,963	823,288	932,251	-69,055	863,196	-707,191	156,005	53
54	05400	Radiology-Diagnostic	521,951	77,517	599,468	-16,933	582,535	1,438	583,973	54
56	05600	Radioisotope	70,983	137,208	208,191	-542	207,649		207,649	56
56.01	03630	ULTRA SOUND	267,162	8,311	275,473	-320	275,153		275,153	56.01
57	05700	CT Scan	142,838	45,696	188,534	-3,420	185,114	-762	184,352	57
58	05800	MRI	79,033	10,510	89,543	-1,147	88,396		88,396	58
59	05900	Cardiac Catheterization	252,530	248,435	500,965	-198,585	302,380	-15,731	286,649	59
60	06000	Laboratory	745,680	587,648	1,333,328	-537	1,332,791	-6,061	1,326,730	60
63	06300	Blood Storing, Processing & Trans.		84,973	84,973		84,973		84,973	63
65	06500	Respiratory Therapy	378,438	44,095	422,533	-30,219	392,314	15,925	408,239	65
66	06600	Physical Therapy	470,762	31,371	502,133	-489	501,644	-56,942	444,702	66
67	06700	Occupational Therapy	214,145	57,633	271,778		271,778		271,778	67
68	06800	Speech Pathology	74,612	-8,363	66,249	-749	65,500		65,500	68
69	06900	Electrocardiology	124,122	33,727	157,849	-960	156,889	-19,193	137,696	69
70	07000	Electroencephalography	11,761		11,761		11,761		11,761	70
71	07100	Medical Supplies Charged to Patients				701,821	701,821		701,821	71
72	07200	Impl. Dev. Charged to Patients				681,408	681,408		681,408	72
73	07300	Drugs Charged to Patients				883,900	883,900		883,900	73
74	07400	Renal Dialysis		206,691	206,691		206,691		206,691	74
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	1,100,700	951,221	2,051,921	-37,602	2,014,319	-728,747	1,285,572	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	18,026,569	21,790,714	39,817,283	-33,596	39,783,687	-1,191,980	38,591,707	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		760	760		760		760	190
191	19100	Research	84,953	15,845	100,798		100,798		100,798	191
192	19200	Physicians' Private Offices								192
194	07950	MARKETING	21,631	179,842	201,473		201,473		201,473	194
194.02	07952	COMMUNITY RELATIONS	61,623	-3,393	58,230		58,230		58,230	194.02
194.03	07953	SENIOR CENTER								194.03
194.04	07954	PHYSICIAN CLINICS				33,596	33,596		33,596	194.04
194.05	07955	POB		25,216	25,216		25,216		25,216	194.05
194.06	07956	TRITON HLTH CAREER SCHOLARSHIP PROG	3,418		3,418		3,418		3,418	194.06
194.07	07957	GUEST TRAYS & CATERING MEALS								194.07
194.08	07958	HOSPICE								194.08
200		TOTAL (sum of lines 118-199)	18,198,194	22,008,984	40,207,178		40,207,178	-1,191,980	39,015,198	200

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	DEPRECIATION EXPENSE	A	Cap Rel Costs-Bldg & Fixt	1		1,101,902
2	DEPRECIATION EXPENSE	A	Cap Rel Costs-Mvble Equip	2		423,663
500	Total reclassifications					1,525,565
	Code Letter - A					
1	RENTS	B	Cap Rel Costs-Bldg & Fixt	1		217,175
2	RENTS	B	Cap Rel Costs-Mvble Equip	2		204,766
3	RENTS	B	Employee Benefits Department	4		119
4	RENTS	B				
5	RENTS	B				
6	RENTS	B				
7	RENTS	B				
8	RENTS	B				
9	RENTS	B				
10	RENTS	B				
500	Total reclassifications					422,060
	Code Letter - B					
1	PROPERTY TAXES	C	Cap Rel Costs-Bldg & Fixt	1		1,075,027
500	Total reclassifications					1,075,027
	Code Letter - C					
1	INSURANCE	D	Cap Rel Costs-Bldg & Fixt	1		9,728
500	Total reclassifications					9,728
	Code Letter - D					
1	BILLABLE DRUGS	E	Drugs Charged to Patients	73		883,900
2	BILLABLE DRUGS	E	Subprovider - IPF	40		212
3	BILLABLE DRUGS	E	Radioisotope	56		1,689
4	BILLABLE DRUGS	E				
5	BILLABLE DRUGS	E				
6	BILLABLE DRUGS	E				
7	BILLABLE DRUGS	E				
8	BILLABLE DRUGS	E				
9	BILLABLE DRUGS	E				
10	BILLABLE DRUGS	E				
11	BILLABLE DRUGS	E				
12	BILLABLE DRUGS	E				
13	BILLABLE DRUGS	E				
14	BILLABLE DRUGS	E				
15	BILLABLE DRUGS	E				
16	BILLABLE DRUGS	E				
17	BILLABLE DRUGS	E				
18	BILLABLE DRUGS	E				
19	BILLABLE DRUGS	E				
20	BILLABLE DRUGS	E				
21	BILLABLE DRUGS	E				
500	Total reclassifications					885,801
	Code Letter - E					
1	LAUNDRY	F	Laundry & Linen Service	8		5,566
2	LAUNDRY	F				
3	LAUNDRY	F				
4	LAUNDRY	F				
5	LAUNDRY	F				
6	LAUNDRY	F				
7	LAUNDRY	F				
8	LAUNDRY	F				
9	LAUNDRY	F				
10	LAUNDRY	F				
11	LAUNDRY	F				
12	LAUNDRY	F				
500	Total reclassifications					5,566
	Code Letter - F					
1	BILLABLE SUPPLIES	G	Medical Supplies Charged to P	71		701,821
2	BILLABLE SUPPLIES	G	Physical Therapy	66		27
3	BILLABLE SUPPLIES	G				
4	BILLABLE SUPPLIES	G				
5	BILLABLE SUPPLIES	G				
6	BILLABLE SUPPLIES	G				
7	BILLABLE SUPPLIES	G				
8	BILLABLE SUPPLIES	G				
9	BILLABLE SUPPLIES	G				
10	BILLABLE SUPPLIES	G				
11	BILLABLE SUPPLIES	G				

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
12	BILLABLE SUPPLIES	G					12
13	BILLABLE SUPPLIES	G					13
14	BILLABLE SUPPLIES	G					14
15	BILLABLE SUPPLIES	G					15
16	BILLABLE SUPPLIES	G					16
17	BILLABLE SUPPLIES	G					17
18	BILLABLE SUPPLIES	G					18
19	BILLABLE SUPPLIES	G					19
20	BILLABLE SUPPLIES	G					20
21	BILLABLE SUPPLIES	G					21
22	BILLABLE SUPPLIES	G					22
500	Total reclassifications					701,848	500
	Code Letter - G						
1	IMPLANTABLE DEVICE	H	Impl. Dev. Charged to Patient	72		681,408	1
2	IMPLANTABLE DEVICE	H					2
3	IMPLANTABLE DEVICE	H					3
4	IMPLANTABLE DEVICE	H					4
5	IMPLANTABLE DEVICE	H					5
6	IMPLANTABLE DEVICE	H					6
7	IMPLANTABLE DEVICE	H					7
500	Total reclassifications					681,408	500
	Code Letter - H						
1	NURSERY	I	Nursery	43	456,607	48,353	1
500	Total reclassifications				456,607	48,353	500
	Code Letter - I						
1	REGIONAL	J	Employee Benefits Department	4	19,093		1
2	REGIONAL	J	Pharmacy	15	7,396	149	2
3	REGIONAL	J	Medical Records & Library	16	156,932	1,346	3
4	REGIONAL	J	PHYSICIAN CLINICS	194.04	28,315	5,281	4
500	Total reclassifications				211,736	6,776	500
	Code Letter - J						
	GRAND TOTAL (Increases)				668,343	5,362,132	

(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.

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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	DEPRECIATION EXPENSE	A	Administrative & General	5		1,525,565	9	1
2	DEPRECIATION EXPENSE	A					9	2
500	Total reclassifications					1,525,565		500
	Code letter - A							
1	RENTS	B	Administrative & General	5		186,258	10	1
2	RENTS	B	Operation of Plant	7		22,668	10	2
3	RENTS	B	Central Services & Supply	14		82,929		3
4	RENTS	B	Pharmacy	15		49,606		4
5	RENTS	B	Adults & Pediatrics	30		4,296		5
6	RENTS	B	Operating Room	50		3,830		6
7	RENTS	B	Anesthesiology	53		41,793		7
8	RENTS	B	Radiology-Diagnostic	54		15,861		8
9	RENTS	B	CT Scan	57		228		9
10	RENTS	B	Respiratory Therapy	65		14,591		10
500	Total reclassifications					422,060		500
	Code letter - B							
1	PROPERTY TAXES	C	Administrative & General	5		1,075,027	13	1
500	Total reclassifications					1,075,027		500
	Code letter - C							
1	INSURANCE	D	Administrative & General	5		9,728	12	1
500	Total reclassifications					9,728		500
	Code letter - D							
1	BILLABLE DRUGS	E	Employee Benefits Department	4		6,553		1
2	BILLABLE DRUGS	E	Administrative & General	5		5,167		2
3	BILLABLE DRUGS	E	Operation of Plant	7		28		3
4	BILLABLE DRUGS	E	Central Services & Supply	14		402		4
5	BILLABLE DRUGS	E	Pharmacy	15		783,875		5
6	BILLABLE DRUGS	E	Adults & Pediatrics	30		22,632		6
7	BILLABLE DRUGS	E	Intensive Care Unit	31		4,457		7
8	BILLABLE DRUGS	E	Subprovider - IRF	41		950		8
9	BILLABLE DRUGS	E	Nursery	43		6,177		9
10	BILLABLE DRUGS	E	Operating Room	50		19,019		10
11	BILLABLE DRUGS	E	GASTRO INTESTINAL SERVICES	50.01		4,990		11
12	BILLABLE DRUGS	E	Recovery Room	51		152		12
13	BILLABLE DRUGS	E	Anesthesiology	53		2,145		13
14	BILLABLE DRUGS	E	Radiology-Diagnostic	54		774		14
15	BILLABLE DRUGS	E	ULTRA SOUND	56.01		41		15
16	BILLABLE DRUGS	E	CT Scan	57		3,170		16
17	BILLABLE DRUGS	E	MRI	58		1,145		17
18	BILLABLE DRUGS	E	Cardiac Catheterization	59		2,083		18
19	BILLABLE DRUGS	E	Laboratory	60		48		19
20	BILLABLE DRUGS	E	Physical Therapy	66		126		20
21	BILLABLE DRUGS	E	Emergency	91		21,867		21
500	Total reclassifications					885,801		500
	Code letter - E							
1	LAUNDRY	F	Administrative & General	5		348		1
2	LAUNDRY	F	Central Services & Supply	14		91		2
3	LAUNDRY	F	Adults & Pediatrics	30		2,175		3
4	LAUNDRY	F	Intensive Care Unit	31		435		4
5	LAUNDRY	F	Subprovider - IPF	40		306		5
6	LAUNDRY	F	Subprovider - IRF	41		22		6
7	LAUNDRY	F	Operating Room	50		405		7
8	LAUNDRY	F	GASTRO INTESTINAL SERVICES	50.01		19		8
9	LAUNDRY	F	Radiology-Diagnostic	54		30		9
10	LAUNDRY	F	Cardiac Catheterization	59		65		10
11	LAUNDRY	F	Physical Therapy	66		390		11
12	LAUNDRY	F	Emergency	91		1,280		12
500	Total reclassifications					5,566		500
	Code letter - F							
1	BILLABLE SUPPLIES	G	Administrative & General	5		211		1
2	BILLABLE SUPPLIES	G	Housekeeping	9		66		2
3	BILLABLE SUPPLIES	G	Central Services & Supply	14		4,687		3
4	BILLABLE SUPPLIES	G	Adults & Pediatrics	30		72,920		4
5	BILLABLE SUPPLIES	G	Intensive Care Unit	31		6,629		5
6	BILLABLE SUPPLIES	G	Subprovider - IPF	40		2,041		6
7	BILLABLE SUPPLIES	G	Subprovider - IRF	41		5,488		7
8	BILLABLE SUPPLIES	G	Nursery	43		1,174		8
9	BILLABLE SUPPLIES	G	Operating Room	50		521,861		9
10	BILLABLE SUPPLIES	G	GASTRO INTESTINAL SERVICES	50.01		2,383		10

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RECLASSIFICATIONS
WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
11	BILLABLE SUPPLIES	G	Recovery Room	51		618		11
12	BILLABLE SUPPLIES	G	Anesthesiology	53		21,972		12
13	BILLABLE SUPPLIES	G	Radiology-Diagnostic	54		268		13
14	BILLABLE SUPPLIES	G	Radioisotope	56		2,231		14
15	BILLABLE SUPPLIES	G	ULTRA SOUND	56.01		279		15
16	BILLABLE SUPPLIES	G	CT Scan	57		22		16
17	BILLABLE SUPPLIES	G	MRI	58		2		17
18	BILLABLE SUPPLIES	G	Cardiac Catheterization	59		27,464		18
19	BILLABLE SUPPLIES	G	Laboratory	60		489		19
20	BILLABLE SUPPLIES	G	Respiratory Therapy	65		15,628		20
21	BILLABLE SUPPLIES	G	Electrocardiology	69		960		21
22	BILLABLE SUPPLIES	G	Emergency	91		14,455		22
500	Total reclassifications					701,848		500
	Code letter - G							
1	IMPLANTABLE DEVICE	H	Dietary	10		186		1
2	IMPLANTABLE DEVICE	H	Central Services & Supply	14		1,893		2
3	IMPLANTABLE DEVICE	H	Operating Room	50		506,151		3
4	IMPLANTABLE DEVICE	H	GASTRO INTESTINAL SERVICES	50.01		311		4
5	IMPLANTABLE DEVICE	H	Anesthesiology	53		3,145		5
6	IMPLANTABLE DEVICE	H	Cardiac Catheterization	59		168,973		6
7	IMPLANTABLE DEVICE	H	Speech Pathology	68		749		7
500	Total reclassifications					681,408		500
	Code letter - H							
1	NURSERY	I	Adults & Pediatrics	30	456,607	48,353		1
500	Total reclassifications				456,607	48,353		500
	Code letter - I							
1	REGIONAL	J	Administrative & General	5	211,736	6,776		1
2	REGIONAL	J						2
3	REGIONAL	J						3
4	REGIONAL	J						4
500	Total reclassifications				211,736	6,776		500
	Code letter - J							
	GRAND TOTAL (Decreases)				668,343	5,362,132		

(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.

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Acquisitions				Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		Beginning Balances	Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	4,187,868					4,187,868		1
2	Land Improvements	4,893,624					4,893,624		2
3	Buildings and Fixtures	66,849,889					66,849,889		3
4	Building Improvements	6,522,157	79,470		79,470		6,601,627		4
5	Fixed Equipment	4,124,706	178,576		178,576		4,303,282		5
6	Movable Equipment	76,213,683	478,000		478,000		76,691,683		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	162,791,927	736,046		736,046		163,527,973		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	162,791,927	736,046		736,046		163,527,973		10

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

	Description	SUMMARY OF CAPITAL							
		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								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								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

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		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	78,345,140		78,345,140	0.491685					1
2	Cap Rel Costs-Mvble Equip	80,994,965		80,994,965	0.508315					2
3	Total (sum of lines 1-2)	159,340,105		159,340,105	1.000000					3

	Description	SUMMARY OF CAPITAL							
		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	1,393,421	217,175		9,728	1,183,992		2,804,316	1
2	Cap Rel Costs-Mvble Equip	931,365	204,766					1,136,131	2
3	Total (sum of lines 1-2)	2,324,786	421,941		9,728	1,183,992		3,940,447	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.)

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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	Trade, 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	-2,867,500				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-681,185				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-76,012	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	-2,303	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-6,820	Dietary	10		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						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	A	-107,265	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	542,392	Cap Rel Costs-Mvble Equip	2	9	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	DIRECT PHONE COSTS	A	-30,859	Administrative & General	5		33
33.01	PBX SALARY	A	-15,814	Administrative & General	5		33.01
33.02	PBX BENEFITS	A	-15,472	Employee Benefits Department	4		33.02
33.03	TELEVISION CABLE/SATELITE & DEPREC	A	-34,690	Cap Rel Costs-Mvble Equip	2	9	33.03
33.04	ADMIN SVCS	B	-43,914	Administrative & General	5		33.04
33.05	DRUG SCREENS	B	-359,400	Administrative & General	5		33.05
33.06	OTHER OPERATING REVENUE	B	-80	Operation of Plant	7		33.06
33.07	BARIATRIC PHONE LINE	B	-269	Operating Room	50		33.07
33.08	OTHER OPERATING REVENUE	B	-2	Delivery Room & Labor Room	52		33.08
33.09	SEASON HOSPICE	B	-105	Radiology-Diagnostic	54		33.09
33.10	OTHER OPERATING REVENUE	B	1,543	Radiology-Diagnostic	54		33.10
33.11	FITNESS CENTER REVENUE	B	-56,937	Physical Therapy	66		33.11
33.12	ADVERTISING	A	-1,881	Employee Benefits Department	4		33.12
33.13	ADVERTISING	A	3,828	Administrative & General	5		33.13
33.14	ADVERTISING	A	760	Operation of Plant	7		33.14
33.15	PURCHASED SVCS	A	-1,965	Administrative & General	5		33.15
33.16	PURCHASED SVCS	A	-43	Pharmacy	15		33.16
33.17	PURCHASED SVCS	A	-3,959	Medical Records & Library	16		33.17
33.18	PURCHASED SVCS	A	-18,311	Operating Room	50		33.18
33.19	TRAVEL	A	-77	Administrative & General	5		33.19
33.20	TRAVEL	A	-53	Subprovider - IRF	41		33.20
33.21	MEALS	A	-77	Administrative & General	5		33.21
33.22	MEALS	A	-9	Dietary	10		33.22
33.23	MEALS	A	-5	Physical Therapy	66		33.23
33.24	PROPERTY TAXES	A	108,965	Cap Rel Costs-Bldg & Fixt	1	13	33.24
33.25	DONATIONS/CONTRIBUTIONS	A	-521	Administrative & General	5		33.25
33.26	DUES & SUBSCRIPTION	A	-1,904	Administrative & General	5		33.26
33.27	LOBBYING	A	-14,255	Administrative & General	5		33.27
33.28	PATIENT TRANSPORTATION	A	-1,277	Administrative & General	5		33.28
33.29	LEGAL	A	-22,014	Administrative & General	5		33.29
33.30	PENALTIES AND FINES	A	-3,050	Administrative & General	5		33.30
33.31	PENALTIES AND FINES	A	-1,002	Pharmacy	15		33.31
33.32	H.O. WORKER COMPENSATION	A	433,299	Employee Benefits Department	4		33.32

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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	
33.33	PERIOD 13 ADJUSTMENTS	A	-117,592	Employee Benefits Department	4		33.33
33.34	PERIOD 13 ADJUSTMENTS	A	2,269,847	Administrative & General	5		33.34
33.35	CHIEF STRATEGY OFFICER	A	-54,629	Administrative & General	5		33.35
33.36	CHIEF STRATEGY OFFICER	A	-11,363	Employee Benefits Department	4		33.36
34							34
35							35
36							36
37							37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
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)		-1,191,980				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.

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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	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE DIRECT CAPITAL	204,589		204,589	9	1
2	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE POOLED CAPITAL	194,195		194,195	9	2
3	5	Administrative & General	HOME OFFICE SHARED SERVICES	-101,339		-101,339		3
4	5	Administrative & General	PERIOD 13 ADJ - IC OVERHEAD ALLOC		978,630	-978,630		4
4.01	1	Cap Rel Costs-Bldg & Fixt	REGIONAL ALLOCATION	179,286	179,286		10	4.01
4.02	2	Cap Rel Costs-Mvble Equip	REGIONAL ALLOCATION	771	771		10	4.02
4.03	4	Employee Benefits Department	REGIONAL ALLOCATION	19,092	19,092			4.03
4.04	5	Administrative & General	REGIONAL ALLOCATION	1,891,589	1,891,589			4.04
4.05	15	Pharmacy	REGIONAL ALLOCATION	7,545	7,545			4.05
4.06	16	Medical Records & Library	REGIONAL ALLOCATION	158,279	158,279			4.06
4.08	194.04	PHYSICIAN CLINICS	REGIONAL ALLOCATION	33,596	33,596			4.08
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			2,587,603	3,268,788	-681,185		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			TENET HLTHCARE	100.00	HEALTHCARE	6
7	G			REGIONAL	1.00	HEALTHCARE	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: SHARED SVCS

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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	5	Administrative & Gen ADMINISTRATIVE	702,650	702,650						1
2	30	Adults & Pediatrics ADULTS & PEDIAT	11,197	11,197						2
3	40	Subprovider - IPF SUBPROVIDER - I	11,197	11,197						3
4	41	Subprovider - IRF SUBPROVIDER - I	49,130	49,130						4
5	43	Nursery NURSERY	268,097	268,097						5
6	50	Operating Room OPERATING ROOM	16,053	16,053						6
7	52	Delivery Room & Labo LABOR ROOM & DE	347,416	347,416						7
8	53	Anesthesiology ANESTHESIOLOGY	707,191	707,191						8
9	57	CT Scan CT SCAN	762	762						9
10	59	Cardiac Catheterizat CARDIAC CATHETE	15,731	15,731						10
11	60	Laboratory LABORATORY	6,061	6,061						11
12	65	Respiratory Therapy RESPIRATORY THE	-15,925	-15,925						12
13	69	Electrocardiology ELECTRO CARDIOL	19,193	19,193						13
14	91	Emergency EMERGENCY	728,747	728,747						14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,867,500	2,867,500						200

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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	5	Administrative & Gen ADMINISTRATIVE							702,650	1
2	30	Adults & Pediatrics ADULTS & PEDIAT							11,197	2
3	40	Subprovider - IPF SUBPROVIDER - I							11,197	3
4	41	Subprovider - IRF SUBPROVIDER - I							49,130	4
5	43	Nursery NURSERY							268,097	5
6	50	Operating Room OPERATING ROOM							16,053	6
7	52	Delivery Room & Labo LABOR ROOM & DE							347,416	7
8	53	Anesthesiology ANESTHESIOLOGY							707,191	8
9	57	CT Scan CT SCAN							762	9
10	59	Cardiac Catheterizat CARDIAC CATHETE							15,731	10
11	60	Laboratory LABORATORY							6,061	11
12	65	Respiratory Therapy RESPIRATORY THE							-15,925	12
13	69	Electrocardiology ELECTRO CARDIOL							19,193	13
14	91	Emergency EMERGENCY							728,747	14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							2,867,500	200

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,804,316	2,804,316					1
2	Cap Rel Costs-Mvble Equip	1,136,131		1,136,131				2
4	Employee Benefits Department	3,960,890			3,960,890			4
5	Administrative & General	4,584,836	184,076	74,576	200,120	5,043,608	5,043,608	5
7	Operation of Plant	3,452,362	381,426	154,530	156,460	4,144,778	615,354	7
8	Laundry & Linen Service	245,439	15,085	6,112		266,636	39,586	8
9	Housekeeping	685,080	24,457	9,908	101,291	820,736	121,851	9
10	Dietary	603,861	96,288	39,010	102,462	841,621	124,951	10
11	Cafeteria							11
13	Nursing Administration	361,397	13,609	5,513	79,402	459,921	68,282	13
14	Central Services & Supply	127,574	18,619	7,543	13,989	167,725	24,901	14
15	Pharmacy	862,467	18,136	7,348	146,067	1,034,018	153,515	15
16	Medical Records & Library	1,237,366	28,799	11,668	244,162	1,521,995	225,963	16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,837,179	209,684	84,951	798,420	4,930,234	731,988	30
31	Intensive Care Unit	728,482	60,983	24,707	150,347	964,519	143,197	31
40	Subprovider - IPF	671,590	52,351	21,209	139,693	884,843	131,368	40
41	Subprovider - IRF	718,273	112,552	45,599	154,246	1,030,670	153,018	41
43	Nursery	753,369	44,360	17,972	154,792	970,493	144,084	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,331,909	112,613	45,624	234,364	2,724,510	404,494	50
50.01	GASTRO INTESTINAL SERVICES	184,544	16,527	6,696	23,335	231,102	34,311	50.01
51	Recovery Room	198,658	12,132	4,915	42,193	257,898	38,289	51
52	Delivery Room & Labor Room	813,036	173,315	70,216	168,853	1,225,420	181,932	52
53	Anesthesiology	156,005	3,499	1,418	24,034	184,956	27,459	53
54	Radiology-Diagnostic	583,973	91,682	37,144	115,125	827,924	122,918	54
56	Radioisotope	207,649	6,813	2,760	15,656	232,878	34,574	56
56.01	ULTRA SOUND	275,153	5,187	2,101	58,927	341,368	50,681	56.01
57	CT Scan	184,352	7,297	2,956	31,505	226,110	33,569	57
58	MRI	88,396	6,655	2,696	115,179	17,100	17,100	58
59	Cardiac Catheterization	286,649	30,672	12,426	55,700	385,447	57,225	59
60	Laboratory	1,326,730	58,513	23,706	164,472	1,573,421	233,598	60
63	Blood Storing, Processing & Trans.	84,973	2,435	987	88,395	13,124	13,124	63
65	Respiratory Therapy	408,239	5,222	2,116	83,471	499,048	74,091	65
66	Physical Therapy	444,702	51,392	20,821	103,834	620,749	92,160	66
67	Occupational Therapy	271,778			47,233	319,011	47,362	67
68	Speech Pathology	65,500	4,114	1,667	16,457	87,738	13,026	68
69	Electrocardiology	137,696	18,118	7,340	27,377	190,531	28,287	69
70	Electroencephalography	11,761			2,594	14,355	2,131	70
71	Medical Supplies Charged to Patients	701,821				701,821	104,196	71
72	Impl. Dev. Charged to Patients	681,408				681,408	101,165	72
73	Drugs Charged to Patients	883,900				883,900	131,228	73
74	Renal Dialysis	206,691				206,691	30,686	74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,285,572	97,115	39,345	242,777	1,664,809	247,166	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	38,591,707	1,963,726	795,580	3,916,790	37,366,466	4,798,830	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	760	1,626	659		3,045	452	190
191	Research	100,798			18,738	119,536	17,747	191
192	Physicians' Private Offices							192
194	MARKETING	201,473	5,160	2,091	4,771	213,495	31,697	194
194.02	COMMUNITY RELATIONS	58,230	4,422	1,791	13,592	78,035	11,585	194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS	33,596	11,042	4,473	6,245	55,356	8,218	194.04
194.05	POB	25,216	818,340	331,537		1,175,093	174,460	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG	3,418			754	4,172	619	194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	39,015,198	2,804,316	1,136,131	3,960,890	39,015,198	5,043,608	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant	4,760,132						7
8	Laundry & Linen Service	32,074	338,296					8
9	Housekeeping	51,999	3,833	998,419				9
10	Dietary	204,727		43,713	1,215,012			10
11	Cafeteria				431,519	431,519		11
13	Nursing Administration	28,934		6,178		8,271	571,586	13
14	Central Services & Supply	39,588		8,453		4,708		14
15	Pharmacy	38,560		8,233		14,514		15
16	Medical Records & Library	61,233		13,074		12,706		16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	445,827	163,703	95,192	383,418	115,081	222,448	30
31	Intensive Care Unit	129,662	19,486	27,685	42,072	16,920	32,704	31
40	Subprovider - IPF	111,307	22,658	23,766	74,744	20,886	40,371	40
41	Subprovider - IRF	239,306	16,676	51,096	79,093	20,353	39,341	41
43	Nursery	94,317		20,138		18,441	35,620	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	239,436	27,779	51,124		32,317	62,443	50
50.01	GASTRO INTESTINAL SERVICES	35,140	10,426	7,503		2,393	4,625	50.01
51	Recovery Room	25,794		5,507		4,071	7,893	51
52	Delivery Room & Labor Room	368,500		78,681		21,913	42,357	52
53	Anesthesiology	7,439		1,588		4,435	8,547	53
54	Radiology-Diagnostic	194,932	22,776	41,621		15,541		54
56	Radioisotope	14,486		3,093		1,470		56
56.01	ULTRA SOUND	11,028		2,355		6,372		56.01
57	CT Scan	15,514		3,312		3,576		57
58	MRI	14,149		3,021		1,704		58
59	Cardiac Catheterization	65,214		13,924		4,643	8,974	59
60	Laboratory	124,410	58	26,564		29,716		60
63	Blood Storing, Processing & Trans.	5,178		1,105				63
65	Respiratory Therapy	11,103	2,999	2,371		12,524		65
66	Physical Therapy	109,270	15,766	23,331		14,878		66
67	Occupational Therapy		395			5,657		67
68	Speech Pathology	8,748		1,868		1,977		68
69	Electrocardiology	38,523		8,225		3,719	7,189	69
70	Electroencephalography					481	930	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	206,484	30,661	44,088		30,081	58,144	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,972,882	337,216	616,809	1,010,846	429,348	571,586	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,458		738				190
191	Research							191
192	Physicians' Private Offices				199,579			192
194	MARKETING	10,972		2,343		949		194
194.02	COMMUNITY RELATIONS	9,402		2,007		637		194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS	23,476		5,013		585		194.04
194.05	POB	1,739,942	1,080	371,509				194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS				4,587			194.07
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,760,132	338,296	998,419	1,215,012	431,519	571,586	202

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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	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply	245,375						14
15	Pharmacy		1,248,840					15
16	Medical Records & Library			1,834,971				16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			319,028	7,406,919		7,406,919	30
31	Intensive Care Unit			49,627	1,425,872		1,425,872	31
40	Subprovider - IPF			46,314	1,356,257		1,356,257	40
41	Subprovider - IRF			19,255	1,648,808		1,648,808	41
43	Nursery			23,498	1,306,591		1,306,591	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			120,867	3,662,970		3,662,970	50
50.01	GASTRO INTESTINAL SERVICES			18,743	344,243		344,243	50.01
51	Recovery Room			26,874	366,326		366,326	51
52	Delivery Room & Labor Room			39,794	1,958,597		1,958,597	52
53	Anesthesiology			42,191	276,615		276,615	53
54	Radiology-Diagnostic			40,646	1,266,358		1,266,358	54
56	Radioisotope			11,239	297,740		297,740	56
56.01	ULTRA SOUND			44,374	456,178		456,178	56.01
57	CT Scan			152,287	434,368		434,368	57
58	MRI			15,061	166,214		166,214	58
59	Cardiac Catheterization			36,420	571,847		571,847	59
60	Laboratory			180,676	2,168,443		2,168,443	60
63	Blood Storing, Processing & Trans.			12,948	120,750		120,750	63
65	Respiratory Therapy			19,634	621,770		621,770	65
66	Physical Therapy			41,246	917,400		917,400	66
67	Occupational Therapy			23,666	396,091		396,091	67
68	Speech Pathology			5,934	119,291		119,291	68
69	Electrocardiology			29,010	305,484		305,484	69
70	Electroencephalography			663	18,560		18,560	70
71	Medical Supplies Charged to Patients	124,503		49,288	979,808		979,808	71
72	Impl. Dev. Charged to Patients	120,872		40,757	944,202		944,202	72
73	Drugs Charged to Patients		1,248,840	197,325	2,461,293		2,461,293	73
74	Renal Dialysis			5,412	242,789		242,789	74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency			222,194	2,503,627		2,503,627	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	245,375	1,248,840	1,834,971	34,745,411		34,745,411	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				7,693		7,693	190
191	Research				137,283		137,283	191
192	Physicians' Private Offices				199,579		199,579	192
194	MARKETING				259,456		259,456	194
194.02	COMMUNITY RELATIONS				101,666		101,666	194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS				92,648		92,648	194.04
194.05	POB				3,462,084		3,462,084	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG				4,791		4,791	194.06
194.07	GUEST TRAYS & CATERING MEALS				4,587		4,587	194.07
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	245,375	1,248,840	1,834,971	39,015,198		39,015,198	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		184,076	74,576	258,652	258,652		5
7	Operation of Plant		381,426	154,530	535,956	31,558	567,514	7
8	Laundry & Linen Service		15,085	6,112	21,197	2,030	3,824	8
9	Housekeeping		24,457	9,908	34,365	6,249	6,199	9
10	Dietary		96,288	39,010	135,298	6,408	24,408	10
11	Cafeteria							11
13	Nursing Administration		13,609	5,513	19,122	3,502	3,450	13
14	Central Services & Supply		18,619	7,543	26,162	1,277	4,720	14
15	Pharmacy		18,136	7,348	25,484	7,873	4,597	15
16	Medical Records & Library		28,799	11,668	40,467	11,588	7,300	16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		209,684	84,951	294,635	37,532	53,152	30
31	Intensive Care Unit		60,983	24,707	85,690	7,344	15,459	31
40	Subprovider - IPF		52,351	21,209	73,560	6,737	13,270	40
41	Subprovider - IRF		112,552	45,599	158,151	7,848	28,531	41
43	Nursery		44,360	17,972	62,332	7,389	11,245	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		112,613	45,624	158,237	20,744	28,546	50
50.01	GASTRO INTESTINAL SERVICES		16,527	6,696	23,223	1,760	4,189	50.01
51	Recovery Room		12,132	4,915	17,047	1,964	3,075	51
52	Delivery Room & Labor Room		173,315	70,216	243,531	9,330	43,933	52
53	Anesthesiology		3,499	1,418	4,917	1,408	887	53
54	Radiology-Diagnostic		91,682	37,144	128,826	6,304	23,240	54
56	Radioisotope		6,813	2,760	9,573	1,773	1,727	56
56.01	ULTRA SOUND		5,187	2,101	7,288	2,599	1,315	56.01
57	CT Scan		7,297	2,956	10,253	1,722	1,850	57
58	MRI		6,655	2,696	9,351	877	1,687	58
59	Cardiac Catheterization		30,672	12,426	43,098	2,935	7,775	59
60	Laboratory		58,513	23,706	82,219	11,980	14,832	60
63	Blood Storing, Processing & Trans.		2,435	987	3,422	673	617	63
65	Respiratory Therapy		5,222	2,116	7,338	3,800	1,324	65
66	Physical Therapy		51,392	20,821	72,213	4,726	13,027	66
67	Occupational Therapy					2,429		67
68	Speech Pathology		4,114	1,667	5,781	668	1,043	68
69	Electrocardiology		18,118	7,340	25,458	1,451	4,593	69
70	Electroencephalography					109		70
71	Medical Supplies Charged to Patients					5,344		71
72	Impl. Dev. Charged to Patients					5,188		72
73	Drugs Charged to Patients					6,730		73
74	Renal Dialysis					1,574		74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		97,115	39,345	136,460	12,676	24,617	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		1,963,726	795,580	2,759,306	246,099	354,432	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		1,626	659	2,285	23	412	190
191	Research					910		191
192	Physicians' Private Offices							192
194	MARKETING		5,160	2,091	7,251	1,626	1,308	194
194.02	COMMUNITY RELATIONS		4,422	1,791	6,213	594	1,121	194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS		11,042	4,473	15,515	421	2,799	194.04
194.05	POB		818,340	331,537	1,149,877	8,947	207,442	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG					32		194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,804,316	1,136,131	3,940,447	258,652	567,514	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	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	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service	27,051						8
9	Housekeeping	307	47,120					9
10	Dietary		2,063	168,177				10
11	Cafeteria			59,729	59,729			11
13	Nursing Administration		292		1,145	27,511		13
14	Central Services & Supply		399		652		33,210	14
15	Pharmacy		389		2,009			15
16	Medical Records & Library		617		1,759			16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,089	4,493	53,071	15,929	10,706		30
31	Intensive Care Unit	1,558	1,307	5,823	2,342	1,574		31
40	Subprovider - IPF	1,812	1,122	10,346	2,891	1,943		40
41	Subprovider - IRF	1,333	2,411	10,948	2,817	1,894		41
43	Nursery		950		2,553	1,714		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,221	2,413		4,473	3,005		50
50.01	GASTRO INTESTINAL SERVICES	834	354		331	223		50.01
51	Recovery Room		260		563	380		51
52	Delivery Room & Labor Room		3,713		3,033	2,039		52
53	Anesthesiology		75		614	411		53
54	Radiology-Diagnostic	1,821	1,964		2,151			54
56	Radioisotope		146		203			56
56.01	ULTRA SOUND		111		882			56.01
57	CT Scan		156		495			57
58	MRI		143		236			58
59	Cardiac Catheterization		657		643	432		59
60	Laboratory	5	1,254		4,113			60
63	Blood Storing, Processing & Trans.		52					63
65	Respiratory Therapy	240	112		1,733			65
66	Physical Therapy	1,261	1,101		2,059			66
67	Occupational Therapy	32			783			67
68	Speech Pathology		88		274			68
69	Electrocardiology		388		515	346		69
70	Electroencephalography				67	45		70
71	Medical Supplies Charged to Patients						16,851	71
72	Impl. Dev. Charged to Patients						16,359	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,452	2,081		4,164	2,799		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	26,965	29,111	139,917	59,429	27,511	33,210	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		35					190
191	Research							191
192	Physicians' Private Offices			27,625				192
194	MARKETING		111		131			194
194.02	COMMUNITY RELATIONS		95		88			194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS		237		81			194.04
194.05	POB	86	17,531					194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS			635				194.07
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	27,051	47,120	168,177	59,729	27,511	33,210	202

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		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	Administrative & General						5
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	40,352					15
16	Medical Records & Library		61,731				16
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics		10,804	493,411		493,411	30
31	Intensive Care Unit		1,667	122,764		122,764	31
40	Subprovider - IPF		1,556	113,237		113,237	40
41	Subprovider - IRF		647	214,580		214,580	41
43	Nursery		789	86,972		86,972	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		4,060	223,699		223,699	50
50.01	GASTRO INTESTINAL SERVICES		630	31,544		31,544	50.01
51	Recovery Room		903	24,192		24,192	51
52	Delivery Room & Labor Room		1,337	306,916		306,916	52
53	Anesthesiology		1,417	9,729		9,729	53
54	Radiology-Diagnostic		1,365	165,671		165,671	54
56	Radioisotope		378	13,800		13,800	56
56.01	ULTRA SOUND		1,491	13,686		13,686	56.01
57	CT Scan		5,116	19,592		19,592	57
58	MRI		506	12,800		12,800	58
59	Cardiac Catheterization		1,223	56,763		56,763	59
60	Laboratory		6,070	120,473		120,473	60
63	Blood Storing, Processing & Trans.		435	5,199		5,199	63
65	Respiratory Therapy		660	15,207		15,207	65
66	Physical Therapy		1,386	95,773		95,773	66
67	Occupational Therapy		795	4,039		4,039	67
68	Speech Pathology		199	8,053		8,053	68
69	Electrocardiology		975	33,726		33,726	69
70	Electroencephalography		22	243		243	70
71	Medical Supplies Charged to Patients		1,656	23,851		23,851	71
72	Impl. Dev. Charged to Patients		1,369	22,916		22,916	72
73	Drugs Charged to Patients	40,352	6,629	53,711		53,711	73
74	Renal Dialysis		182	1,756		1,756	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency		7,464	192,713		192,713	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	40,352	61,731	2,487,016		2,487,016	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen			2,755		2,755	190
191	Research			910		910	191
192	Physicians' Private Offices			27,625		27,625	192
194	MARKETING			10,427		10,427	194
194.02	COMMUNITY RELATIONS			8,111		8,111	194.02
194.03	SENIOR CENTER						194.03
194.04	PHYSICIAN CLINICS			19,053		19,053	194.04
194.05	POB			1,383,883		1,383,883	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG			32		32	194.06
194.07	GUEST TRAYS & CATERING MEALS			635		635	194.07
194.08	HOSPICE						194.08
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	40,352	61,731	3,940,447		3,940,447	202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	318,997						1
2	Cap Rel Costs-Mvble Equip		318,997					2
4	Employee Benefits Department			17,957,858				4
5	Administrative & General	20,939	20,939	907,300	-5,043,608	33,971,590		5
7	Operation of Plant	43,388	43,388	709,359		4,144,778	254,670	7
8	Laundry & Linen Service	1,716	1,716			266,636	1,716	8
9	Housekeeping	2,782	2,782	459,231		820,736	2,782	9
10	Dietary	10,953	10,953	464,541		841,621	10,953	10
11	Cafeteria							11
13	Nursing Administration	1,548	1,548	359,990		459,921	1,548	13
14	Central Services & Supply	2,118	2,118	63,424		167,725	2,118	14
15	Pharmacy	2,063	2,063	662,235		1,034,018	2,063	15
16	Medical Records & Library	3,276	3,276	1,106,981		1,521,995	3,276	16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	23,852	23,852	3,619,897		4,930,234	23,852	30
31	Intensive Care Unit	6,937	6,937	681,641		964,519	6,937	31
40	Subprovider - IPF	5,955	5,955	633,340		884,843	5,955	40
41	Subprovider - IRF	12,803	12,803	699,317		1,030,670	12,803	41
43	Nursery	5,046	5,046	701,795		970,493	5,046	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,810	12,810	1,062,557		2,724,510	12,810	50
50.01	GASTRO INTESTINAL SERVICES	1,880	1,880	105,795		231,102	1,880	50.01
51	Recovery Room	1,380	1,380	191,292		257,898	1,380	51
52	Delivery Room & Labor Room	19,715	19,715	765,543		1,225,420	19,715	52
53	Anesthesiology	398	398	108,963		184,956	398	53
54	Radiology-Diagnostic	10,429	10,429	521,951		827,924	10,429	54
56	Radioisotope	775	775	70,983		232,878	775	56
56.01	ULTRA SOUND	590	590	267,162		341,368	590	56.01
57	CT Scan	830	830	142,838		226,110	830	57
58	MRI	757	757	79,033		115,179	757	58
59	Cardiac Catheterization	3,489	3,489	252,530		385,447	3,489	59
60	Laboratory	6,656	6,656	745,680		1,573,421	6,656	60
63	Blood Storing, Processing & Trans.	277	277			88,395	277	63
65	Respiratory Therapy	594	594	378,438		499,048	594	65
66	Physical Therapy	5,846	5,846	470,762		620,749	5,846	66
67	Occupational Therapy			214,145		319,011		67
68	Speech Pathology	468	468	74,612		87,738	468	68
69	Electrocardiology	2,061	2,061	124,122		190,531	2,061	69
70	Electroencephalography			11,761		14,355		70
71	Medical Supplies Charged to Patients					701,821		71
72	Impl. Dev. Charged to Patients					681,408		72
73	Drugs Charged to Patients					883,900		73
74	Renal Dialysis					206,691		74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	11,047	11,047	1,100,700		1,664,809	11,047	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	223,378	223,378	17,757,918	-5,043,608	32,322,858	159,051	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	185	185			3,045	185	190
191	Research			84,953		119,536		191
192	Physicians' Private Offices							192
194	MARKETING	587	587	21,631		213,495	587	194
194.02	COMMUNITY RELATIONS	503	503	61,623		78,035	503	194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS	1,256	1,256	28,315		55,356	1,256	194.04
194.05	POB	93,088	93,088			1,175,093	93,088	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG			3,418		4,172		194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,804,316	1,136,131	3,960,890		5,043,608	4,760,132	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.791042	3.561573	0.220566		0.148465	18.691373	203
204	Cost to be allocated (Per Wkst. B, Part II)					258,652	567,514	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.007614	2.228429	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	NURSING ADMINIS- TRATION FTES)	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	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	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service	308,962						8
9	Housekeeping	3,501	250,172					9
10	Dietary		10,953	101,972				10
11	Cafeteria			36,216	33,181			11
13	Nursing Administration		1,548		636	22,738		13
14	Central Services & Supply		2,118		362		10,000	14
15	Pharmacy		2,063		1,116			15
16	Medical Records & Library		3,276		977			16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	149,509	23,852	32,179	8,849	8,849		30
31	Intensive Care Unit	17,796	6,937	3,531	1,301	1,301		31
40	Subprovider - IPF	20,693	5,955	6,273	1,606	1,606		40
41	Subprovider - IRF	15,230	12,803	6,638	1,565	1,565		41
43	Nursery		5,046		1,418	1,417		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,370	12,810		2,485	2,484		50
50.01	GASTRO INTESTINAL SERVICES	9,522	1,880		184	184		50.01
51	Recovery Room		1,380		313	314		51
52	Delivery Room & Labor Room		19,715		1,685	1,685		52
53	Anesthesiology		398		341	340		53
54	Radiology-Diagnostic	20,801	10,429		1,195			54
56	Radioisotope		775		113			56
56.01	ULTRA SOUND		590		490			56.01
57	CT Scan		830		275			57
58	MRI		757		131			58
59	Cardiac Catheterization		3,489		357	357		59
60	Laboratory	53	6,656		2,285			60
63	Blood Storing, Processing & Trans.		277					63
65	Respiratory Therapy	2,739	594		963			65
66	Physical Therapy	14,399	5,846		1,144			66
67	Occupational Therapy	361			435			67
68	Speech Pathology		468		152			68
69	Electrocardiology		2,061		286	286		69
70	Electroencephalography				37	37		70
71	Medical Supplies Charged to Patients						5,074	71
72	Impl. Dev. Charged to Patients						4,926	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	28,002	11,047		2,313	2,313		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	307,976	154,553	84,837	33,014	22,738	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		185					190
191	Research							191
192	Physicians' Private Offices			16,750				192
194	MARKETING		587		73			194
194.02	COMMUNITY RELATIONS		503		49			194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS		1,256		45			194.04
194.05	POB	986	93,088					194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS			385				194.07
194.08	HOSPICE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	338,296	998,419	1,215,012	431,519	571,586	245,375	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.094944	3.990930	11.915153	13.005003	25.137919	24.537500	203
204	Cost to be allocated (Per Wkst. B, Part II)	27,051	47,120	168,177	59,729	27,511	33,210	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.087554	0.188350	1.649247	1.800096	1.209913	3.321000	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHAR GES					
		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	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	100						15
16	Medical Records & Library		198,850,280					16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		34,573,835					30
31	Intensive Care Unit		5,377,913					31
40	Subprovider - IPF		5,018,851					40
41	Subprovider - IRF		2,086,609					41
43	Nursery		2,546,372					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		13,097,897					50
50.01	GASTRO INTESTINAL SERVICES		2,031,108					50.01
51	Recovery Room		2,912,267					51
52	Delivery Room & Labor Room		4,312,332					52
53	Anesthesiology		4,572,090					53
54	Radiology-Diagnostic		4,404,630					54
56	Radioisotope		1,217,875					56
56.01	ULTRA SOUND		4,808,620					56.01
57	CT Scan		16,502,689					57
58	MRI		1,632,050					58
59	Cardiac Catheterization		3,946,717					59
60	Laboratory		19,579,083					60
63	Blood Storing, Processing & Trans.		1,403,165					63
65	Respiratory Therapy		2,127,626					65
66	Physical Therapy		4,469,677					66
67	Occupational Therapy		2,564,535					67
68	Speech Pathology		643,093					68
69	Electrocardiology		3,143,687					69
70	Electroencephalography		71,797					70
71	Medical Supplies Charged to Patients		5,341,161					71
72	Impl. Dev. Charged to Patients		4,416,691					72
73	Drugs Charged to Patients	100	21,383,247					73
74	Renal Dialysis		586,473					74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		24,078,190					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	198,850,280					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	MARKETING							194
194.02	COMMUNITY RELATIONS							194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS							194.04
194.05	POB							194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,248,840	1,834,971					202
203	Unit Cost Multiplier (Wkst. B, Part I)	12,488,400000	0.009228					203
204	Cost to be allocated (Per Wkst. B, Part II)	40,352	61,731					204
205	Unit Cost Multiplier (Wkst. B, Part II)	403.520000	0.000310					205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

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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	7,406,919		7,406,919		7,406,919	30
31	Intensive Care Unit	1,425,872		1,425,872		1,425,872	31
40	Subprovider - IPF	1,356,257		1,356,257		1,356,257	40
41	Subprovider - IRF	1,648,808		1,648,808		1,648,808	41
43	Nursery	1,306,591		1,306,591		1,306,591	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,662,970		3,662,970		3,662,970	50
50.01	GASTRO INTESTINAL SERVICES	344,243		344,243		344,243	50.01
51	Recovery Room	366,326		366,326		366,326	51
52	Delivery Room & Labor Room	1,958,597		1,958,597		1,958,597	52
53	Anesthesiology	276,615		276,615		276,615	53
54	Radiology-Diagnostic	1,266,358		1,266,358		1,266,358	54
56	Radioisotope	297,740		297,740		297,740	56
56.01	ULTRA SOUND	456,178		456,178		456,178	56.01
57	CT Scan	434,368		434,368		434,368	57
58	MRI	166,214		166,214		166,214	58
59	Cardiac Catheterization	571,847		571,847		571,847	59
60	Laboratory	2,168,443		2,168,443		2,168,443	60
63	Blood Storing, Processing & Trans.	120,750		120,750		120,750	63
65	Respiratory Therapy	621,770		621,770		621,770	65
66	Physical Therapy	917,400		917,400		917,400	66
67	Occupational Therapy	396,091		396,091		396,091	67
68	Speech Pathology	119,291		119,291		119,291	68
69	Electrocardiology	305,484		305,484		305,484	69
70	Electroencephalography	18,560		18,560		18,560	70
71	Medical Supplies Charged to Patients	979,808		979,808		979,808	71
72	Impl. Dev. Charged to Patients	944,202		944,202		944,202	72
73	Drugs Charged to Patients	2,461,293		2,461,293		2,461,293	73
74	Renal Dialysis	242,789		242,789		242,789	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	2,503,627		2,503,627		2,503,627	91
92	Observation Beds (Non-Distinct Part)	804,031		804,031		804,031	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	35,549,442		35,549,442		35,549,442	200
201	Less Observation Beds	804,031		804,031		804,031	201
202	Total (line 200 minus line 201)	34,745,411		34,745,411		34,745,411	202

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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	30,196,489		30,196,489				30
31	Intensive Care Unit	5,377,913		5,377,913				31
40	Subprovider - IPF	5,018,851		5,018,851				40
41	Subprovider - IRF	2,086,609		2,086,609				41
43	Nursery	2,546,372		2,546,372				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,391,471	8,706,426	13,097,897	0.279661	0.279661	0.279661	50
50.01	GASTRO INTESTINAL SERVICES	643,542	1,387,566	2,031,108	0.169485	0.169485	0.169485	50.01
51	Recovery Room	1,010,534	1,901,733	2,912,267	0.125787	0.125787	0.125787	51
52	Delivery Room & Labor Room	3,986,975	325,357	4,312,332	0.454185	0.454185	0.454185	52
53	Anesthesiology	1,030,580	3,541,510	4,572,090	0.060501	0.060501	0.060501	53
54	Radiology-Diagnostic	896,445	3,508,185	4,404,630	0.287506	0.287506	0.287506	54
56	Radioisotope	509,882	707,993	1,217,875	0.244475	0.244475	0.244475	56
56.01	ULTRA SOUND	893,980	3,914,640	4,808,620	0.094867	0.094867	0.094867	56.01
57	CT Scan	5,353,693	11,148,996	16,502,689	0.026321	0.026321	0.026321	57
58	MRI	535,382	1,096,668	1,632,050	0.101844	0.101844	0.101844	58
59	Cardiac Catheterization	2,487,785	1,458,932	3,946,717	0.144892	0.144892	0.144892	59
60	Laboratory	11,120,065	8,459,018	19,579,083	0.110753	0.110753	0.110753	60
63	Blood Storing, Processing & Trans.	1,148,656	254,509	1,403,165	0.086055	0.086055	0.086055	63
65	Respiratory Therapy	1,955,374	172,252	2,127,626	0.292237	0.292237	0.292237	65
66	Physical Therapy	2,527,371	1,942,306	4,469,677	0.205250	0.205250	0.205250	66
67	Occupational Therapy	2,272,134	292,401	2,564,535	0.154449	0.154449	0.154449	67
68	Speech Pathology	625,765	17,328	643,093	0.185496	0.185496	0.185496	68
69	Electrocardiology	1,528,645	1,615,042	3,143,687	0.097174	0.097174	0.097174	69
70	Electroencephalography	67,921	3,876	71,797	0.258507	0.258507	0.258507	70
71	Medical Supplies Charged to Patients	1,772,582	3,568,579	5,341,161	0.183445	0.183445	0.183445	71
72	Impl. Dev. Charged to Patients	2,266,541	2,150,150	4,416,691	0.213780	0.213780	0.213780	72
73	Drugs Charged to Patients	14,595,405	6,787,842	21,383,247	0.115104	0.115104	0.115104	73
74	Renal Dialysis	573,782	12,691	586,473	0.413982	0.413982	0.413982	74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	3,916,668	20,161,522	24,078,190	0.103979	0.103979	0.103979	91
92	Observation Beds (Non-Distinct Part)	796,292	3,581,054	4,377,346	0.183680	0.183680	0.183680	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	112,133,704	86,716,576	198,850,280				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	112,133,704	86,716,576	198,850,280				202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
40	Subprovider - IPF						40
41	Subprovider - IRF						41
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
50.01	GASTRO INTESTINAL SERVICES						50.01
51	Recovery Room						51
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
56	Radioisotope						56
56.01	ULTRA SOUND						56.01
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
60	Laboratory						60
63	Blood Storing, Processing & Trans.						63
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)						200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)						202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**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	30,196,489		30,196,489				30
31	Intensive Care Unit	5,377,913		5,377,913				31
40	Subprovider - IPF	5,018,851		5,018,851				40
41	Subprovider - IRF	2,086,609		2,086,609				41
43	Nursery	2,546,372		2,546,372				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,391,471	8,706,426	13,097,897				50
50.01	GASTRO INTESTINAL SERVICES	643,542	1,387,566	2,031,108				50.01
51	Recovery Room	1,010,534	1,901,733	2,912,267				51
52	Delivery Room & Labor Room	3,986,975	325,357	4,312,332				52
53	Anesthesiology	1,030,580	3,541,510	4,572,090				53
54	Radiology-Diagnostic	896,445	3,508,185	4,404,630				54
56	Radioisotope	509,882	707,993	1,217,875				56
56.01	ULTRA SOUND	893,980	3,914,640	4,808,620				56.01
57	CT Scan	5,353,693	11,148,996	16,502,689				57
58	MRI	535,382	1,096,668	1,632,050				58
59	Cardiac Catheterization	2,487,785	1,458,932	3,946,717				59
60	Laboratory	11,120,065	8,459,018	19,579,083				60
63	Blood Storing, Processing & Trans.	1,148,656	254,509	1,403,165				63
65	Respiratory Therapy	1,955,374	172,252	2,127,626				65
66	Physical Therapy	2,527,371	1,942,306	4,469,677				66
67	Occupational Therapy	2,272,134	292,401	2,564,535				67
68	Speech Pathology	625,765	17,328	643,093				68
69	Electrocardiology	1,528,645	1,615,042	3,143,687				69
70	Electroencephalography	67,921	3,876	71,797				70
71	Medical Supplies Charged to Patients	1,772,582	3,568,579	5,341,161				71
72	Impl. Dev. Charged to Patients	2,266,541	2,150,150	4,416,691				72
73	Drugs Charged to Patients	14,595,405	6,787,842	21,383,247				73
74	Renal Dialysis	573,782	12,691	586,473				74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	3,916,668	20,161,522	24,078,190				91
92	Observation Beds (Non-Distinct Part)	796,292	3,581,054	4,377,346				92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	112,133,704	86,716,576	198,850,280				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	112,133,704	86,716,576	198,850,280				202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**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	7,406,919		7,406,919		7,406,919	30
31	Intensive Care Unit	1,425,872		1,425,872		1,425,872	31
40	Subprovider - IPF	1,356,257		1,356,257		1,356,257	40
41	Subprovider - IRF	1,648,808		1,648,808		1,648,808	41
43	Nursery	1,306,591		1,306,591		1,306,591	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,662,970		3,662,970		3,662,970	50
50.01	GASTRO INTESTINAL SERVICES	344,243		344,243		344,243	50.01
51	Recovery Room	366,326		366,326		366,326	51
52	Delivery Room & Labor Room	1,958,597		1,958,597		1,958,597	52
53	Anesthesiology	276,615		276,615		276,615	53
54	Radiology-Diagnostic	1,266,358		1,266,358		1,266,358	54
56	Radioisotope	297,740		297,740		297,740	56
56.01	ULTRA SOUND	456,178		456,178		456,178	56.01
57	CT Scan	434,368		434,368		434,368	57
58	MRI	166,214		166,214		166,214	58
59	Cardiac Catheterization	571,847		571,847		571,847	59
60	Laboratory	2,168,443		2,168,443		2,168,443	60
63	Blood Storing, Processing & Trans.	120,750		120,750		120,750	63
65	Respiratory Therapy	621,770		621,770		621,770	65
66	Physical Therapy	917,400		917,400		917,400	66
67	Occupational Therapy	396,091		396,091		396,091	67
68	Speech Pathology	119,291		119,291		119,291	68
69	Electrocardiology	305,484		305,484		305,484	69
70	Electroencephalography	18,560		18,560		18,560	70
71	Medical Supplies Charged to Patients	979,808		979,808		979,808	71
72	Impl. Dev. Charged to Patients	944,202		944,202		944,202	72
73	Drugs Charged to Patients	2,461,293		2,461,293		2,461,293	73
74	Renal Dialysis	242,789		242,789		242,789	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	2,503,627		2,503,627		2,503,627	91
92	Observation Beds (Non-Distinct Part)	804,031		804,031		804,031	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	35,549,442		35,549,442		35,549,442	200
201	Less Observation Beds	804,031		804,031		804,031	201
202	Total (line 200 minus line 201)	34,745,411		34,745,411		34,745,411	202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**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	30,196,489		30,196,489				30
31	Intensive Care Unit	5,377,913		5,377,913				31
40	Subprovider - IPF	5,018,851		5,018,851				40
41	Subprovider - IRF	2,086,609		2,086,609				41
43	Nursery	2,546,372		2,546,372				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,391,471	8,706,426	13,097,897	0.279661	0.279661	0.279661	50
50.01	GASTRO INTESTINAL SERVICES	643,542	1,387,566	2,031,108	0.169485	0.169485	0.169485	50.01
51	Recovery Room	1,010,534	1,901,733	2,912,267	0.125787	0.125787	0.125787	51
52	Delivery Room & Labor Room	3,986,975	325,357	4,312,332	0.454185	0.454185	0.454185	52
53	Anesthesiology	1,030,580	3,541,510	4,572,090	0.060501	0.060501	0.060501	53
54	Radiology-Diagnostic	896,445	3,508,185	4,404,630	0.287506	0.287506	0.287506	54
56	Radioisotope	509,882	707,993	1,217,875	0.244475	0.244475	0.244475	56
56.01	ULTRA SOUND	893,980	3,914,640	4,808,620	0.094867	0.094867	0.094867	56.01
57	CT Scan	5,353,693	11,148,996	16,502,689	0.026321	0.026321	0.026321	57
58	MRI	535,382	1,096,668	1,632,050	0.101844	0.101844	0.101844	58
59	Cardiac Catheterization	2,487,785	1,458,932	3,946,717	0.144892	0.144892	0.144892	59
60	Laboratory	11,120,065	8,459,018	19,579,083	0.110753	0.110753	0.110753	60
63	Blood Storing, Processing & Trans.	1,148,656	254,509	1,403,165	0.086055	0.086055	0.086055	63
65	Respiratory Therapy	1,955,374	172,252	2,127,626	0.292237	0.292237	0.292237	65
66	Physical Therapy	2,527,371	1,942,306	4,469,677	0.205250	0.205250	0.205250	66
67	Occupational Therapy	2,272,134	292,401	2,564,535	0.154449	0.154449	0.154449	67
68	Speech Pathology	625,765	17,328	643,093	0.185496	0.185496	0.185496	68
69	Electrocardiology	1,528,645	1,615,042	3,143,687	0.097174	0.097174	0.097174	69
70	Electroencephalography	67,921	3,876	71,797	0.258507	0.258507	0.258507	70
71	Medical Supplies Charged to Patients	1,772,582	3,568,579	5,341,161	0.183445	0.183445	0.183445	71
72	Impl. Dev. Charged to Patients	2,266,541	2,150,150	4,416,691	0.213780	0.213780	0.213780	72
73	Drugs Charged to Patients	14,595,405	6,787,842	21,383,247	0.115104	0.115104	0.115104	73
74	Renal Dialysis	573,782	12,691	586,473	0.413982	0.413982	0.413982	74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	3,916,668	20,161,522	24,078,190	0.103979	0.103979	0.103979	91
92	Observation Beds (Non-Distinct Part)	796,292	3,581,054	4,377,346	0.183680	0.183680	0.183680	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	112,133,704	86,716,576	198,850,280				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	112,133,704	86,716,576	198,850,280				202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
☐ Title V

☒ Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	3,662,970	223,699	3,439,271		50
50.01	GASTRO INTESTINAL SERVICES	344,243	31,544	312,699		50.01
51	Recovery Room	366,326	24,192	342,134		51
52	Delivery Room & Labor Room	1,958,597	306,916	1,651,681		52
53	Anesthesiology	276,615	9,729	266,886		53
54	Radiology-Diagnostic	1,266,358	165,671	1,100,687		54
56	Radioisotope	297,740	13,800	283,940		56
56.01	ULTRA SOUND	456,178	13,686	442,492		56.01
57	CT Scan	434,368	19,592	414,776		57
58	MRI	166,214	12,800	153,414		58
59	Cardiac Catheterization	571,847	56,763	515,084		59
60	Laboratory	2,168,443	120,473	2,047,970		60
63	Blood Storing, Processing & Trans.	120,750	5,199	115,551		63
65	Respiratory Therapy	621,770	15,207	606,563		65
66	Physical Therapy	917,400	95,773	821,627		66
67	Occupational Therapy	396,091	4,039	392,052		67
68	Speech Pathology	119,291	8,053	111,238		68
69	Electrocardiology	305,484	33,726	271,758		69
70	Electroencephalography	18,560	243	18,317		70
71	Medical Supplies Charged to Patients	979,808	23,851	955,957		71
72	Impl. Dev. Charged to Patients	944,202	22,916	921,286		72
73	Drugs Charged to Patients	2,461,293	53,711	2,407,582		73
74	Renal Dialysis	242,789	1,756	241,033		74
	OUTPATIENT SERVICE COST CENTERS					
91	Emergency	2,503,627	192,713	2,310,914		91
92	Observation Beds (Non-Distinct Part)	804,031	53,561	750,470		92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	22,404,995	1,509,613	20,895,382		200
201	Less Observation Beds	804,031	53,561	750,470		201
202	Total	21,600,964	1,456,052	20,144,912		202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		3,662,970	13,097,897	0.279661	50
50.01	GASTRO INTESTINAL SERVICES		344,243	2,031,108	0.169485	50.01
51	Recovery Room		366,326	2,912,267	0.125787	51
52	Delivery Room & Labor Room		1,958,597	4,312,332	0.454185	52
53	Anesthesiology		276,615	4,572,090	0.060501	53
54	Radiology-Diagnostic		1,266,358	4,404,630	0.287506	54
56	Radioisotope		297,740	1,217,875	0.244475	56
56.01	ULTRA SOUND		456,178	4,808,620	0.094867	56.01
57	CT Scan		434,368	16,502,689	0.026321	57
58	MRI		166,214	1,632,050	0.101844	58
59	Cardiac Catheterization		571,847	3,946,717	0.144892	59
60	Laboratory		2,168,443	19,579,083	0.110753	60
63	Blood Storing, Processing & Trans.		120,750	1,403,165	0.086055	63
65	Respiratory Therapy		621,770	2,127,626	0.292237	65
66	Physical Therapy		917,400	4,469,677	0.205250	66
67	Occupational Therapy		396,091	2,564,535	0.154449	67
68	Speech Pathology		119,291	643,093	0.185496	68
69	Electrocardiology		305,484	3,143,687	0.097174	69
70	Electroencephalography		18,560	71,797	0.258507	70
71	Medical Supplies Charged to Patients		979,808	5,341,161	0.183445	71
72	Impl. Dev. Charged to Patients		944,202	4,416,691	0.213780	72
73	Drugs Charged to Patients		2,461,293	21,383,247	0.115104	73
74	Renal Dialysis		242,789	586,473	0.413982	74
	OUTPATIENT SERVICE COST CENTERS					
91	Emergency		2,503,627	24,078,190	0.103979	91
92	Observation Beds (Non-Distinct Part)		804,031	4,377,346	0.183680	92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		22,404,995	153,624,046		200
201	Less Observation Beds		804,031	4,377,346		201
202	Total		21,600,964	149,246,700		202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V [XX] PPS
Applicable [XX] Title XVIII, Part A [] TEFRA
Boxes: [] 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)	493,411		493,411	9,765	50.53	2,762	139,564	30
31	Intensive Care Unit	122,764		122,764	955	128.55	245	31,495	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	113,237		113,237	1,697	66.73	450	30,029	40
41	Subprovider - IRF	214,580		214,580	1,795	119.54	607	72,561	41
42	Subprovider I								42
43	Nursery	86,972		86,972	1,000	86.97			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,030,964		1,030,964	15,212		4,064	273,649	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0240

WORKSHEET D PART II

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	223,699	13,097,897	0.017079	1,333,082	22,768	50
50.01	GASTRO INTESTINAL SERVICES	31,544	2,031,108	0.015530	282,720	4,391	50.01
51	Recovery Room	24,192	2,912,267	0.008307	309,442	2,571	51
52	Delivery Room & Labor Room	306,916	4,312,332	0.071172	5,439	387	52
53	Anesthesiology	9,729	4,572,090	0.002128	317,179	675	53
54	Radiology-Diagnostic	165,671	4,404,630	0.037613	394,468	14,837	54
56	Radioisotope	13,800	1,217,875	0.011331	198,554	2,250	56
56.01	ULTRA SOUND	13,686	4,808,620	0.002846	339,880	967	56.01
57	CT Scan	19,592	16,502,689	0.001187	1,722,772	2,045	57
58	MRI	12,800	1,632,050	0.007843	195,746	1,535	58
59	Cardiac Catheterization	56,763	3,946,717	0.014382	797,746	11,473	59
60	Laboratory	120,473	19,579,083	0.006153	3,836,522	23,606	60
63	Blood Storing, Processing & Tra	5,199	1,403,165	0.003705	334,429	1,239	63
65	Respiratory Therapy	15,207	2,127,626	0.007147	537,309	3,840	65
66	Physical Therapy	95,773	4,469,677	0.021427	463,680	9,935	66
67	Occupational Therapy	4,039	2,564,535	0.001575	426,994	673	67
68	Speech Pathology	8,053	643,093	0.012522	66,054	827	68
69	Electrocardiology	33,726	3,143,687	0.010728	679,551	7,290	69
70	Electroencephalography	243	71,797	0.003385	24,875	84	70
71	Medical Supplies Charged to Pat	23,851	5,341,161	0.004466	403,531	1,802	71
72	Impl. Dev. Charged to Patients	22,916	4,416,691	0.005188	482,870	2,505	72
73	Drugs Charged to Patients	53,711	21,383,247	0.002512	4,305,939	10,817	73
74	Renal Dialysis	1,756	586,473	0.002994	234,568	702	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	192,713	24,078,190	0.008004	1,292,466	10,345	91
92	Observation Beds (Non-Distinct	53,561	4,377,346	0.012236	282,241	3,454	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,509,613	153,624,046		19,268,057	141,018	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
Applicable ☒ Title XVIII, Part A
Boxes: ☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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.)	
(A)	Cost Center Description	1A	1	2A	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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ 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)	9,765		2,762		30
31	Intensive Care Unit	955		245		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	1,697		450		40
41	Subprovider - IRF	1,795		607		41
42	Subprovider I					42
43	Nursery	1,000				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	15,212		4,064		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0240

WORKSHEET D PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0240

WORKSHEET D PART IV

Check [] Title V [XX] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
Boxes: [] Title XIX [] IRF [] NF [] 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								
50	Operating Room	13,097,897			1,333,082		1,527,266		50
50.01	GASTRO INTESTINAL SERVICES	2,031,108			282,720		396,446		50.01
51	Recovery Room	2,912,267			309,442		499,177		51
52	Delivery Room & Labor Room	4,312,332			5,439				52
53	Anesthesiology	4,572,090			317,179		367,783		53
54	Radiology-Diagnostic	4,404,630			394,468		370,367		54
56	Radioisotope	1,217,875			198,554		255,289		56
56.01	ULTRA SOUND	4,808,620			339,880		106,282		56.01
57	CT Scan	16,502,689			1,722,772		1,700,776		57
58	MRI	1,632,050			195,746		311,315		58
59	Cardiac Catheterization	3,946,717			797,746		239,477		59
60	Laboratory	19,579,083			3,836,522		1,057,506		60
63	Blood Storing, Processing & Tra	1,403,165			334,429		6,823		63
65	Respiratory Therapy	2,127,626			537,309		21,904		65
66	Physical Therapy	4,469,677			463,680		20,277		66
67	Occupational Therapy	2,564,535			426,994		12,785		67
68	Speech Pathology	643,093			66,054		567		68
69	Electrocardiology	3,143,687			679,551		507,543		69
70	Electroencephalography	71,797			24,875		1,244		70
71	Medical Supplies Charged to Pat	5,341,161			403,531		431,301		71
72	Impl. Dev. Charged to Patients	4,416,691			482,870		427,849		72
73	Drugs Charged to Patients	21,383,247			4,305,939		873,665		73
74	Renal Dialysis	586,473			234,568		7,500		74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	24,078,190			1,292,466		2,265,356		91
92	Observation Beds (Non-Distinct	4,377,346			282,241		579,693		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	153,624,046			19,268,057		11,988,191		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0240

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/IID

(A)	Cost Center Description	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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.279661	1,527,266			427,117			50
50.01	GASTRO INTESTINAL SERVICES	0.169485	396,446			67,192			50.01
51	Recovery Room	0.125787	499,177			62,790			51
52	Delivery Room & Labor Room	0.454185							52
53	Anesthesiology	0.060501	367,783			22,251			53
54	Radiology-Diagnostic	0.287506	370,367			106,483			54
56	Radioisotope	0.244475	255,289			62,412			56
56.01	ULTRA SOUND	0.094867	106,282			10,083			56.01
57	CT Scan	0.026321	1,700,776			44,766			57
58	MRI	0.101844	311,315			31,706			58
59	Cardiac Catheterization	0.144892	239,477			34,698			59
60	Laboratory	0.110753	1,057,506			117,122			60
63	Blood Storing, Processing & Tra	0.086055	6,823			587			63
65	Respiratory Therapy	0.292237	21,904			6,401			65
66	Physical Therapy	0.205250	20,277			4,162			66
67	Occupational Therapy	0.154449	12,785			1,975			67
68	Speech Pathology	0.185496	567			105			68
69	Electrocardiology	0.097174	507,543			49,320			69
70	Electroencephalography	0.258507	1,244			322			70
71	Medical Supplies Charged to Pat	0.183445	431,301			79,120			71
72	Impl. Dev. Charged to Patients	0.213780	427,849			91,466			72
73	Drugs Charged to Patients	0.115104	873,665		14,910	100,562		1,716	73
74	Renal Dialysis	0.413982	7,500			3,105			74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.103979	2,265,356			235,549			91
92	Observation Beds (Non-Distinct	0.183680	579,693			106,478			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		11,988,191		14,910	1,665,772		1,716	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		11,988,191		14,910	1,665,772		1,716	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S240

WORKSHEET D PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☒ IPF
Boxes: ☐ Title XIX ☐ IRF ☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	223,699	13,097,897	0.017079			50
50.01	GASTRO INTESTINAL SERVICES	31,544	2,031,108	0.015530	7,191	112	50.01
51	Recovery Room	24,192	2,912,267	0.008307			51
52	Delivery Room & Labor Room	306,916	4,312,332	0.071172			52
53	Anesthesiology	9,729	4,572,090	0.002128	7,749	16	53
54	Radiology-Diagnostic	165,671	4,404,630	0.037613	5,080	191	54
56	Radioisotope	13,800	1,217,875	0.011331	7,821	89	56
56.01	ULTRA SOUND	13,686	4,808,620	0.002846	5,573	16	56.01
57	CT Scan	19,592	16,502,689	0.001187	19,636	23	57
58	MRI	12,800	1,632,050	0.007843			58
59	Cardiac Catheterization	56,763	3,946,717	0.014382			59
60	Laboratory	120,473	19,579,083	0.006153	95,485	588	60
63	Blood Storing, Processing & Tra	5,199	1,403,165	0.003705			63
65	Respiratory Therapy	15,207	2,127,626	0.007147	664	5	65
66	Physical Therapy	95,773	4,469,677	0.021427	6,612	142	66
67	Occupational Therapy	4,039	2,564,535	0.001575	1,407	2	67
68	Speech Pathology	8,053	643,093	0.012522			68
69	Electrocardiology	33,726	3,143,687	0.010728	13,007	140	69
70	Electroencephalography	243	71,797	0.003385	1,244	4	70
71	Medical Supplies Charged to Pat	23,851	5,341,161	0.004466	826	4	71
72	Impl. Dev. Charged to Patients	22,916	4,416,691	0.005188			72
73	Drugs Charged to Patients	53,711	21,383,247	0.002512	200,889	505	73
74	Renal Dialysis	1,756	586,473	0.002994			74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	192,713	24,078,190	0.008004	6,316	51	91
92	Observation Beds (Non-Distinct		4,377,346				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,456,052	153,624,046		379,500	1,888	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S240

WORKSHEET D PART IV

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
 Applicable ☒ Title XVIII, Part A ☒ IPF ☐ SNF ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S240

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ 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								
50	Operating Room	13,097,897							50
50.01	GASTRO INTESTINAL SERVICES	2,031,108			7,191				50.01
51	Recovery Room	2,912,267							51
52	Delivery Room & Labor Room	4,312,332							52
53	Anesthesiology	4,572,090			7,749				53
54	Radiology-Diagnostic	4,404,630			5,080		5,106		54
56	Radioisotope	1,217,875			7,821				56
56.01	ULTRA SOUND	4,808,620			5,573				56.01
57	CT Scan	16,502,689			19,636		12,599		57
58	MRI	1,632,050							58
59	Cardiac Catheterization	3,946,717							59
60	Laboratory	19,579,083			95,485				60
63	Blood Storing, Processing & Tra	1,403,165							63
65	Respiratory Therapy	2,127,626			664				65
66	Physical Therapy	4,469,677			6,612				66
67	Occupational Therapy	2,564,535			1,407				67
68	Speech Pathology	643,093							68
69	Electrocardiology	3,143,687			13,007		1,301		69
70	Electroencephalography	71,797			1,244				70
71	Medical Supplies Charged to Pat	5,341,161			826		65		71
72	Impl. Dev. Charged to Patients	4,416,691							72
73	Drugs Charged to Patients	21,383,247			200,889		1,608		73
74	Renal Dialysis	586,473							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	24,078,190			6,316				91
92	Observation Beds (Non-Distinct	4,377,346							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	153,624,046			379,500		20,679		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S240

WORKSHEET D PART V

Check ☐ Title V - O/P ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF
 Applicable ☒ Title XVIII, Part B ☒ IPF ☐ SNF ☐ Swing Bed NF
 Boxes: ☐ Title XIX - O/P ☐ IRF ☐ NF ☐ ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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								
50	Operating Room	0.279661							50
50.01	GASTRO INTESTINAL SERVICES	0.169485							50.01
51	Recovery Room	0.125787							51
52	Delivery Room & Labor Room	0.454185							52
53	Anesthesiology	0.060501							53
54	Radiology-Diagnostic	0.287506	5,106			1,468			54
56	Radioisotope	0.244475							56
56.01	ULTRA SOUND	0.094867							56.01
57	CT Scan	0.026321	12,599			332			57
58	MRI	0.101844							58
59	Cardiac Catheterization	0.144892							59
60	Laboratory	0.110753							60
63	Blood Storing, Processing & Tra	0.086055							63
65	Respiratory Therapy	0.292237							65
66	Physical Therapy	0.205250							66
67	Occupational Therapy	0.154449							67
68	Speech Pathology	0.185496							68
69	Electrocardiology	0.097174	1,301			126			69
70	Electroencephalography	0.258507							70
71	Medical Supplies Charged to Pat	0.183445	65			12			71
72	Impl. Dev. Charged to Patients	0.213780							72
73	Drugs Charged to Patients	0.115104	1,608		1,196	185		138	73
74	Renal Dialysis	0.413982							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.103979							91
92	Observation Beds (Non-Distinct	0.183680							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		20,679		1,196	2,123		138	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		20,679		1,196	2,123		138	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T240

WORKSHEET D PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF
Boxes: ☐ Title XIX ☒ IRF ☐ TEFRA

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	223,699	13,097,897	0.017079	63,917	1,092	50
50.01	GASTRO INTESTINAL SERVICES	31,544	2,031,108	0.015530	2,257	35	50.01
51	Recovery Room	24,192	2,912,267	0.008307			51
52	Delivery Room & Labor Room	306,916	4,312,332	0.071172			52
53	Anesthesiology	9,729	4,572,090	0.002128	861	2	53
54	Radiology-Diagnostic	165,671	4,404,630	0.037613	21,916	824	54
56	Radioisotope	13,800	1,217,875	0.011331			56
56.01	ULTRA SOUND	13,686	4,808,620	0.002846			56.01
57	CT Scan	19,592	16,502,689	0.001187	17,114	20	57
58	MRI	12,800	1,632,050	0.007843			58
59	Cardiac Catheterization	56,763	3,946,717	0.014382			59
60	Laboratory	120,473	19,579,083	0.006153	256,397	1,578	60
63	Blood Storing, Processing & Tra	5,199	1,403,165	0.003705	4,205	16	63
65	Respiratory Therapy	15,207	2,127,626	0.007147	69,418	496	65
66	Physical Therapy	95,773	4,469,677	0.021427	594,974	12,749	66
67	Occupational Therapy	4,039	2,564,535	0.001575	523,973	825	67
68	Speech Pathology	8,053	643,093	0.012522	205,336	2,571	68
69	Electrocardiology	33,726	3,143,687	0.010728	8,121	87	69
70	Electroencephalography	243	71,797	0.003385			70
71	Medical Supplies Charged to Pat	23,851	5,341,161	0.004466	995	4	71
72	Impl. Dev. Charged to Patients	22,916	4,416,691	0.005188	2,356	12	72
73	Drugs Charged to Patients	53,711	21,383,247	0.002512	475,602	1,195	73
74	Renal Dialysis	1,756	586,473	0.002994	124,089	372	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	192,713	24,078,190	0.008004			91
92	Observation Beds (Non-Distinct		4,377,346				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,456,052	153,624,046		2,371,531	21,878	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T240

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T240

WORKSHEET D PART IV

Check [] Title V [] Hospital [] SUB (Other) [] ICF/IID [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
Boxes: [] Title XIX [XX] IRF [] NF [] 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								
50	Operating Room	13,097,897			63,917				50
50.01	GASTRO INTESTINAL SERVICES	2,031,108			2,257				50.01
51	Recovery Room	2,912,267							51
52	Delivery Room & Labor Room	4,312,332							52
53	Anesthesiology	4,572,090			861				53
54	Radiology-Diagnostic	4,404,630			21,916		990		54
56	Radioisotope	1,217,875							56
56.01	ULTRA SOUND	4,808,620							56.01
57	CT Scan	16,502,689			17,114				57
58	MRI	1,632,050							58
59	Cardiac Catheterization	3,946,717							59
60	Laboratory	19,579,083			256,397				60
63	Blood Storing, Processing & Tra	1,403,165			4,205				63
65	Respiratory Therapy	2,127,626			69,418				65
66	Physical Therapy	4,469,677			594,974				66
67	Occupational Therapy	2,564,535			523,973				67
68	Speech Pathology	643,093			205,336				68
69	Electrocardiology	3,143,687			8,121				69
70	Electroencephalography	71,797							70
71	Medical Supplies Charged to Pat	5,341,161			995				71
72	Impl. Dev. Charged to Patients	4,416,691			2,356				72
73	Drugs Charged to Patients	21,383,247			475,602		1,379		73
74	Renal Dialysis	586,473			124,089				74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	24,078,190							91
92	Observation Beds (Non-Distinct	4,377,346							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	153,624,046			2,371,531		2,369		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T240

WORKSHEET D PART V

Check ☐ Title V - O/P ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF
 Applicable ☒ Title XVIII, Part B ☐ IPF ☐ SNF ☐ Swing Bed NF
 Boxes: ☐ Title XIX - O/P ☒ IRF ☐ NF ☐ ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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								
50	Operating Room	0.279661							50
50.01	GASTRO INTESTINAL SERVICES	0.169485							50.01
51	Recovery Room	0.125787							51
52	Delivery Room & Labor Room	0.454185							52
53	Anesthesiology	0.060501							53
54	Radiology-Diagnostic	0.287506	990			285			54
56	Radioisotope	0.244475							56
56.01	ULTRA SOUND	0.094867							56.01
57	CT Scan	0.026321							57
58	MRI	0.101844							58
59	Cardiac Catheterization	0.144892							59
60	Laboratory	0.110753							60
63	Blood Storing, Processing & Tra	0.086055							63
65	Respiratory Therapy	0.292237							65
66	Physical Therapy	0.205250							66
67	Occupational Therapy	0.154449							67
68	Speech Pathology	0.185496							68
69	Electrocardiology	0.097174							69
70	Electroencephalography	0.258507							70
71	Medical Supplies Charged to Pat	0.183445							71
72	Impl. Dev. Charged to Patients	0.213780							72
73	Drugs Charged to Patients	0.115104	1,379			159			73
74	Renal Dialysis	0.413982							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.103979							91
92	Observation Beds (Non-Distinct	0.183680							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		2,369			444			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,369			444			202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V
Applicable [] Title XVIII, Part A
Boxes: [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)	493,411		493,411	9,765	50.53	1,054	53,259	30
31	Intensive Care Unit	122,764		122,764	955	128.55	55	7,070	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	113,237		113,237	1,697	66.73	697	46,511	40
41	Subprovider - IRF	214,580		214,580	1,795	119.54	202	24,147	41
42	Subprovider I								42
43	Nursery	86,972		86,972	1,000	86.97	210	18,264	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,030,964		1,030,964	15,212		2,218	149,251	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0240

WORKSHEET D
PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other)
 Applicable ☐ Title XVIII, Part A ☐ IPF
 Boxes: ☒ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	223,699	13,097,897	0.017079			50
50.01	GASTRO INTESTINAL SERVICES	31,544	2,031,108	0.015530			50.01
51	Recovery Room	24,192	2,912,267	0.008307			51
52	Delivery Room & Labor Room	306,916	4,312,332	0.071172			52
53	Anesthesiology	9,729	4,572,090	0.002128			53
54	Radiology-Diagnostic	165,671	4,404,630	0.037613			54
56	Radioisotope	13,800	1,217,875	0.011331			56
56.01	ULTRA SOUND	13,686	4,808,620	0.002846			56.01
57	CT Scan	19,592	16,502,689	0.001187			57
58	MRI	12,800	1,632,050	0.007843			58
59	Cardiac Catheterization	56,763	3,946,717	0.014382			59
60	Laboratory	120,473	19,579,083	0.006153			60
63	Blood Storing, Processing & Tra	5,199	1,403,165	0.003705			63
65	Respiratory Therapy	15,207	2,127,626	0.007147			65
66	Physical Therapy	95,773	4,469,677	0.021427			66
67	Occupational Therapy	4,039	2,564,535	0.001575			67
68	Speech Pathology	8,053	643,093	0.012522			68
69	Electrocardiology	33,726	3,143,687	0.010728			69
70	Electroencephalography	243	71,797	0.003385			70
71	Medical Supplies Charged to Pat	23,851	5,341,161	0.004466			71
72	Impl. Dev. Charged to Patients	22,916	4,416,691	0.005188			72
73	Drugs Charged to Patients	53,711	21,383,247	0.002512			73
74	Renal Dialysis	1,756	586,473	0.002994			74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	192,713	24,078,190	0.008004			91
92	Observation Beds (Non-Distinct	53,561	4,377,346	0.012236			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,509,613	153,624,046				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ TEFRA
Boxes: ☒ Title XIX ☒ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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.)	
(A)	Cost Center Description	1A	1	2A	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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ 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)	9,765		1,054		30
31	Intensive Care Unit	955		55		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	1,697		697		40
41	Subprovider - IRF	1,795		202		41
42	Subprovider I					42
43	Nursery	1,000		210		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	15,212		2,218		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0240

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0240

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ 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								
50	Operating Room	13,097,897							50
50.01	GASTRO INTESTINAL SERVICES	2,031,108							50.01
51	Recovery Room	2,912,267							51
52	Delivery Room & Labor Room	4,312,332							52
53	Anesthesiology	4,572,090							53
54	Radiology-Diagnostic	4,404,630							54
56	Radioisotope	1,217,875							56
56.01	ULTRA SOUND	4,808,620							56.01
57	CT Scan	16,502,689							57
58	MRI	1,632,050							58
59	Cardiac Catheterization	3,946,717							59
60	Laboratory	19,579,083							60
63	Blood Storing, Processing & Tra	1,403,165							63
65	Respiratory Therapy	2,127,626							65
66	Physical Therapy	4,469,677							66
67	Occupational Therapy	2,564,535							67
68	Speech Pathology	643,093							68
69	Electrocardiology	3,143,687							69
70	Electroencephalography	71,797							70
71	Medical Supplies Charged to Pat	5,341,161							71
72	Impl. Dev. Charged to Patients	4,416,691							72
73	Drugs Charged to Patients	21,383,247							73
74	Renal Dialysis	586,473							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	24,078,190							91
92	Observation Beds (Non-Distinct	4,377,346							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	153,624,046							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0240

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/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.279661							50
50.01	GASTRO INTESTINAL SERVICES	0.169485							50.01
51	Recovery Room	0.125787							51
52	Delivery Room & Labor Room	0.454185							52
53	Anesthesiology	0.060501							53
54	Radiology-Diagnostic	0.287506							54
56	Radioisotope	0.244475							56
56.01	ULTRA SOUND	0.094867							56.01
57	CT Scan	0.026321							57
58	MRI	0.101844							58
59	Cardiac Catheterization	0.144892							59
60	Laboratory	0.110753							60
63	Blood Storing, Processing & Tra	0.086055							63
65	Respiratory Therapy	0.292237							65
66	Physical Therapy	0.205250							66
67	Occupational Therapy	0.154449							67
68	Speech Pathology	0.185496							68
69	Electrocardiology	0.097174							69
70	Electroencephalography	0.258507							70
71	Medical Supplies Charged to Pat	0.183445							71
72	Impl. Dev. Charged to Patients	0.213780							72
73	Drugs Charged to Patients	0.115104							73
74	Renal Dialysis	0.413982							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.103979							91
92	Observation Beds (Non-Distinct	0.183680							92
	OTHER REIMBURSABLE COST CENTERS								
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S240

WORKSHEET D
PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other)
Applicable ☐ Title XVIII, Part A ☒ IPF
Boxes: ☒ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	223,699	13,097,897	0.017079			50
50.01	GASTRO INTESTINAL SERVICES	31,544	2,031,108	0.015530			50.01
51	Recovery Room	24,192	2,912,267	0.008307			51
52	Delivery Room & Labor Room	306,916	4,312,332	0.071172			52
53	Anesthesiology	9,729	4,572,090	0.002128			53
54	Radiology-Diagnostic	165,671	4,404,630	0.037613			54
56	Radioisotope	13,800	1,217,875	0.011331			56
56.01	ULTRA SOUND	13,686	4,808,620	0.002846			56.01
57	CT Scan	19,592	16,502,689	0.001187			57
58	MRI	12,800	1,632,050	0.007843			58
59	Cardiac Catheterization	56,763	3,946,717	0.014382			59
60	Laboratory	120,473	19,579,083	0.006153			60
63	Blood Storing, Processing & Tra	5,199	1,403,165	0.003705			63
65	Respiratory Therapy	15,207	2,127,626	0.007147			65
66	Physical Therapy	95,773	4,469,677	0.021427			66
67	Occupational Therapy	4,039	2,564,535	0.001575			67
68	Speech Pathology	8,053	643,093	0.012522			68
69	Electrocardiology	33,726	3,143,687	0.010728			69
70	Electroencephalography	243	71,797	0.003385			70
71	Medical Supplies Charged to Pat	23,851	5,341,161	0.004466			71
72	Impl. Dev. Charged to Patients	22,916	4,416,691	0.005188			72
73	Drugs Charged to Patients	53,711	21,383,247	0.002512			73
74	Renal Dialysis	1,756	586,473	0.002994			74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	192,713	24,078,190	0.008004			91
92	Observation Beds (Non-Distinct		4,377,346				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,456,052	153,624,046				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S240

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S240

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ 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								
50	Operating Room	13,097,897							50
50.01	GASTRO INTESTINAL SERVICES	2,031,108							50.01
51	Recovery Room	2,912,267							51
52	Delivery Room & Labor Room	4,312,332							52
53	Anesthesiology	4,572,090							53
54	Radiology-Diagnostic	4,404,630							54
56	Radioisotope	1,217,875							56
56.01	ULTRA SOUND	4,808,620							56.01
57	CT Scan	16,502,689							57
58	MRI	1,632,050							58
59	Cardiac Catheterization	3,946,717							59
60	Laboratory	19,579,083							60
63	Blood Storing, Processing & Tra	1,403,165							63
65	Respiratory Therapy	2,127,626							65
66	Physical Therapy	4,469,677							66
67	Occupational Therapy	2,564,535							67
68	Speech Pathology	643,093							68
69	Electrocardiology	3,143,687							69
70	Electroencephalography	71,797							70
71	Medical Supplies Charged to Pat	5,341,161							71
72	Impl. Dev. Charged to Patients	4,416,691							72
73	Drugs Charged to Patients	21,383,247							73
74	Renal Dialysis	586,473							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	24,078,190							91
92	Observation Beds (Non-Distinct	4,377,346							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	153,624,046							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S240

WORKSHEET D
PART V

Check ☐ Title V - O/P ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF
Applicable ☐ Title XVIII, Part B ☒ IPF ☐ SNF ☐ Swing Bed NF
Boxes: ☒ Title XIX - O/P ☐ IRF ☐ NF ☐ ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
50	Operating Room	0.279661							50
50.01	GASTRO INTESTINAL SERVICES	0.169485							50.01
51	Recovery Room	0.125787							51
52	Delivery Room & Labor Room	0.454185							52
53	Anesthesiology	0.060501							53
54	Radiology-Diagnostic	0.287506							54
56	Radioisotope	0.244475							56
56.01	ULTRA SOUND	0.094867							56.01
57	CT Scan	0.026321							57
58	MRI	0.101844							58
59	Cardiac Catheterization	0.144892							59
60	Laboratory	0.110753							60
63	Blood Storing, Processing & Tra	0.086055							63
65	Respiratory Therapy	0.292237							65
66	Physical Therapy	0.205250							66
67	Occupational Therapy	0.154449							67
68	Speech Pathology	0.185496							68
69	Electrocardiology	0.097174							69
70	Electroencephalography	0.258507							70
71	Medical Supplies Charged to Pat	0.183445							71
72	Impl. Dev. Charged to Patients	0.213780							72
73	Drugs Charged to Patients	0.115104							73
74	Renal Dialysis	0.413982							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.103979							91
92	Observation Beds (Non-Distinct	0.183680							92
	OTHER REIMBURSABLE COST CENTERS								
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 14-T240****WORKSHEET D
PART II**

Check ☐ Title V ☐ Hospital ☐ SUB (Other)
Applicable ☐ Title XVIII, Part A ☐ IPF
Boxes: ☒ Title XIX ☒ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	223,699	13,097,897	0.017079			50
50.01	GASTRO INTESTINAL SERVICES	31,544	2,031,108	0.015530			50.01
51	Recovery Room	24,192	2,912,267	0.008307			51
52	Delivery Room & Labor Room	306,916	4,312,332	0.071172			52
53	Anesthesiology	9,729	4,572,090	0.002128			53
54	Radiology-Diagnostic	165,671	4,404,630	0.037613			54
56	Radioisotope	13,800	1,217,875	0.011331			56
56.01	ULTRA SOUND	13,686	4,808,620	0.002846			56.01
57	CT Scan	19,592	16,502,689	0.001187			57
58	MRI	12,800	1,632,050	0.007843			58
59	Cardiac Catheterization	56,763	3,946,717	0.014382			59
60	Laboratory	120,473	19,579,083	0.006153			60
63	Blood Storing, Processing & Tra	5,199	1,403,165	0.003705			63
65	Respiratory Therapy	15,207	2,127,626	0.007147			65
66	Physical Therapy	95,773	4,469,677	0.021427			66
67	Occupational Therapy	4,039	2,564,535	0.001575			67
68	Speech Pathology	8,053	643,093	0.012522			68
69	Electrocardiology	33,726	3,143,687	0.010728			69
70	Electroencephalography	243	71,797	0.003385			70
71	Medical Supplies Charged to Pat	23,851	5,341,161	0.004466			71
72	Impl. Dev. Charged to Patients	22,916	4,416,691	0.005188			72
73	Drugs Charged to Patients	53,711	21,383,247	0.002512			73
74	Renal Dialysis	1,756	586,473	0.002994			74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	192,713	24,078,190	0.008004			91
92	Observation Beds (Non-Distinct		4,377,346				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,456,052	153,624,046				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T240

WORKSHEET D PART IV

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☒ Title XIX ☒ IRF ☐ NF ☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	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	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-T240

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ Hospital
☐ IPF
☒ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ 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								
50	Operating Room	13,097,897							50
50.01	GASTRO INTESTINAL SERVICES	2,031,108							50.01
51	Recovery Room	2,912,267							51
52	Delivery Room & Labor Room	4,312,332							52
53	Anesthesiology	4,572,090							53
54	Radiology-Diagnostic	4,404,630							54
56	Radioisotope	1,217,875							56
56.01	ULTRA SOUND	4,808,620							56.01
57	CT Scan	16,502,689							57
58	MRI	1,632,050							58
59	Cardiac Catheterization	3,946,717							59
60	Laboratory	19,579,083							60
63	Blood Storing, Processing & Tra	1,403,165							63
65	Respiratory Therapy	2,127,626							65
66	Physical Therapy	4,469,677							66
67	Occupational Therapy	2,564,535							67
68	Speech Pathology	643,093							68
69	Electrocardiology	3,143,687							69
70	Electroencephalography	71,797							70
71	Medical Supplies Charged to Pat	5,341,161							71
72	Impl. Dev. Charged to Patients	4,416,691							72
73	Drugs Charged to Patients	21,383,247							73
74	Renal Dialysis	586,473							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	24,078,190							91
92	Observation Beds (Non-Distinct	4,377,346							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	153,624,046							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T240

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☐ Title XVIII, Part B

☒ Title XIX - O/P

☐ Hospital

☐ IPF

☒ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

(A)	Cost Center Description	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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.279661							50
50.01	GASTRO INTESTINAL SERVICES	0.169485							50.01
51	Recovery Room	0.125787							51
52	Delivery Room & Labor Room	0.454185							52
53	Anesthesiology	0.060501							53
54	Radiology-Diagnostic	0.287506							54
56	Radioisotope	0.244475							56
56.01	ULTRA SOUND	0.094867							56.01
57	CT Scan	0.026321							57
58	MRI	0.101844							58
59	Cardiac Catheterization	0.144892							59
60	Laboratory	0.110753							60
63	Blood Storing, Processing & Tra	0.086055							63
65	Respiratory Therapy	0.292237							65
66	Physical Therapy	0.205250							66
67	Occupational Therapy	0.154449							67
68	Speech Pathology	0.185496							68
69	Electrocardiology	0.097174							69
70	Electroencephalography	0.258507							70
71	Medical Supplies Charged to Pat	0.183445							71
72	Impl. Dev. Charged to Patients	0.213780							72
73	Drugs Charged to Patients	0.115104							73
74	Renal Dialysis	0.413982							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.103979							91
92	Observation Beds (Non-Distinct	0.183680							92
	OTHER REIMBURSABLE COST CENTERS								
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0240****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **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)	9,765	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,765	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)	8,705	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)	2,762	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)	7,406,919	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)	7,406,919	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	7,406,919	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0240****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
Boxes: ☐ Title XIX - I/P ☐ IRF ☐ 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)					758.52	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,095,032	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)					2,095,032	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	1,425,872	955	1,493.06	245	365,800	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)					2,669,143	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					5,129,975	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					171,059	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					141,018	51
52	Total Program excludable cost (sum of lines 50 and 51)					312,077	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					4,817,898	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 enter 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

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,060	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					758.52	88
89	Observation bed cost (line 87 x line 88) (see instructions)					804,031	89
		Cost	Routine Cost (from line 21)	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	493,411	7,406,919	0.066615	804,031	53,561	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-S240****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☒ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **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)	1,697	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,697	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)	1,697	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)	450	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)	1,356,257	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)	1,356,257	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)	1,356,257	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-S240****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☒ Title XVIII, Part A ☒ IPF ☐ TEFRA
 Boxes: ☐ Title XIX - I/P ☐ IRF ☐ 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)	799.21	38
39	Program general inpatient routine service cost (line 9 x line 38)	359,645	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)	359,645	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	43,968	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	403,613	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	30,029	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,888	51
52	Total Program excludable cost (sum of lines 50 and 51)	31,917	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	371,696	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 enter 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

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T240****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **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)	1,795	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,795	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)	1,795	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)	607	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)	1,648,808	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)	1,648,808	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	1,648,808	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T240****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☐ Title XIX - I/P ☒ IRF ☐ 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)	918.56	38
39	Program general inpatient routine service cost (line 9 x line 38)	557,566	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)	557,566	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	422,832	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	980,398	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	72,561	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	21,878	51
52	Total Program excludable cost (sum of lines 50 and 51)	94,439	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	885,959	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 enter 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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0240****WORKSHEET D-1
PART I**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ 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)	9,765	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,765	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)	8,705	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)	1,054	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)	1,000	15
16	Nursery days (title V or XIX only)	210	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)	7,406,919	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)	7,406,919	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 35 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)	7,406,919	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0240****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☒ Title XIX - I/P ☐ IRF ☒ 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)						758.52	38
39	Program general inpatient routine service cost (line 9 x line 38)						799,480	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)						799,480	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)	1,306,591	1,000	1,306.59	210	274,384		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	1,425,872	955	1,493.06	55	82,118		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)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						1,155,982	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						78,593	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51
52	Total Program excludable cost (sum of lines 50 and 51)						78,593	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 enter 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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,060	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 21)	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

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-S240****WORKSHEET D-1
PART I**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☒ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ 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)	1,697	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,697	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)	1,697	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)	697	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)	1,356,257	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)	1,356,257	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	1,356,257	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-S240****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☐ PPS
 Applicable ☐ Title XVIII, Part A ☒ IPF ☐ TEFRA
 Boxes: ☒ Title XIX - I/P ☐ IRF ☒ 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)	799.21	38
39	Program general inpatient routine service cost (line 9 x line 38)	557,049	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)	557,049	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	557,049	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	46,511	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	46,511	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 enter 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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T240****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☐ **PPS**
Applicable ☐ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☒ **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)	1,795	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,795	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)	1,795	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)	202	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)	1,648,808	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)	1,648,808	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)	1,648,808	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-T240****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☒ Title XIX - I/P ☒ IRF ☒ 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)	918,56	38
39	Program general inpatient routine service cost (line 9 x line 38)	185,549	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)	185,549	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	185,549	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	24,147	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	24,147	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 enter 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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0240

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		10,720,144		30
31	Intensive Care Unit		1,480,290		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.279661	1,333,082	372,811	50
50.01	GASTRO INTESTINAL SERVICES	0.169485	282,720	47,917	50.01
51	Recovery Room	0.125787	309,442	38,924	51
52	Delivery Room & Labor Room	0.454185	5,439	2,470	52
53	Anesthesiology	0.060501	317,179	19,190	53
54	Radiology-Diagnostic	0.287506	394,468	113,412	54
56	Radioisotope	0.244475	198,554	48,541	56
56.01	ULTRA SOUND	0.094867	339,880	32,243	56.01
57	CT Scan	0.026321	1,722,772	45,345	57
58	MRI	0.101844	195,746	19,936	58
59	Cardiac Catheterization	0.144892	797,746	115,587	59
60	Laboratory	0.110753	3,836,522	424,906	60
63	Blood Storing, Processing & Trans.	0.086055	334,429	28,779	63
65	Respiratory Therapy	0.292237	537,309	157,022	65
66	Physical Therapy	0.205250	463,680	95,170	66
67	Occupational Therapy	0.154449	426,994	65,949	67
68	Speech Pathology	0.185496	66,054	12,253	68
69	Electrocardiology	0.097174	679,551	66,035	69
70	Electroencephalography	0.258507	24,875	6,430	70
71	Medical Supplies Charged to Patients	0.183445	403,531	74,026	71
72	Impl. Dev. Charged to Patients	0.213780	482,870	103,228	72
73	Drugs Charged to Patients	0.115104	4,305,939	495,631	73
74	Renal Dialysis	0.413982	234,568	97,107	74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.103979	1,292,466	134,389	91
92	Observation Beds (Non-Distinct Part)	0.183680	282,241	51,842	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		19,268,057	2,669,143	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		19,268,057		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S240

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		1,311,300		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.279661			50
50.01	GASTRO INTESTINAL SERVICES	0.169485	7,191	1,219	50.01
51	Recovery Room	0.125787			51
52	Delivery Room & Labor Room	0.454185			52
53	Anesthesiology	0.060501	7,749	469	53
54	Radiology-Diagnostic	0.287506	5,080	1,461	54
56	Radioisotope	0.244475	7,821	1,912	56
56.01	ULTRA SOUND	0.094867	5,573	529	56.01
57	CT Scan	0.026321	19,636	517	57
58	MRI	0.101844			58
59	Cardiac Catheterization	0.144892			59
60	Laboratory	0.110753	95,485	10,575	60
63	Blood Storing, Processing & Trans.	0.086055			63
65	Respiratory Therapy	0.292237	664	194	65
66	Physical Therapy	0.205250	6,612	1,357	66
67	Occupational Therapy	0.154449	1,407	217	67
68	Speech Pathology	0.185496			68
69	Electrocardiology	0.097174	13,007	1,264	69
70	Electroencephalography	0.258507	1,244	322	70
71	Medical Supplies Charged to Patients	0.183445	826	152	71
72	Impl. Dev. Charged to Patients	0.213780			72
73	Drugs Charged to Patients	0.115104	200,889	23,123	73
74	Renal Dialysis	0.413982			74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.103979	6,316	657	91
92	Observation Beds (Non-Distinct Part)	0.183680			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		379,500	43,968	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		379,500		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T240

WORKSHEET D-3

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☐ Title XIX ☒ IRF ☐ NF ☐ ICF/IID ☐ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF		768,462		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.279661	63,917	17,875	50
50.01	GASTRO INTESTINAL SERVICES	0.169485	2,257	383	50.01
51	Recovery Room	0.125787			51
52	Delivery Room & Labor Room	0.454185			52
53	Anesthesiology	0.060501	861	52	53
54	Radiology-Diagnostic	0.287506	21,916	6,301	54
56	Radioisotope	0.244475			56
56.01	ULTRA SOUND	0.094867			56.01
57	CT Scan	0.026321	17,114	450	57
58	MRI	0.101844			58
59	Cardiac Catheterization	0.144892			59
60	Laboratory	0.110753	256,397	28,397	60
63	Blood Storing, Processing & Trans.	0.086055	4,205	362	63
65	Respiratory Therapy	0.292237	69,418	20,287	65
66	Physical Therapy	0.205250	594,974	122,118	66
67	Occupational Therapy	0.154449	523,973	80,927	67
68	Speech Pathology	0.185496	205,336	38,089	68
69	Electrocardiology	0.097174	8,121	789	69
70	Electroencephalography	0.258507			70
71	Medical Supplies Charged to Patients	0.183445	995	183	71
72	Impl. Dev. Charged to Patients	0.213780	2,356	504	72
73	Drugs Charged to Patients	0.115104	475,602	54,744	73
74	Renal Dialysis	0.413982	124,089	51,371	74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.103979			91
92	Observation Beds (Non-Distinct Part)	0.183680			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,371,531	422,832	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,371,531		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0240

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.279661			50
50.01	GASTRO INTESTINAL SERVICES	0.169485			50.01
51	Recovery Room	0.125787			51
52	Delivery Room & Labor Room	0.454185			52
53	Anesthesiology	0.060501			53
54	Radiology-Diagnostic	0.287506			54
56	Radioisotope	0.244475			56
56.01	ULTRA SOUND	0.094867			56.01
57	CT Scan	0.026321			57
58	MRI	0.101844			58
59	Cardiac Catheterization	0.144892			59
60	Laboratory	0.110753			60
63	Blood Storing, Processing & Trans.	0.086055			63
65	Respiratory Therapy	0.292237			65
66	Physical Therapy	0.205250			66
67	Occupational Therapy	0.154449			67
68	Speech Pathology	0.185496			68
69	Electrocardiology	0.097174			69
70	Electroencephalography	0.258507			70
71	Medical Supplies Charged to Patients	0.183445			71
72	Impl. Dev. Charged to Patients	0.213780			72
73	Drugs Charged to Patients	0.115104			73
74	Renal Dialysis	0.413982			74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.103979			91
92	Observation Beds (Non-Distinct Part)	0.183680			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S240

WORKSHEET D-3

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☐ PPS
 Applicable ☐ Title XVIII, Part A ☒ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.279661			50
50.01	GASTRO INTESTINAL SERVICES	0.169485			50.01
51	Recovery Room	0.125787			51
52	Delivery Room & Labor Room	0.454185			52
53	Anesthesiology	0.060501			53
54	Radiology-Diagnostic	0.287506			54
56	Radioisotope	0.244475			56
56.01	ULTRA SOUND	0.094867			56.01
57	CT Scan	0.026321			57
58	MRI	0.101844			58
59	Cardiac Catheterization	0.144892			59
60	Laboratory	0.110753			60
63	Blood Storing, Processing & Trans.	0.086055			63
65	Respiratory Therapy	0.292237			65
66	Physical Therapy	0.205250			66
67	Occupational Therapy	0.154449			67
68	Speech Pathology	0.185496			68
69	Electrocardiology	0.097174			69
70	Electroencephalography	0.258507			70
71	Medical Supplies Charged to Patients	0.183445			71
72	Impl. Dev. Charged to Patients	0.213780			72
73	Drugs Charged to Patients	0.115104			73
74	Renal Dialysis	0.413982			74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.103979			91
92	Observation Beds (Non-Distinct Part)	0.183680			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T240

WORKSHEET D-3

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☒ Title XIX ☒ IRF ☐ NF ☐ ICF/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.279661			50
50.01	GASTRO INTESTINAL SERVICES	0.169485			50.01
51	Recovery Room	0.125787			51
52	Delivery Room & Labor Room	0.454185			52
53	Anesthesiology	0.060501			53
54	Radiology-Diagnostic	0.287506			54
56	Radioisotope	0.244475			56
56.01	ULTRA SOUND	0.094867			56.01
57	CT Scan	0.026321			57
58	MRI	0.101844			58
59	Cardiac Catheterization	0.144892			59
60	Laboratory	0.110753			60
63	Blood Storing, Processing & Trans.	0.086055			63
65	Respiratory Therapy	0.292237			65
66	Physical Therapy	0.205250			66
67	Occupational Therapy	0.154449			67
68	Speech Pathology	0.185496			68
69	Electrocardiology	0.097174			69
70	Electroencephalography	0.258507			70
71	Medical Supplies Charged to Patients	0.183445			71
72	Impl. Dev. Charged to Patients	0.213780			72
73	Drugs Charged to Patients	0.115104			73
74	Renal Dialysis	0.413982			74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.103979			91
92	Observation Beds (Non-Distinct Part)	0.183680			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,650,470			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,141,278			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	59,787			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payment for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments	1,113,034			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	115.98			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)				5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.				7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)				9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)				12
13	Total allowable FTE count for the prior year				13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero				14
15	Sum of lines 12 through 14 divided by 3				15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count				18
19	Current year resident to bed ratio (line 18 divided by line 4)				19
20	Prior year resident to bed ratio (see instructions)				20
21	Enter the lesser of lines 19 or 20 (see instructions)				21
22	IME payment adjustment (see instructions)				22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)				24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)				29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1002			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4297			31
32	Sum of lines 30 and 31	0.5299			32
33	Allowable disproportionate share percentage (see instructions)	0.3293			33
34	Disproportionate share adjustment (see instructions)	312,156			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)	6,766,695,164		8,272,872,447	35
35.01	Factor 3 (see instructions)	0.000208798		0.000165612	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,412,872		1,370,085	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	356,121		446,685	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	802,806			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	4,966,497			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	4,966,497			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	346,632			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)				52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	5,313,129			59
60	Primary payer payments	260			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	5,312,869			61
62	Deductibles billed to program beneficiaries	433,564			62
63	Coinurance billed to program beneficiaries	39,937			63
64	Allowable bad debts (see instructions)	376,898			64
65	Adjusted reimbursable bad debts (see instructions)	244,984			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	278,909			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	5,084,352			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-2,768			70.93
70.94	HRR adjustment amount (see instructions)	-5,955			70.94
70.99	HAC adjustment amount (see instructions)	29,780			70.99
71	Amount due provider (see instructions)	5,045,849			71
71.01	Sequestration adjustment (see instructions)	100,917			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	4,839,680			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	105,252			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	327,095			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION
EXHIBIT 5

		(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to October 1		On or After October 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	1,650,470	1,650,470				1,650,470	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	2,141,278			2,141,278		2,141,278	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	59,787	39,286		20,501		59,787	2
2.01	Outlier payment for discharges for Model 4 BPCI							2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)							2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)							2.03
3	Operating outlier reconciliation							3
4	Managed Care Simulated Payments	1,113,034	461,010		652,024		1,113,034	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	0.3293	0.3293	0.3293	0.3293	0.3293		10
11	Disproportionate share adjustment	312,156	135,875		176,281		312,156	11
11.01	Uncompensated care payments	802,806	356,121		446,685		802,806	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12	Total ESRD additional payment							12
13	Subtotal	4,966,497	2,181,752		2,784,745		4,966,497	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	4,966,497	2,181,752		2,784,745		4,966,497	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	346,632	151,598		195,034		346,632	16
17	Special add-on payments for new technologies							17
17.01	DO NOT USE THIS LINE							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		2,333,350		2,979,779		5,313,129	19
20	Capital DRG other than outlier	308,624	134,422		174,202		308,624	20
20.01	Model 4 BPCI Capital DRG other than outlier							20.01
21	Capital DRG outlier payments	3,041	1,946		1,095		3,041	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	0.1133	0.1133		0.1133			24
25	Disproportionate share adjustment	34,967	15,230		19,737		34,967	25
26	Total prospective capital payments	346,632	151,598		195,034		346,632	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	-2,768	-2,473		-295		-2,768	30
30.01	HVBP payment adjustment for HSP bonus payment							30.01
31	HRR adjustment	-5,955	-4,456		-1,499		-5,955	31
31.01	HRR adjustment for HSP bonus payment							31.01
32	HAC Reduction Program adjustment				29,780		29,780	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-0240****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	1,716			1
2	Medical and other services reimbursed under OPPS (see instructions)	1,665,772			2
3	OPPS payments	1,301,822			3
4	Outlier payment (see instructions)	1,097			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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)	1,716			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	14,910			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)	14,910			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)	14,910			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	13,194			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 (see instructions)	1,716			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, 4.01, 8 and 9)	1,302,919			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	255,178			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)	1,049,457			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)	1,049,457			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	1,049,457			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)	137,522			34
35	Adjusted reimbursable bad debts (see instructions)	89,389			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	110,069			36
37	Subtotal (see instructions)	1,138,846			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)	1,138,846			40
40.01	Sequestration adjustment (see instructions)	22,777			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	1,039,226			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	76,843			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 (see 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

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-S240****WORKSHEET E
PART B**Check applicable box: ☐ Hospital ☒ IPF ☐ IRF ☐ SUB (Other) ☐ SNF**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	138			1
2	Medical and other services reimbursed under OPPS (see instructions)	2,123			2
3	OPPS payments	1,098			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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)	138			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,196			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)	1,196			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)	1,196			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	1,058			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 (see instructions)	138			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, 4.01, 8 and 9)	1,098			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	204			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)	1,032			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)	1,032			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	1,032			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)	1,032			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)	1,032			40
40.01	Sequestration adjustment (see instructions)	21			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	908			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	103			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 (see 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

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-T240****WORKSHEET E
PART B**Check applicable box: ☐ Hospital ☐ IPF ☒ IRF ☐ SUB (Other) ☐ SNF**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)	444			2
3	OPPS payments	187			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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 reasonable 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 (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, 4.01, 8 and 9)	187			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	37			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)	150			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)	150			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	150			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)	150			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)	150			40
40.01	Sequestration adjustment (see instructions)	3			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	147			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				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 (see 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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-0240****WORKSHEET E-1
PART I**

Check ☒ Hospital ☐ SUB (Other)
Applicable ☐ IPF ☐ SNF
Boxes: ☐ IRF ☐ 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			4,839,680		1,039,226	1
2	Interim payments payable on individual bills, either 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				3.01
	amount based on subsequent revision of the interim		.02				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				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)			4,839,680		1,039,226	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	105,252		76,843	6.01
	based on the cost report (1)		.02				6.02
7	Total Medicare program liability (see instructions)			4,944,932		1,116,069	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.

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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WORKSHEET E-1
PART I

			INPATIENT PART A		PART B		
DESCRIPTION			mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider			362,056		908	1
2	Interim payments payable on individual bills, either 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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01				3.01
			.02				3.02
		Program	.03				3.03
		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				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)			362,056		908	4
	TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01				5.01
			.02				5.02
		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) based on the cost report (1)		.01			103	6.01
			.02				6.02
7	Total Medicare program liability (see instructions)			362,056		1,011	7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)		8

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-T240

WORKSHEET E-1
PART I

Check ☐ Hospital ☐ SUB (Other)
Applicable ☐ IPF ☐ SNF
Boxes: ☒ IRF ☐ 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			919,107		147
2	Interim payments payable on individual bills, either 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			3.01
	amount based on subsequent revision of the interim		.02			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			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)			919,107		147
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) based on the cost report (1)		.01	19,814		6.01
			.02			6.02
7	Total Medicare program liability (see instructions)			938,921		147
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-S240****WORKSHEET E-3
PART II**

Check ☐ Hospital
Applicable ☒ Subprovider IPF
Box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	400,891	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment	2,449	3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	8.042654	9
10	Teaching adjustment factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	403,340	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	403,340	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	403,340	18
19	Deductibles	20,124	19
20	Subtotal (line 18 minus line 19)	383,216	20
21	Coinurance	13,771	21
22	Subtotal (line 20 minus line 21)	369,445	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23
24	Adjusted reimbursable bad debts (see instructions)		24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)	369,445	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	369,445	31
31.01	Sequestration adjustment (see instructions)	7,389	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	362,056	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (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

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-T240****WORKSHEET E-3
PART III**

Check ☐ Hospital
Applicable ☒ Subprovider IRF
Box:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	825,249		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.073400		2
3	Inpatient Rehabilitation LIP payments (see instructions)	92,263		3
4	Outlier payments	64,691		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	8.507109		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	982,203		13
14	Nursing and allied health managed care payments (see instructions)			14
15	Organ acquisition DO NOT USE THIS LINE			15
16	Cost of physicians' services in a teaching hospital (see instructions)			16
17	Subtotal (see instructions)	982,203		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	982,203		19
20	Deductibles			20
21	Subtotal (line 19 minus line 20)	982,203		21
22	Coinsurance	24,120		22
23	Subtotal (line 21 minus line 22)	958,083		23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)			24
25	Adjusted reimbursable bad debts (see instructions)			25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)			26
27	Subtotal (sum of lines 23 and 25)	958,083		27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (For free standing IRF only)			28
29	Other pass through costs (see instructions)			29
30	Outlier payments reconciliation			30
31	Other adjustments (specify) (see instructions)			31
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			31.50
32	Total amount payable to the provider (see instructions)	958,083		32
32.01	Sequestration adjustment (see instructions)	19,162		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	919,107		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	19,814		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	120,709		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)	64,691		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

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0240

WORKSHEET E-3
PART VII

Check ☐ Title V ☒ Hospital ☐ NF ☐ PPS
Applicable ☒ Title XIX ☐ SUB (Other) ☐ ICF/IID ☐ TEFRA
Boxes: ☐ SNF ☒ 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	1,155,982		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	1,155,982		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,155,982		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			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)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге 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)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,155,982		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)			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)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	1,155,982		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			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)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			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)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S240

WORKSHEET E-3
PART VII

Check ☐ Title V ☐ Hospital ☐ NF ☐ PPS
 Applicable ☒ Title XIX ☒ Subprovider IPF ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☒ 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	557,049		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	557,049		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	557,049		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			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)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге 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)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	557,049		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)			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)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	557,049		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			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)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			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)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 01/27/2019	Run Date: 12/03/2019 Run Time: 16:08 Version: 2018.12 (10/24/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T240

WORKSHEET E-3
PART VII

Check ☐ Title V ☐ Hospital ☐ NF ☐ PPS
 Applicable ☒ Title XIX ☒ Subprovider IRF ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☒ 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	185,549		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	185,549		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	185,549		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			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)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге 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)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	185,549		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)			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)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	185,549		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			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)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			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)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	-1,903,584				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	19,617,834				4
5	Other receivables	478,844				5
6	Allowances for uncollectible notes and accounts receivable	-2,430,402				6
7	Inventory	1,938,766				7
8	Prepaid expenses	304,326				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	18,005,784				11
	FIXED ASSETS					
12	Land	9,300,000				12
13	Land improvements	260,000				13
14	Accumulated depreciation					14
15	Buildings	19,617,785				15
16	Accumulated depreciation					16
17	Leasehold improvements	2,300				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	5,273,663				23
24	Accumulated depreciation	-12,787,552				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	288,078				29
30	Total fixed assets (sum of lines 12-29)	21,954,274				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	299,330				34
35	Total other assets (sum of lines 31-34)	299,330				35
36	Total assets (sum of lines 11, 30 and 35)	40,259,388				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	3,384,628				37
38	Salaries, wages and fees payable	5,442,484				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	-314,660				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	106,811				44
45	Total current liabilities (sum of lines 37 thru 44)	8,619,263				45
	LONG TERM LIABILITIES					
46	Mortgage payable	106,016,323				46
47	Notes payable	-42,668				47
48	Unsecured loans					48
49	Other long term liabilities	2,692,167				49
50	Total long term liabilities (sum of lines 46 thru 49)	108,665,822				50
51	Total liabilities (sum of lines 45 and 50)	117,285,085				51
	CAPITAL ACCOUNTS					
52	General fund balance	-77,025,697				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)	-77,025,697				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	40,259,388				60

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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		-62,247,036		1
2	Net income (loss) (from Worksheet G-3, line 29)		-10,990,346		2
3	Total (sum of line 1 and line 2)		-73,237,382		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)		-73,237,382		11
12	Deductions (debit adjustments) (specify)				12
13	CHANGE IN RETAINED EARNINGS	3,723,094			13
14	RECONCILING ITEM	65,221			14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		3,788,315		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-77,025,697		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	CHANGE IN RETAINED EARNINGS				13
14	RECONCILING ITEM				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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	32,742,861		32,742,861	1
2	Subprovider IPF	5,018,851		5,018,851	2
3	Subprovider IRF	2,086,609		2,086,609	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				9
10	Total general inpatient care services (sum of lines 1-9)	39,848,321		39,848,321	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	5,377,913		5,377,913	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)	5,377,913		5,377,913	16
17	Total inpatient routine care services (sum of lines 10 and 16)	45,226,234		45,226,234	17
18	Ancillary services	62,194,508	62,973,999	125,168,507	18
19	Outpatient services	4,712,961	23,742,576	28,455,537	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)	112,133,703	86,716,575	198,850,278	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		40,207,178	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)		40,207,178	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	198,850,278	1
2	Less contractual allowances and discounts on patients' accounts	170,715,026	2
3	Net patient revenues (line 1 minus line 2)	28,135,252	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	40,207,178	4
5	Net income from service to patients (line 3 minus line 4)	-12,071,926	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		14
15	Revenue from rental of living quarters		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		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	6,820	21
22	Rental of hosptial space	421,651	22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	653,109	24
25	Total other income (sum of lines 6-24)	1,081,580	25
26	Total (line 5 plus line 25)	-10,990,346	26
29	Net income (or loss) for the period (line 26 minus line 28)	-10,990,346	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0240

WORKSHEET L

Check ☐ Title V ☒ Hospital ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ SUB (Other) ☐ Cost Method
 Boxes: ☐ Title XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	308,624	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	3,041	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	46.06	3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1002	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4297	8
9	Sum of lines 7 and 8	0.5299	9
10	Allowable disproportionate share percentage (see instructions)	0.1133	10
11	Disproportionate share adjustment (see instructions)	34,967	11
12	Total prospective capital payments (see instructions)	346,632	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	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	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
50.01	GASTRO INTESTINAL SERVICES							50.01
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
56.01	ULTRA SOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	MARKETING							194
194.02	COMMUNITY RELATIONS							194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS							194.04
194.05	POB							194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202