WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S**
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/17/2015 Time: 16:02 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		195,649	-268,588	-15,141		1
2	SUBPROVIDER - IPF		-1	146			2
3	SUBPROVIDER - IRF		-196,851	287			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		-1,203	-268,155	-15,141		200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,
search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence

not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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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 2

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015	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)	N	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.	6,256	1,641			3,251	165	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.	866						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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, 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
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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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 oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

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

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

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

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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 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 a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination 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

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, 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

		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	713,378	5,310	1	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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	Y	HB0557	140

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

141	Name: TENET HEALTHCARE CORP	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		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 transitional factor. (see instructions)	0.75		169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2014	06 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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 Accnountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	C	12/31/2013	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.	Y		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y	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	09/10/2015	Y	09/01/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

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

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

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

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

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

Cost Report Preparer Contact Information				
41	First name: BETH	Last name: SLOAN	Title: DIRECTOR	41
42	Employer: TENET			42
43	Phone number: 6156656064	E-mail Address: BETH.SLOAN@TENETHEALHT.COM		43

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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	121	44,165			5,870	6,415	20,047	1
2	HMO and other (see instructions)						1,837	3,258		2
3	HMO IPF Subprovider						629			3
4	HMO IRF Subprovider						317			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)		121	44,165			5,870	6,415	20,047	7
8	Intensive Care Unit	31	12	4,380			711	366	2,474	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						1,274	1,833	13
14	Total (see instructions)		133	48,545			6,581	8,055	24,354	14
15	CAH Visits									15
16	Subprovider - IPF	40	17	6,205			2,277		4,429	16
17	Subprovider - IRF	41	40	14,600			1,834	866	3,965	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)		190							27
28	Observation Bed Days								1,070	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)								266	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,110	1,612	4,835	1
2	HMO and other (see instructions)					308			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	0.34	465.61			1,110	1,612	4,835	14
15	CAH Visits								15
16	Subprovider - IPF		12.25			171	37	414	16
17	Subprovider - IRF		18.63			135	30	275	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)	0.34	496.49						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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	31,298,989		31,298,989	1,014,323.00	30.86	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21						7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		2,300,223	150,596	2,450,819	72,200.00	33.94	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		589,297		589,297	16,332.00	36.08	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		245,701		245,701	2,155.00	114.01	13
14	Home office salaries & wage-related costs		1,372,160		1,372,160	10,505.00	130.62	14
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		6,034,272		6,034,272			17
18	Wage-related costs (other)(see instructions)		93,281		93,281			18
19	Excluded areas		520,672		520,672			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		267,197	91,646	358,843	9,538.00	37.62	26
27	Administrative & General		5,474,177	-657,860	4,816,317	140,287.00	34.33	27
28	Administrative & General under contract (see instructions)		96,822		96,822	1,870.00	51.78	28
29	Maintenance & Repairs							29
30	Operation of Plant		1,017,793		1,017,793	40,498.00	25.13	30
31	Laundry & Linen Service							31
32	Housekeeping		826,549		826,549	61,522.00	13.44	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		854,047		854,047	55,121.00	15.49	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		694,816		694,816	15,771.00	44.06	38
39	Central Services and Supply		207,438		207,438	10,388.00	19.97	39
40	Pharmacy		934,752	108,237	1,042,989	25,493.00	40.91	40
41	Medical Records & Medical Records Library		200,691	307,381	508,072	22,416.00	22.67	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		31,395,811		31,395,811	1,016,193.00	30.90	1
2	Excluded area salaries (see instructions)		2,300,223	150,596	2,450,819	72,200.00	33.94	2
3	Subtotal salarles (line 1 minus line 2)		29,095,588	-150,596	28,944,992	943,993.00	30.66	3
4	Subtotal other wages & related costs (see instructions)		2,207,158		2,207,158	28,992.00	76.13	4
5	Subtotal wage-related costs (see instructions)		6,127,553		6,127,553		21.17%	5
6	Total (sum of lines 3 through 5)		37,430,299	-150,596	37,279,703	972,985.00	38.31	6
7	Total overhead cost (see instructions)		10,574,282	-150,596	10,423,686	382,904.00	27.22	7

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

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	347,242	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)	2,130,277	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	1,971	10
11	Life Insurance (If employee is owner or beneficiary)	44,009	11
12	Accident Insurance (If employee is owner or beneficiary)	31	12
13	Disability Insurance (If employee is owner or beneficiary)	36,606	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	485,192	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	1,893,016	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	1,001,926	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	94,002	22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	6,034,272	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTS (FRINGE B	93,281	25

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

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

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

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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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			1
2	Hospital			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

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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)	0.183880	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	11,954,466	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 or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	6,057,818	5
6	Medicaid charges	129,777,473	6
7	Medicaid cost (line 1 times line 6)	23,863,482	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.	5,851,198	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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig 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)	5,851,198	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	4,163,991	103,408	4,267,399	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	765,675	19,015	784,690	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	765,675	19,015	784,690	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, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	5,820,774	26
27	Medicare bad debts for the entire hospital complex (see instructions)	611,424	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,209,350	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	957,895	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,742,585	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,593,783	31

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				4,135,586	4,135,586	364,916	4,500,502	1
2	00200	Cap Rel Costs-Mvble Equip				-617,573	-617,573	5,230,861	4,613,288	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	267,197	6,568,358	6,835,555	114,017	6,949,572	-1,048,080	5,901,492	4
5	00500	Administrative & General	5,474,177	10,797,377	16,271,554	-4,125,863	12,145,691	-1,956,545	10,189,146	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,017,793	3,955,486	4,973,279	-66,807	4,906,472		4,906,472	7
8	00800	Laundry & Linen Service		387,274	387,274	66,424	453,698		453,698	8
9	00900	Housekeeping	826,549	340,349	1,166,898	-838	1,166,060		1,166,060	9
10	01000	Dietary	854,047	405,825	1,259,872	-3,400	1,256,472	-140,886	1,115,586	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	694,816	11,935	706,751	-1,407	705,344	-2,500	702,844	13
14	01400	Central Services & Supply	207,438	267,081	474,519	3,756	478,275	-18,284	459,991	14
15	01500	Pharmacy	934,752	2,101,532	3,036,284	-1,349,045	1,687,239	-703,673	983,566	15
16	01600	Medical Records & Library	200,691	162,124	362,815	416,074	778,889	-9,725	769,164	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd		1,138	1,138		1,138		1,138	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	6,710,574	777,184	7,487,758	-868,729	6,619,029	-494,457	6,124,572	30
31	03100	Intensive Care Unit	1,504,447	209,720	1,714,167	-88,457	1,625,710	-5,000	1,620,710	31
40	04000	Subprovider - IPF	776,639	82,432	859,071	-8,620	850,451	-27,197	823,254	40
41	04100	Subprovider - IRF	1,202,530	172,974	1,375,504	-32,171	1,343,333	-44,307	1,299,026	41
43	04300	Nursery	347,627	481,548	829,175	529,321	1,358,496	-448,887	909,609	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,076,118	3,427,130	5,503,248	-2,427,477	3,075,771	-111,618	2,964,153	50
50.01	03340	GASTRO INTESTINAL SERVICES	206,711	89,702	296,413	-30,574	265,839		265,839	50.01
51	05100	Recovery Room	389,526	12,631	402,157	-6,784	395,373		395,373	51
52	05200	Delivery Room & Labor Room	1,172,180	892,948	2,065,128	-318	2,064,810	-808,244	1,256,566	52
53	05300	Anesthesiology	92,855	403,118	495,973	-116,477	379,496	-262,207	117,289	53
54	05400	Radiology-Diagnostic	916,238	110,522	1,026,760	-32,810	993,950	-2,907	991,043	54
56	05600	Radioisotope	117,127	206,023	323,150	-27,042	296,108		296,108	56
56.01	03630	ULTRA SOUND	431,277	12,830	444,107	-4,856	439,251	-2,987	436,264	56.01
57	05700	CT Scan	158,592	54,712	213,304	-30,692	182,612	-4,333	178,279	57
58	05800	MRI	130,901	16,373	147,274	-2,198	145,076	-310	144,766	58
59	05900	Cardiac Catheterization	399,071	737,864	1,136,935	-570,898	566,037	-163,649	402,388	59
60	06000	Laboratory	56,960	1,964,807	2,021,767	263	2,022,030	-9,238	2,012,792	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.		108,150	108,150	-1,638	106,512	-2,870	103,642	63
65	06500	Respiratory Therapy	623,821	134,852	758,673	-86,453	672,220	-95,036	577,184	65
66	06600	Physical Therapy	663,943	70,406	734,349	-3,598	730,751	-55,234	675,517	66
67	06700	Occupational Therapy	367,493	66,276	433,769	-401	433,368		433,368	67
68	06800	Speech Pathology	115,620	1,380	117,000		117,000	-618	116,382	68
69	06900	Electrocardiology	208,366	33,108	241,474	-3,888	237,586	-18,700	218,886	69
70	07000	Electroencephalography	12,515	12,134	24,649		24,649	-11,920	12,729	70
71	07100	Medical Supplies Charged to Patients				1,855,082	1,855,082		1,855,082	71
72	07200	Impl. Dev. Charged to Patients				1,747,868	1,747,868		1,747,868	72
73	07300	Drugs Charged to Patients				1,602,275	1,602,275		1,602,275	73
74	07400	Renal Dialysis		263,190	263,190	-2,775	260,415		260,415	74
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	1,819,344	1,293,229	3,112,573	-183,874	2,928,699	-970,379	1,958,320	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	30,977,935	36,633,722	67,611,657	-224,997	67,386,660	-1,824,014	65,562,646	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		13,060	13,060		13,060	-2,235	10,825	190

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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	
192	19200	Physicians' Private Offices								192
194	07950	MARKETING	100,935	139,257	240,192	171,987	412,179		412,179	194
194.02	07952	COMMUNITY RELATIONS	144,467	11,391	155,858	-505	155,353		155,353	194.02
194.03	07953	SENIOR CENTER		40,658	40,658		40,658		40,658	194.03
194.04	07954	PHYSICIAN CLINICS				67,204	67,204		67,204	194.04
194.05	07955	POB		298,763	298,763	-13,689	285,074		285,074	194.05
194.06	07956	TRITON HLTH CAREER SCHOLARSHIP PROG	75,652	72	75,724		75,724		75,724	194.06
194.07	07957	GUEST TRAYS & CATERING MEALS								194.07
194.08	07958	HOSPICE								194.08
200		TOTAL (sum of lines 118-199)	31,298,989	37,136,923	68,435,912		68,435,912	-1,826,249	66,609,663	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRECIATION	A	Cap Rel Costs-Bldg & Fixt	1		2,720,263	1
2	DEPRECIATION	A					2
500	Total reclassifications					2,720,263	500
	Code Letter - A						
1	RENTS	B	Cap Rel Costs-Bldg & Fixt	1		225,029	1
2	RENTS	B	Cap Rel Costs-Mvble Equip	2		274,254	2
3	RENTS	B					3
4	RENTS	B					4
5	RENTS	B					5
6	RENTS	B					6
7	RENTS	B					7
8	RENTS	B					8
9	RENTS	B					9
10	RENTS	B					10
11	RENTS	B					11
12	RENTS	B					12
13	RENTS	B					13
14	RENTS	B					14
15	RENTS	B					15
16	RENTS	B					16
17	RENTS	B					17
18	RENTS	B					18
19	RENTS	B	Laboratory	60		263	19
20	RENTS	B					20
21	RENTS	B					21
22	RENTS	B					22
23	RENTS	B					23
24	RENTS	B					24
25	RENTS	B					25
26	RENTS	B					26
27	RENTS	B					27
500	Total reclassifications					499,546	500
	Code Letter - B						
1	PROPERTY TAXES	C	Cap Rel Costs-Bldg & Fixt	1		1,190,294	1
500	Total reclassifications					1,190,294	500
	Code Letter - C						
1	CHARGEABLE DRUGS	D	Drugs Charged to Patients	73		1,602,275	1
2	CHARGEABLE DRUGS	D					2
3	CHARGEABLE DRUGS	D					3
4	CHARGEABLE DRUGS	D					4
5	CHARGEABLE DRUGS	D					5
6	CHARGEABLE DRUGS	D					6
7	CHARGEABLE DRUGS	D					7
8	CHARGEABLE DRUGS	D					8
9	CHARGEABLE DRUGS	D					9
10	CHARGEABLE DRUGS	D					10
11	CHARGEABLE DRUGS	D					11
12	CHARGEABLE DRUGS	D					12
13	CHARGEABLE DRUGS	D					13
14	CHARGEABLE DRUGS	D					14
15	CHARGEABLE DRUGS	D					15
16	CHARGEABLE DRUGS	D					16
17	CHARGEABLE DRUGS	D					17
18	CHARGEABLE DRUGS	D					18
19	CHARGEABLE DRUGS	D					19
20	CHARGEABLE DRUGS	D					20
21	CHARGEABLE DRUGS	D					21
22	CHARGEABLE DRUGS	D					22
23	CHARGEABLE DRUGS	D					23
24	CHARGEABLE DRUGS	D					24
25	CHARGEABLE DRUGS	D					25
26	CHARGEABLE DRUGS	D					26
27	CHARGEABLE DRUGS	D					27
500	Total reclassifications					1,602,275	500
	Code Letter - D						
1	LINEN	E	Laundry & Linen Service	8		66,424	1

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
2	LINEN	E					2
3	LINEN	E					3
4	LINEN	E					4
5	LINEN	E					5
6	LINEN	E					6
7	LINEN	E					7
8	LINEN	E					8
9	LINEN	E					9
10	LINEN	E					10
11	LINEN	E					11
12	LINEN	E					12
13	LINEN	E					13
14	LINEN	E					14
15	LINEN	E					15
16	LINEN	E					16
17	LINEN	E					17
500	Total reclassifications					66,424	500
	Code Letter - E						
1	CHARGEABLE MEDICAL SUPPLIES	F	Medical Supplies Charged to P	71		1,855,082	1
2	CHARGEABLE MEDICAL SUPPLIES	F	Central Services & Supply	14		39,719	2
3	CHARGEABLE MEDICAL SUPPLIES	F					3
4	CHARGEABLE MEDICAL SUPPLIES	F					4
5	CHARGEABLE MEDICAL SUPPLIES	F					5
6	CHARGEABLE MEDICAL SUPPLIES	F					6
7	CHARGEABLE MEDICAL SUPPLIES	F					7
8	CHARGEABLE MEDICAL SUPPLIES	F					8
9	CHARGEABLE MEDICAL SUPPLIES	F					9
10	CHARGEABLE MEDICAL SUPPLIES	F					10
11	CHARGEABLE MEDICAL SUPPLIES	F					11
12	CHARGEABLE MEDICAL SUPPLIES	F					12
13	CHARGEABLE MEDICAL SUPPLIES	F					13
14	CHARGEABLE MEDICAL SUPPLIES	F					14
15	CHARGEABLE MEDICAL SUPPLIES	F					15
16	CHARGEABLE MEDICAL SUPPLIES	F					16
17	CHARGEABLE MEDICAL SUPPLIES	F					17
18	CHARGEABLE MEDICAL SUPPLIES	F					18
19	CHARGEABLE MEDICAL SUPPLIES	F					19
20	CHARGEABLE MEDICAL SUPPLIES	F					20
21	CHARGEABLE MEDICAL SUPPLIES	F					21
22	CHARGEABLE MEDICAL SUPPLIES	F					22
23	CHARGEABLE MEDICAL SUPPLIES	F					23
24	CHARGEABLE MEDICAL SUPPLIES	F					24
25	CHARGEABLE MEDICAL SUPPLIES	F					25
26	CHARGEABLE MEDICAL SUPPLIES	F					26
27	CHARGEABLE MEDICAL SUPPLIES	F					27
500	Total reclassifications					1,894,801	500
	Code Letter - F						
1	IMPLANTABLE DEVICE	G	Impl. Dev. Charged to Patient	72		1,747,868	1
2	IMPLANTABLE DEVICE	G	Housekeeping	9		447	2
3	IMPLANTABLE DEVICE	G					3
4	IMPLANTABLE DEVICE	G					4
5	IMPLANTABLE DEVICE	G					5
6	IMPLANTABLE DEVICE	G					6
500	Total reclassifications					1,748,315	500
	Code Letter - G						
1	NURSERY	H	Nursery	43	472,997	91,902	1
500	Total reclassifications				472,997	91,902	500
	Code Letter - H						
1	HOSPITAL SPACE IN POB	I	Employee Benefits Department	4		2,422	1
2	HOSPITAL SPACE IN POB	I	Radiology-Diagnostic	54		11,267	2
500	Total reclassifications					13,689	500
	Code Letter - I						
1	REGIONAL COSTS	J	Employee Benefits Department	4	91,646	22,078	1
2	REGIONAL COSTS	J	Pharmacy	15	108,237	4,314	2
3	REGIONAL COSTS	J	Medical Records & Library	16	307,381	112,358	3

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
4	REGIONAL COSTS	J	MARKETING	194	87,985	84,002	4
5	REGIONAL COSTS	J	PHYSICIAN CLINICS	194.04	62,611	4,593	5
500	Total reclassifications				657,860	227,345	500
	Code Letter - J						
	GRAND TOTAL (Increases)				1,130,857	10,054,854	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION	A	Administrative & General	5		1,828,436	9	1
2	DEPRECIATION	A	Cap Rel Costs-Mvble Equip	2		891,827	9	2
500	Total reclassifications					2,720,263		500
	Code letter - A							
1	RENTS	B	Employee Benefits Department	4		1,897	10	1
2	RENTS	B	Administrative & General	5		215,270	10	2
3	RENTS	B	Operation of Plant	7		66,169		3
4	RENTS	B	Dietary	10		1,846		4
5	RENTS	B	Nursing Administration	13		1,387		5
6	RENTS	B	Central Services & Supply	14		35,572		6
7	RENTS	B	Pharmacy	15		1,160		7
8	RENTS	B	Medical Records & Library	16		3,665		8
9	RENTS	B	Adults & Pediatrics	30		1,387		9
10	RENTS	B	Intensive Care Unit	31		387		10
11	RENTS	B	Subprovider - IPF	40		387		11
12	RENTS	B	Subprovider - IRF	41		574		12
13	RENTS	B	Operating Room	50		23,869		13
14	RENTS	B	GASTRO INTESTINAL SERVICES	50.01		299		14
15	RENTS	B	Recovery Room	51		387		15
16	RENTS	B	Anesthesiology	53		68,410		16
17	RENTS	B	Radiology-Diagnostic	54		39,103		17
18	RENTS	B	Cardiac Catheterization	59		387		18
19	RENTS	B						19
20	RENTS	B	Blood Storing, Processing & T	63		387		20
21	RENTS	B	Respiratory Therapy	65		31,907		21
22	RENTS	B	Physical Therapy	66		387		22
23	RENTS	B	Occupational Therapy	67		387		23
24	RENTS	B	Electrocardiology	69		387		24
25	RENTS	B	Renal Dialysis	74		2,775		25
26	RENTS	B	Emergency	91		1,160		26
27	RENTS	B						27
500	Total reclassifications					499,546		500
	Code letter - B							
1	PROPERTY TAXES	C	Administrative & General	5		1,190,294	13	1
500	Total reclassifications					1,190,294		500
	Code letter - C							
1	CHARGEABLE DRUGS	D	Employee Benefits Department	4		74		1
2	CHARGEABLE DRUGS	D	Administrative & General	5		3,973		2
3	CHARGEABLE DRUGS	D	Operation of Plant	7		39		3
4	CHARGEABLE DRUGS	D	Dietary	10		383		4
5	CHARGEABLE DRUGS	D	Central Services & Supply	14		391		5
6	CHARGEABLE DRUGS	D	Pharmacy	15		1,432,104		6
7	CHARGEABLE DRUGS	D	Adults & Pediatrics	30		28,670		7
8	CHARGEABLE DRUGS	D	Intensive Care Unit	31		12,478		8
9	CHARGEABLE DRUGS	D	Subprovider - IPF	40		1,427		9
10	CHARGEABLE DRUGS	D	Subprovider - IRF	41		1,156		10
11	CHARGEABLE DRUGS	D	Nursery	43		367		11
12	CHARGEABLE DRUGS	D	Operating Room	50		20,088		12
13	CHARGEABLE DRUGS	D	GASTRO INTESTINAL SERVICES	50.01		2,827		13
14	CHARGEABLE DRUGS	D	Recovery Room	51		144		14
15	CHARGEABLE DRUGS	D	Delivery Room & Labor Room	52		318		15
16	CHARGEABLE DRUGS	D	Anesthesiology	53		10,454		16
17	CHARGEABLE DRUGS	D	Radiology-Diagnostic	54		300		17
18	CHARGEABLE DRUGS	D	Radioisotope	56		26,521		18
19	CHARGEABLE DRUGS	D	ULTRA SOUND	56.01		728		19
20	CHARGEABLE DRUGS	D	CT Scan	57		4,085		20
21	CHARGEABLE DRUGS	D	MRI	58		1,224		21
22	CHARGEABLE DRUGS	D	Cardiac Catheterization	59		3,133		22
23	CHARGEABLE DRUGS	D	Blood Storing, Processing & T	63		1,251		23
24	CHARGEABLE DRUGS	D	Respiratory Therapy	65		213		24
25	CHARGEABLE DRUGS	D	Electrocardiology	69		122		25
26	CHARGEABLE DRUGS	D	Emergency	91		49,300		26
27	CHARGEABLE DRUGS	D	COMMUNITY RELATIONS	194.02		505		27
500	Total reclassifications					1,602,275		500
	Code letter - D							

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	LINEN	E	Administrative & General	5		90		1
2	LINEN	E	Pharmacy	15		234		2
3	LINEN	E	Adults & Pediatrics	30		10,254		3
4	LINEN	E	Intensive Care Unit	31		594		4
5	LINEN	E	Subprovider - IPF	40		1,533		5
6	LINEN	E	Subprovider - IRF	41		680		6
7	LINEN	E	Operating Room	50		45,920		7
8	LINEN	E	GASTRO INTESTINAL SERVICES	50.01		6		8
9	LINEN	E	Anesthesiology	53		2,341		9
10	LINEN	E	Radiology-Diagnostic	54		407		10
11	LINEN	E	Radioisotope	56		12		11
12	LINEN	E						12
13	LINEN	E						13
14	LINEN	E	Cardiac Catheterization	59		2,447		14
15	LINEN	E						15
16	LINEN	E	Electrocardiology	69		19		16
17	LINEN	E	Emergency	91		1,887		17
500	Total reclassifications					66,424		500
	Code letter - E							
1	CHARGEABLE MEDICAL SUPPLIES	F	Employee Benefits Department	4		158		1
2	CHARGEABLE MEDICAL SUPPLIES	F	Administrative & General	5		2,445		2
3	CHARGEABLE MEDICAL SUPPLIES	F	Operation of Plant	7		3		3
4	CHARGEABLE MEDICAL SUPPLIES	F	Housekeeping	9		1,285		4
5	CHARGEABLE MEDICAL SUPPLIES	F	Dietary	10		9		5
6	CHARGEABLE MEDICAL SUPPLIES	F	Nursing Administration	13		20		6
7	CHARGEABLE MEDICAL SUPPLIES	F	Pharmacy	15		28,098		7
8	CHARGEABLE MEDICAL SUPPLIES	F	Adults & Pediatrics	30		263,519		8
9	CHARGEABLE MEDICAL SUPPLIES	F	Intensive Care Unit	31		74,998		9
10	CHARGEABLE MEDICAL SUPPLIES	F	Subprovider - IPF	40		5,273		10
11	CHARGEABLE MEDICAL SUPPLIES	F	Subprovider - IRF	41		29,761		11
12	CHARGEABLE MEDICAL SUPPLIES	F	Nursery	43		35,211		12
13	CHARGEABLE MEDICAL SUPPLIES	F	Operating Room	50		957,477		13
14	CHARGEABLE MEDICAL SUPPLIES	F	GASTRO INTESTINAL SERVICES	50.01		26,389		14
15	CHARGEABLE MEDICAL SUPPLIES	F	Recovery Room	51		6,253		15
16	CHARGEABLE MEDICAL SUPPLIES	F	Anesthesiology	53		35,272		16
17	CHARGEABLE MEDICAL SUPPLIES	F	Radiology-Diagnostic	54		4,267		17
18	CHARGEABLE MEDICAL SUPPLIES	F	Radioisotope	56		509		18
19	CHARGEABLE MEDICAL SUPPLIES	F	ULTRA SOUND	56.01		4,128		19
20	CHARGEABLE MEDICAL SUPPLIES	F	CT Scan	57		26,607		20
21	CHARGEABLE MEDICAL SUPPLIES	F	MRI	58		974		21
22	CHARGEABLE MEDICAL SUPPLIES	F	Cardiac Catheterization	59		199,700		22
23	CHARGEABLE MEDICAL SUPPLIES	F	Respiratory Therapy	65		54,333		23
24	CHARGEABLE MEDICAL SUPPLIES	F	Physical Therapy	66		3,211		24
25	CHARGEABLE MEDICAL SUPPLIES	F	Occupational Therapy	67		14		25
26	CHARGEABLE MEDICAL SUPPLIES	F	Electrocardiology	69		3,360		26
27	CHARGEABLE MEDICAL SUPPLIES	F	Emergency	91		131,527		27
500	Total reclassifications					1,894,801		500
	Code letter - F							
1	IMPLANTABLE DEVICE	G	Administrative & General	5		150		1
2	IMPLANTABLE DEVICE	G	Operation of Plant	7		596		2
3	IMPLANTABLE DEVICE	G	Dietary	10		1,162		3
4	IMPLANTABLE DEVICE	G	Operating Room	50		1,380,123		4
5	IMPLANTABLE DEVICE	G	GASTRO INTESTINAL SERVICES	50.01		1,053		5
6	IMPLANTABLE DEVICE	G	Cardiac Catheterization	59		365,231		6
500	Total reclassifications					1,748,315		500
	Code letter - G							
1	NURSERY	H	Adults & Pediatrics	30	472,997	91,902		1
500	Total reclassifications				472,997	91,902		500
	Code letter - H							
1	HOSPITAL SPACE IN POB	I	POB	194.05		13,689		1
2	HOSPITAL SPACE IN POB	I						2
500	Total reclassifications					13,689		500
	Code letter - I							
1	REGIONAL COSTS	J	Administrative & General	5	657,860	227,345		1

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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	
2	REGIONAL COSTS	J						2
3	REGIONAL COSTS	J						3
4	REGIONAL COSTS	J						4
5	REGIONAL COSTS	J						5
500	Total reclassifications				657,860	227,345		500
	Code letter - J							
	GRAND TOTAL (Decreases)				1,130,857	10,054,854		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	4,187,868					4,187,868		1
2	Land Improvements	4,893,624					4,893,624		2
3	Buildings and Fixtures	66,106,726					66,106,726		3
4	Building Improvements	6,039,774					6,039,774		4
5	Fixed Equipment	4,124,706					4,124,706		5
6	Movable Equipment	73,677,100	258,972		258,972	2,136	73,933,936		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	159,029,798	258,972		258,972	2,136	159,286,634		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	159,029,798	258,972		258,972	2,136	159,286,634		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								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

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	77,040,124		77,040,124	0.496717					1
2	Cap Rel Costs-Mvble Equ	78,058,642		78,058,642	0.503283					2
3	Total (sum of lines 1-2)	155,098,766		155,098,766	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	2,006,155	225,029	663,887		1,605,431		4,500,502	1
2	Cap Rel Costs-Mvble Equip	4,339,034	274,254					4,613,288	2
3	Total (sum of lines 1-2)	6,345,189	499,283	663,887		1,605,431		9,113,790	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.)

				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	-3,951,348				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-785,605				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-135,611	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	-9,725	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-5,275	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	-714,108	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	5,283,221	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	-38,923	Administrative & General	5		33
33.01	PBX SALARY	A	-23,344	Administrative & General	5		33.01
33.02	PBX BENEFITS	A	-19,590	Employee Benefits Department	4		33.02
33.03	TELEVISION CABLE/SATELITE & DEPREC	A	-52,360	Cap Rel Costs-Mvble Equip	2	9	33.03
33.04	EMPLOYEE BADGES	B	-321	Employee Benefits Department	4		33.04
33.05	GREAT WEST LIFE	B	-7,870	Employee Benefits Department	4		33.05
33.06	ADMIN SVCS	B	-6,031	Administrative & General	5		33.06
33.07	RUSH UNIV STUDENTS	B	-20,000	Administrative & General	5		33.07
33.08	PENALTY PAYMENTS	B	323	Administrative & General	5		33.08
33.09	GRANT REVENUE	B	-92,867	Administrative & General	5		33.09
33.10	SEASON HOSPICE	B	-2,500	Nursing Administration	13		33.10
33.11	SEASON HOSPICE	B	-18,284	Central Services & Supply	14		33.11
33.12	RENTAL INCOME	B	-449,603	Adults & Pediatrics	30		33.12
33.13	VENDING MACHINE	B	-4,117	Operating Room	50		33.13
33.14	BARIATRIC PHONE LINE	B	-10,097	Operating Room	50		33.14
33.15	SEASON HOSPICE	B	-2,268	Radiology-Diagnostic	54		33.15
33.16	SEASON HOSPICE	B	-2,987	ULTRA SOUND	56.01		33.16
33.17	SEASON HOSPICE	B	-3,207	CT Scan	57		33.17
33.18	SEASON HOSPICE	B	-38,486	Cardiac Catheterization	59		33.18
33.19	SEASON HOSPICE	B	-9,238	Laboratory	60		33.19
33.20	SEASON HOSPICE	B	-2,870	Blood Storing, Processing & Trans.	63		33.20
33.21	SEASON HOSPICE	B	-72,254	Respiratory Therapy	65		33.21
33.22	SEASON HOSPICE	B	-375	Physical Therapy	66		33.22
33.25	FITNESS CENTER REVENUE	B	-54,560	Physical Therapy	66		33.25
33.26	SEASON HOSPICE	B	-618	Speech Pathology	68		33.26

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	
33.27	SEASON HOSPICE	B	-821	Emergency	91		33.27
33.29	ADVERTISING	A	-5,657	Administrative & General	5		33.29
33.30	ADVERTISING	A	-548	Radiology-Diagnostic	54		33.30
33.31	ADVERTISING	A	-310	MRI	58		33.31
33.32	ADVERTISING	A	-165	Respiratory Therapy	65		33.32
33.33	OTHER EXPENSE	A	-655	Administrative & General	5		33.33
33.34	OTHER EXPENSE	A	-950	Adults & Pediatrics	30		33.34
33.35	OTHER EXPENSE	A	-213	Subprovider - IRF	41		33.35
33.36	OTHER EXPENSE	A	-91	Radiology-Diagnostic	54		33.36
33.37	OTHER EXPENSE	A	-299	Physical Therapy	66		33.37
33.38	OTHER EXPENSE	A	-2,235	Gift, Flower, Coffee Shop & Canteen	190		33.38
33.42	PURCHASED SVCS	A	-56,109	Administrative & General	5		33.42
33.47	PHYSICIAN INCENTIVE	A	-600	Administrative & General	5		33.47
33.48	PHYSICIAN RELOCATION	A	-2,162	Administrative & General	5		33.48
33.49	TRAVEL	A	-35	Administrative & General	5		33.49
33.51	MEALS	A	-1,442	Administrative & General	5		33.51
33.52	MEALS	A	-24	Subprovider - IRF	41		33.52
33.54	PROPERTY TAXES	A	415,137	Cap Rel Costs-Bldg & Fixt	1	13	33.54
33.55	DONATIONS/CONTRIBUTIONS	A	-9,085	Administrative & General	5		33.55
33.56	DUES & SUBSCRIPTION	A	-21,484	Administrative & General	5		33.56
33.57	DUES & SUBSCRIPTION	A	-1,920	Operating Room	50		33.57
33.59	LOBBYING	A	-48,367	Administrative & General	5		33.59
33.60	PATIENT TRANSPORTATION	A	-422	Administrative & General	5		33.60
33.61	LEGAL	A	-50,738	Administrative & General	5		33.61
33.62	IDPA TAX ASSESSMENT	A	-7,306	Administrative & General	5		33.62
33.63	PENALTIES & FINES	A	-1,143	Administrative & General	5		33.63
33.64	PATIENT TRANSPORTATION	A	-289	Subprovider - IRF	41		33.64
34	STUDENT SERVICES	A	-73,745	Administrative & General	5		34
35	SEASON HOSPICE	A	-703,673	Pharmacy	15		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)		-1,826,249				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	AUTO INSURANCE		409	-409		1
2	5	Administrative & General	PROPERTY INSURANCE		26,601	-26,601		2
3	5	Administrative & General	MALPRACTICE INSURANCE		1,443,376	-1,443,376		3
3.01	50	Operating Room	MALPRACTICE INSURANCE		28,710	-28,710		3.01
3.02	69	Electrocardiology	MALPRACTICE INSURANCE		-7,670	7,670		3.02
3.03	4	Employee Benefits Department	WORKERS COMP		526,420	-526,420		3.03
3.04	5	Administrative & General	INTEREST EXPENSE		2,081,814	-2,081,814		3.04
3.05	4	Employee Benefits Department	CORPORATE ALLOCATION		493,879	-493,879		3.05
3.06	1	Cap Rel Costs-Bldg & Fixt	DIRECT ALLOC - CAPITAL	399,573		399,573	11	3.06
3.07	1	Cap Rel Costs-Bldg & Fixt	POOLED ALLOC - INT EXP	264,314		264,314	11	3.07
3.08	5	Administrative & General	POOLED ALLOCATION NONCAP	3,144,047		3,144,047		3.08
3.09	60	Laboratory	GENESIS LAB	1,594,410	1,594,410			3.09
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			5,402,344	6,187,949	-785,605		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		HEALTHCARE	6
7	G			GENESIS LAB		LAB	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:

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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	1,127,074	1,088,600	38,474	177,200	521	44,385	2,219	1
2	7	Operation of Plant OPERATION OF PL								2
3	30	Adults & Pediatrics ADULTS & PEDIAT	60,499	26,899	33,600	154,100	224	16,595	830	3
4	31	Intensive Care Unit INTENSIVE CARE	15,000	5,000	10,000	177,200	123	10,479	524	4
5	40	Subprovider - IPF SUBPROVIDER - I	43,200	10,800	32,400	154,100	216	16,003	800	5
6	41	Subprovider - IRF SUBPROVIDER - I	101,967	35,000	66,967	177,200	683	58,186	2,909	6
7	43	Nursery NURSERY	448,887	448,887						7
8	50	Operating Room OPERATING ROOM	83,674	49,414	34,260	208,000	169	16,900	845	8
9	52	Delivery Room & Labo LABOR ROOM & DE	808,244	808,244						9
10	53	Anesthesiology ANESTHESIOLOGY	262,207	262,207						10
11	59	Cardiac Catheterizat CARDIAC CATHETE	133,767	113,767	20,000	177,200	101	8,604	430	11
12	65	Respiratory Therapy RESPIRATORY THE	32,617	22,617	10,000	177,200	118	10,053	503	12
13	69	Electrocardiology ELECTRO CARDIOL	26,370	26,370						13
14	70	Electroencephalograp ELECTROENCEPHAL	11,920	11,920						14
15	91	Emergency EMERGENCY	969,558	969,558						15
16	57	CT Scan MED SPECIALIST	1,126	1,126						16
17										17
18										18
19										19
20										20
200		TOTAL	4,126,110	3,880,409	245,701		2,155	181,205	9,060	200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen ADMINISTRATIVE					44,385		1,088,600	1
2	7	Operation of Plant OPERATION OF PL								2
3	30	Adults & Pediatrics ADULTS & PEDIAT					16,595	17,005	43,904	3
4	31	Intensive Care Unit INTENSIVE CARE					10,479		5,000	4
5	40	Subprovider - IPF SUBPROVIDER - I					16,003	16,397	27,197	5
6	41	Subprovider - IRF SUBPROVIDER - I					58,186	8,781	43,781	6
7	43	Nursery NURSERY							448,887	7
8	50	Operating Room OPERATING ROOM					16,900	17,360	66,774	8
9	52	Delivery Room & Labo LABOR ROOM & DE							808,244	9
10	53	Anesthesiology ANESTHESIOLOGY							262,207	10
11	59	Cardiac Catheterizat CARDIAC CATHETE					8,604	11,396	125,163	11
12	65	Respiratory Therapy RESPIRATORY THE					10,053		22,617	12
13	69	Electrocardiology ELECTRO CARDIOL							26,370	13
14	70	Electroencephalograp ELECTROENCEPHAL							11,920	14
15	91	Emergency EMERGENCY							969,558	15
16	57	CT Scan MED SPECIALIST							1,126	16
17										17
18										18
19										19
20										20
200		TOTAL					181,205	70,939	3,951,348	200

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	4,500,502	4,500,502					1
2	Cap Rel Costs-Mvble Equip	4,613,288		4,613,288				2
4	Employee Benefits Department	5,901,492			5,901,492			4
5	Administrative & General	10,189,146	295,413	302,817	918,659	11,706,035	11,706,035	5
6	Maintenance & Repairs							6
7	Operation of Plant	4,906,472	612,130	627,471	194,133	6,340,206	1,351,802	7
8	Laundry & Linen Service	453,698	24,210	24,817		502,725	107,186	8
9	Housekeeping	1,166,060	39,249	40,233	157,655	1,403,197	299,177	9
10	Dietary	1,115,586	154,528	158,401	162,900	1,591,415	339,307	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	702,844	21,840	22,387	132,529	879,600	187,540	13
14	Central Services & Supply	459,991	29,881	30,630	39,567	560,069	119,413	14
15	Pharmacy	983,566	29,105	29,835	198,939	1,241,445	264,690	15
16	Medical Records & Library	769,164	46,219	47,377	96,909	959,669	204,612	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	1,138				1,138	243	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,124,572	336,511	344,944	1,189,750	7,995,777	1,704,763	30
31	Intensive Care Unit	1,620,710	97,869	100,322	286,957	2,105,858	448,992	31
40	Subprovider - IPF	823,254	84,015	86,120	148,135	1,141,524	243,385	40
41	Subprovider - IRF	1,299,026	180,628	185,155	229,369	1,894,178	403,860	41
43	Nursery	909,609	71,190	72,975	156,525	1,210,299	258,049	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,964,153	180,727	185,256	395,997	3,726,133	794,453	50
50.01	GASTRO INTESTINAL SERVICES	265,839	26,524	27,188	39,428	358,979	76,538	50.01
51	Recovery Room	395,373	19,469	19,957	74,298	509,097	108,545	51
52	Delivery Room & Labor Room	1,256,566	178,583	183,058	223,580	1,841,787	392,689	52
53	Anesthesiology	117,289	5,615	5,756	17,711	146,371	31,208	53
54	Radiology-Diagnostic	991,043	147,135	150,823	174,762	1,463,763	312,090	54
56	Radioisotope	296,108	10,934	11,208	22,341	340,591	72,618	56
56.01	ULTRA SOUND	436,264	8,324	8,532	82,261	535,381	114,149	56.01
57	CT Scan	178,279	11,710	12,003	30,250	232,242	49,517	57
58	MRI	144,766	10,680	10,948	24,968	191,362	40,800	58
59	Cardiac Catheterization	402,388	49,224	50,457	76,118	578,187	123,276	59
60	Laboratory	2,012,792	93,905	96,258	10,864	2,213,819	472,011	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	103,642	3,908	4,006		111,556	23,785	63
65	Respiratory Therapy	577,184	8,380	8,590	118,987	713,141	152,050	65
66	Physical Therapy	675,517	82,477	84,544	126,640	969,178	206,639	66
67	Occupational Therapy	433,368			70,095	503,463	107,344	67
68	Speech Pathology	116,382	6,603	6,768	22,053	151,806	32,367	68
69	Electrocardiology	218,886	29,077	29,806	39,744	317,513	67,697	69
70	Electroencephalography	12,729			2,387	15,116	3,223	70
71	Medical Supplies Charged to Patients	1,855,082				1,855,082	395,524	71
72	Impl. Dev. Charged to Patients	1,747,868				1,747,868	372,665	72
73	Drugs Charged to Patients	1,602,275				1,602,275	341,623	73
74	Renal Dialysis	260,415				260,415	55,523	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	1,958,320	155,854	159,760	347,020	2,620,954	558,816	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	65,562,646	3,051,917	3,128,402	5,811,531	62,539,214	10,838,169	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	10,825	2,610	2,675		16,110	3,435	190
192	Physicians' Private Offices							192
194	MARKETING	412,179	8,282	8,489	36,034	464,984	99,140	194

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	
194.02	COMMUNITY RELATIONS	155,353	7,096	7,274	27,555	197,278	42,062	194.02
194.03	SENIOR CENTER	40,658				40,658	8,669	194.03
194.04	PHYSICIAN CLINICS	67,204	17,720	18,164	11,942	115,030	24,526	194.04
194.05	POB	285,074	1,313,315	1,346,227		2,944,616	627,825	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG	75,724			14,430	90,154	19,222	194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE		99,562	102,057		201,619	42,987	194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	66,609,663	4,500,502	4,613,288	5,901,492	66,609,663	11,706,035	202

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
6	Maintenance & Repairs							6
7	Operation of Plant	7,692,008						7
8	Laundry & Linen Service	51,830	661,741					8
9	Housekeeping	84,027	7,498	1,793,899				9
10	Dietary	330,822		78,540	2,340,084			10
11	Cafeteria				714,763	714,763		11
12	Maintenance of Personnel							12
13	Nursing Administration	46,756		11,100		15,915	1,140,911	13
14	Central Services & Supply	63,972		15,187		10,477		14
15	Pharmacy	62,310		14,793		25,741		15
16	Medical Records & Library	98,948		23,491		22,634		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd		140					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	720,422	320,080	171,035	844,488	206,621	466,849	30
31	Intensive Care Unit	209,524	38,116	49,743	101,411	42,244	95,448	31
40	Subprovider - IPF	179,864	44,322	42,701	166,590	25,699	58,065	40
41	Subprovider - IRF	386,700	32,619	91,806	132,199	38,947	88,000	41
43	Nursery	152,409		36,183		19,379	43,786	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	386,911	54,339	91,856		59,208	133,778	50
50.01	GASTRO INTESTINAL SERVICES	56,783		13,481		4,514	10,199	50.01
51	Recovery Room	41,681	20,394	9,896		7,873	17,790	51
52	Delivery Room & Labor Room	382,320		90,766		33,446	75,571	52
53	Anesthesiology	12,021		2,854		4,892	11,053	53
54	Radiology-Diagnostic	314,996	44,551	74,783		30,486		54
56	Radioisotope	23,408		5,557		2,436		56
56.01	ULTRA SOUND	17,820		4,231		10,162		56.01
57	CT Scan	25,069		5,952		4,346	9,820	57
58	MRI	22,864		5,428		2,876		58
59	Cardiac Catheterization	105,381		25,018		8,797	19,877	59
60	Laboratory	201,037	114	47,728		16,251		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	8,366		1,986				63
65	Respiratory Therapy	17,941	5,866	4,259		20,660		65
66	Physical Therapy	176,572	30,841	41,920		21,500		66
67	Occupational Therapy		774			12,157		67
68	Speech Pathology	14,135		3,356		2,939		68
69	Electrocardiology	62,250		14,779		6,824		69
70	Electroencephalography					525		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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	333,662	59,975	79,214		48,983	110,675	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,590,801	659,629	1,057,643	1,959,451	706,532	1,140,911	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,588		1,327				190
192	Physicians' Private Offices				320,056			192
194	MARKETING	17,730		4,209		4,661		194
194.02	COMMUNITY RELATIONS	15,193		3,607		2,100		194.02

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	
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS	37,936		9,006		1,470		194.04
194.05	POB	2,811,612	2,112	667,504				194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS				4,800			194.07
194.08	HOSPICE	213,148		50,603	55,777			194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	7,692,008	661,741	1,793,899	2,340,084	714,763	1,140,911	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	22	24	25	
	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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	769,118						14
15	Pharmacy		1,608,979					15
16	Medical Records & Library			1,309,354				16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd				1,521			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			240,795	1,521	12,672,351	-1,521	30
31	Intensive Care Unit			44,343		3,135,679		31
40	Subprovider - IPF			44,134		1,946,284		40
41	Subprovider - IRF			16,149		3,084,458		41
43	Nursery			12,366		1,732,471		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			89,597		5,336,275		50
50.01	GASTRO INTESTINAL SERVICES			11,869		532,363		50.01
51	Recovery Room			21,446		736,722		51
52	Delivery Room & Labor Room			30,263		2,846,842		52
53	Anesthesiology			20,303		228,702		53
54	Radiology-Diagnostic			32,734		2,273,403		54
56	Radioisotope			10,042		454,652		56
56.01	ULTRA SOUND			30,299		712,042		56.01
57	CT Scan			87,025		413,971		57
58	MRI			15,622		278,952		58
59	Cardiac Catheterization			30,420		890,956		59
60	Laboratory			126,911		3,077,871		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			8,026		153,719		63
65	Respiratory Therapy			17,867		931,784		65
66	Physical Therapy			27,404		1,474,054		66
67	Occupational Therapy			16,938		640,676		67
68	Speech Pathology			3,905		208,508		68
69	Electrocardiology			19,945		489,008		69
70	Electroencephalography			1,228		20,092		70
71	Medical Supplies Charged to Patients	396,019		32,535		2,679,160		71
72	Impl. Dev. Charged to Patients	373,099		21,519		2,515,151		72
73	Drugs Charged to Patients		1,608,979	164,023		3,716,900		73
74	Renal Dialysis			1,903		317,841		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency			129,743		3,942,022		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	769,118	1,608,979	1,309,354	1,521	57,442,909	-1,521	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					26,460		190
192	Physicians' Private Offices					320,056		192
194	MARKETING					590,724		194
194.02	COMMUNITY RELATIONS					260,240		194.02

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	22	24	25	
194.03	SENIOR CENTER					49,327		194.03
194.04	PHYSICIAN CLINICS					187,968		194.04
194.05	POB					7,053,669		194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG					109,376		194.06
194.07	GUEST TRAYS & CATERING MEALS					4,800		194.07
194.08	HOSPICE					564,134		194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	769,118	1,608,979	1,309,354	1,521	66,609,663	-1,521	202

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

	COST CENTER DESCRIPTIONS	TOTAL						
		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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	12,670,830						30
31	Intensive Care Unit	3,135,679						31
40	Subprovider - IPF	1,946,284						40
41	Subprovider - IRF	3,084,458						41
43	Nursery	1,732,471						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,336,275						50
50.01	GASTRO INTESTINAL SERVICES	532,363						50.01
51	Recovery Room	736,722						51
52	Delivery Room & Labor Room	2,846,842						52
53	Anesthesiology	228,702						53
54	Radiology-Diagnostic	2,273,403						54
56	Radioisotope	454,652						56
56.01	ULTRA SOUND	712,042						56.01
57	CT Scan	413,971						57
58	MRI	278,952						58
59	Cardiac Catheterization	890,956						59
60	Laboratory	3,077,871						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	153,719						63
65	Respiratory Therapy	931,784						65
66	Physical Therapy	1,474,054						66
67	Occupational Therapy	640,676						67
68	Speech Pathology	208,508						68
69	Electrocardiology	489,008						69
70	Electroencephalography	20,092						70
71	Medical Supplies Charged to Patients	2,679,160						71
72	Impl. Dev. Charged to Patients	2,515,151						72
73	Drugs Charged to Patients	3,716,900						73
74	Renal Dialysis	317,841						74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	3,942,022						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	57,441,388						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	26,460						190
192	Physicians' Private Offices	320,056						192
194	MARKETING	590,724						194
194.02	COMMUNITY RELATIONS	260,240						194.02

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

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
194.03	SENIOR CENTER	49,327						194.03
194.04	PHYSICIAN CLINICS	187,968						194.04
194.05	POB	7,053,669						194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG	109,376						194.06
194.07	GUEST TRAYS & CATERING MEALS	4,800						194.07
194.08	HOSPICE	564,134						194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	66,608,142						202

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	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		295,413	302,817	598,230	598,230		5
6	Maintenance & Repairs							6
7	Operation of Plant		612,130	627,471	1,239,601	69,083	1,308,684	7
8	Laundry & Linen Service		24,210	24,817	49,027	5,478	8,818	8
9	Housekeeping		39,249	40,233	79,482	15,289	14,296	9
10	Dietary		154,528	158,401	312,929	17,340	56,285	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		21,840	22,387	44,227	9,584	7,955	13
14	Central Services & Supply		29,881	30,630	60,511	6,103	10,884	14
15	Pharmacy		29,105	29,835	58,940	13,527	10,601	15
16	Medical Records & Library		46,219	47,377	93,596	10,457	16,835	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					12		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		336,511	344,944	681,455	87,121	122,569	30
31	Intensive Care Unit		97,869	100,322	198,191	22,945	35,647	31
40	Subprovider - IPF		84,015	86,120	170,135	12,438	30,601	40
41	Subprovider - IRF		180,628	185,155	365,783	20,639	65,791	41
43	Nursery		71,190	72,975	144,165	13,187	25,930	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		180,727	185,256	365,983	40,600	65,827	50
50.01	GASTRO INTESTINAL SERVICES		26,524	27,188	53,712	3,911	9,661	50.01
51	Recovery Room		19,469	19,957	39,426	5,547	7,091	51
52	Delivery Room & Labor Room		178,583	183,058	361,641	20,068	65,046	52
53	Anesthesiology		5,615	5,756	11,371	1,595	2,045	53
54	Radiology-Diagnostic		147,135	150,823	297,958	15,949	53,592	54
56	Radioisotope		10,934	11,208	22,142	3,711	3,983	56
56.01	ULTRA SOUND		8,324	8,532	16,856	5,834	3,032	56.01
57	CT Scan		11,710	12,003	23,713	2,531	4,265	57
58	MRI		10,680	10,948	21,628	2,085	3,890	58
59	Cardiac Catheterization		49,224	50,457	99,681	6,300	17,929	59
60	Laboratory		93,905	96,258	190,163	24,122	34,203	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		3,908	4,006	7,914	1,216	1,423	63
65	Respiratory Therapy		8,380	8,590	16,970	7,770	3,052	65
66	Physical Therapy		82,477	84,544	167,021	10,560	30,041	66
67	Occupational Therapy					5,486		67
68	Speech Pathology		6,603	6,768	13,371	1,654	2,405	68
69	Electrocardiology		29,077	29,806	58,883	3,460	10,591	69
70	Electroencephalography					165		70
71	Medical Supplies Charged to Patients					20,213		71
72	Impl. Dev. Charged to Patients					19,045		72
73	Drugs Charged to Patients					17,458		73
74	Renal Dialysis					2,837		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		155,854	159,760	315,614	28,558	56,768	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		3,051,917	3,128,402	6,180,319	553,878	781,056	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,610	2,675	5,285	176	951	190
192	Physicians' Private Offices							192
194	MARKETING		8,282	8,489	16,771	5,066	3,016	194
194.02	COMMUNITY RELATIONS		7,096	7,274	14,370	2,150	2,585	194.02

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	
194.03	SENIOR CENTER					443		194.03
194.04	PHYSICIAN CLINICS		17,720	18,164	35,884	1,253	6,454	194.04
194.05	POB		1,313,315	1,346,227	2,659,542	32,085	478,358	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG					982		194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE		99,562	102,057	201,619	2,197	36,264	194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		4,500,502	4,613,288	9,113,790	598,230	1,308,684	202

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	63,323						8
9	Housekeeping	718	109,785					9
10	Dietary		4,807	391,361				10
11	Cafeteria			119,539	119,539			11
12	Maintenance of Personnel							12
13	Nursing Administration		679		2,662	65,107		13
14	Central Services & Supply		929		1,752		80,179	14
15	Pharmacy		905		4,305			15
16	Medical Records & Library		1,438		3,785			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	13						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	30,630	10,467	141,234	34,554	26,641		30
31	Intensive Care Unit	3,647	3,044	16,960	7,065	5,447		31
40	Subprovider - IPF	4,241	2,613	27,861	4,298	3,314		40
41	Subprovider - IRF	3,121	5,618	22,109	6,514	5,022		41
43	Nursery		2,214		3,241	2,499		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,200	5,622		9,902	7,634		50
50.01	GASTRO INTESTINAL SERVICES		825		755	582		50.01
51	Recovery Room	1,952	606		1,317	1,015		51
52	Delivery Room & Labor Room		5,555		5,594	4,312		52
53	Anesthesiology		175		818	631		53
54	Radiology-Diagnostic	4,263	4,577		5,099			54
56	Radioisotope		340		407			56
56.01	ULTRA SOUND		259		1,700			56.01
57	CT Scan		364		727	560		57
58	MRI		332		481			58
59	Cardiac Catheterization		1,531		1,471	1,134		59
60	Laboratory	11	2,921		2,718			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		122					63
65	Respiratory Therapy	561	261		3,455			65
66	Physical Therapy	2,951	2,565		3,596			66
67	Occupational Therapy	74			2,033			67
68	Speech Pathology		205		492			68
69	Electrocardiology		904		1,141			69
70	Electroencephalography				88			70
71	Medical Supplies Charged to Patients						41,284	71
72	Impl. Dev. Charged to Patients						38,895	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	5,739	4,848		8,192	6,316		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	63,121	64,726	327,703	118,162	65,107	80,179	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		81					190
192	Physicians' Private Offices			53,527				192
194	MARKETING		258		780			194
194.02	COMMUNITY RELATIONS		221		351			194.02

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	
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS		551		246			194.04
194.05	POB	202	40,851					194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS			803				194.07
194.08	HOSPICE		3,097	9,328				194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	63,323	109,785	391,361	119,539	65,107	80,179	202

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	22	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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	88,278						15
16	Medical Records & Library		126,111					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd			25				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		23,107		1,157,778		1,157,778	30
31	Intensive Care Unit		4,275		297,221		297,221	31
40	Subprovider - IPF		4,254		259,755		259,755	40
41	Subprovider - IRF		1,557		496,154		496,154	41
43	Nursery		1,192		192,428		192,428	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		8,637		509,405		509,405	50
50.01	GASTRO INTESTINAL SERVICES		1,144		70,590		70,590	50.01
51	Recovery Room		2,067		59,021		59,021	51
52	Delivery Room & Labor Room		2,917		465,133		465,133	52
53	Anesthesiology		1,957		18,592		18,592	53
54	Radiology-Diagnostic		3,155		384,593		384,593	54
56	Radioisotope		968		31,551		31,551	56
56.01	ULTRA SOUND		2,921		30,602		30,602	56.01
57	CT Scan		8,389		40,549		40,549	57
58	MRI		1,506		29,922		29,922	58
59	Cardiac Catheterization		2,932		130,978		130,978	59
60	Laboratory		12,234		266,372		266,372	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		774		11,449		11,449	63
65	Respiratory Therapy		1,722		33,791		33,791	65
66	Physical Therapy		2,642		219,376		219,376	66
67	Occupational Therapy		1,633		9,226		9,226	67
68	Speech Pathology		376		18,503		18,503	68
69	Electrocardiology		1,923		76,902		76,902	69
70	Electroencephalography		118		371		371	70
71	Medical Supplies Charged to Patients		3,136		64,633		64,633	71
72	Impl. Dev. Charged to Patients		2,074		60,014		60,014	72
73	Drugs Charged to Patients	88,278	15,811		121,547		121,547	73
74	Renal Dialysis		183		3,020		3,020	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		12,507		438,542		438,542	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	88,278	126,111		5,498,018		5,498,018	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				6,493		6,493	190
192	Physicians' Private Offices				53,527		53,527	192
194	MARKETING				25,891		25,891	194
194.02	COMMUNITY RELATIONS				19,677		19,677	194.02

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

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	22	24	25	26	
194.03	SENIOR CENTER				443		443	194.03
194.04	PHYSICIAN CLINICS				44,388		44,388	194.04
194.05	POB				3,211,038		3,211,038	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG				982		982	194.06
194.07	GUEST TRAYS & CATERING MEALS				803		803	194.07
194.08	HOSPICE				252,505		252,505	194.08
200	Cross Foot Adjustments			25	25		25	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	88,278	126,111	25	9,113,790		9,113,790	202

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			30,940,146				4
5	Administrative & General	20,939	20,939	4,816,317	-11,706,035	54,903,628		5
6	Maintenance & Repairs							6
7	Operation of Plant	43,388	43,388	1,017,793		6,340,206	254,670	7
8	Laundry & Linen Service	1,716	1,716			502,725	1,716	8
9	Housekeeping	2,782	2,782	826,549		1,403,197	2,782	9
10	Dietary	10,953	10,953	854,047		1,591,415	10,953	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,548	1,548	694,816		879,600	1,548	13
14	Central Services & Supply	2,118	2,118	207,438		560,069	2,118	14
15	Pharmacy	2,063	2,063	1,042,989		1,241,445	2,063	15
16	Medical Records & Library	3,276	3,276	508,072		959,669	3,276	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd					1,138		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	23,852	23,852	6,237,577		7,995,777	23,852	30
31	Intensive Care Unit	6,937	6,937	1,504,447		2,105,858	6,937	31
40	Subprovider - IPF	5,955	5,955	776,639		1,141,524	5,955	40
41	Subprovider - IRF	12,803	12,803	1,202,530		1,894,178	12,803	41
43	Nursery	5,046	5,046	820,624		1,210,299	5,046	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,810	12,810	2,076,118		3,726,133	12,810	50
50.01	GASTRO INTESTINAL SERVICES	1,880	1,880	206,711		358,979	1,880	50.01
51	Recovery Room	1,380	1,380	389,526		509,097	1,380	51
52	Delivery Room & Labor Room	12,658	12,658	1,172,180		1,841,787	12,658	52
53	Anesthesiology	398	398	92,855		146,371	398	53
54	Radiology-Diagnostic	10,429	10,429	916,238		1,463,763	10,429	54
56	Radioisotope	775	775	117,127		340,591	775	56
56.01	ULTRA SOUND	590	590	431,277		535,381	590	56.01
57	CT Scan	830	830	158,592		232,242	830	57
58	MRI	757	757	130,901		191,362	757	58
59	Cardiac Catheterization	3,489	3,489	399,071		578,187	3,489	59
60	Laboratory	6,656	6,656	56,960		2,213,819	6,656	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	277	277			111,556	277	63
65	Respiratory Therapy	594	594	623,821		713,141	594	65
66	Physical Therapy	5,846	5,846	663,943		969,178	5,846	66
67	Occupational Therapy			367,493		503,463		67
68	Speech Pathology	468	468	115,620		151,806	468	68
69	Electrocardiology	2,061	2,061	208,366		317,513	2,061	69
70	Electroencephalography			12,515		15,116		70
71	Medical Supplies Charged to Patients					1,855,082		71
72	Impl. Dev. Charged to Patients					1,747,868		72
73	Drugs Charged to Patients					1,602,275		73
74	Renal Dialysis					260,415		74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	11,047	11,047	1,819,344		2,620,954	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)	216,321	216,321	30,468,496	-11,706,035	50,833,179	151,994	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	185	185			16,110	185	190
192	Physicians' Private Offices							192
194	MARKETING	587	587	188,920		464,984	587	194

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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	
194.02	COMMUNITY RELATIONS	503	503	144,467		197,278	503	194.02
194.03	SENIOR CENTER					40,658		194.03
194.04	PHYSICIAN CLINICS	1,256	1,256	62,611		115,030	1,256	194.04
194.05	POB	93,088	93,088			2,944,616	93,088	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG			75,652		90,154		194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE	7,057	7,057			201,619	7,057	194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,500,502	4,613,288	5,901,492		11,706,035	7,692,008	202
203	Unit Cost Multiplier (Wkst. B, Part I)	14.108289	14.461854	0.190739		0.213211	30.203825	203
204	Cost to be allocated (Per Wkst. B, Part II)					598,230	1,308,684	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.010896	5.138744	205

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	582,539						8
9	Housekeeping	6,601	250,172					9
10	Dietary		10,953	236,453				10
11	Cafeteria			72,223	34,043			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,548		758	24,050		13
14	Central Services & Supply		2,118		499		10,000	14
15	Pharmacy		2,063		1,226			15
16	Medical Records & Library		3,276		1,078			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	123						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	281,771	23,852	85,331	9,841	9,841		30
31	Intensive Care Unit	33,554	6,937	10,247	2,012	2,012		31
40	Subprovider - IPF	39,017	5,955	16,833	1,224	1,224		40
41	Subprovider - IRF	28,715	12,803	13,358	1,855	1,855		41
43	Nursery		5,046		923	923		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	47,835	12,810		2,820	2,820		50
50.01	GASTRO INTESTINAL SERVICES		1,880		215	215		50.01
51	Recovery Room	17,953	1,380		375	375		51
52	Delivery Room & Labor Room		12,658		1,593	1,593		52
53	Anesthesiology		398		233	233		53
54	Radiology-Diagnostic	39,219	10,429		1,452			54
56	Radioisotope		775		116			56
56.01	ULTRA SOUND		590		484			56.01
57	CT Scan		830		207	207		57
58	MRI		757		137			58
59	Cardiac Catheterization		3,489		419	419		59
60	Laboratory	100	6,656		774			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		277					63
65	Respiratory Therapy	5,164	594		984			65
66	Physical Therapy	27,150	5,846		1,024			66
67	Occupational Therapy	681			579			67
68	Speech Pathology		468		140			68
69	Electrocardiology		2,061		325			69
70	Electroencephalography				25			70
71	Medical Supplies Charged to Patients						5,149	71
72	Impl. Dev. Charged to Patients						4,851	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	52,797	11,047		2,333	2,333		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	580,680	147,496	197,992	33,651	24,050	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		185					190
192	Physicians' Private Offices			32,340				192
194	MARKETING		587		222			194
194.02	COMMUNITY RELATIONS		503		100			194.02

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	
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS		1,256		70			194.04
194.05	POB	1,859	93,088					194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS			485				194.07
194.08	HOSPICE		7,057	5,636				194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	661,741	1,793,899	2,340,084	714,763	1,140,911	769,118	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.135960	7.170663	9.896614	20.995888	47.439127	76.911800	203
204	Cost to be allocated (Per Wkst. B, Part II)	63,323	109,785	391,361	119,539	65,107	80,179	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.108702	0.438838	1.655132	3.511412	2.707152	8.017900	205

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME			
		15	16	21	22			
	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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	100						15
16	Medical Records & Library		312,385,287					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			100				21
22	I&R Services-Other Prgm Costs Apprvd				100			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		57,420,390	100	100			30
31	Intensive Care Unit		10,580,494					31
40	Subprovider - IPF		10,530,585					40
41	Subprovider - IRF		3,853,206					41
43	Nursery		2,950,703					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		21,378,539					50
50.01	GASTRO INTESTINAL SERVICES		2,832,139					50.01
51	Recovery Room		5,117,065					51
52	Delivery Room & Labor Room		7,220,838					52
53	Anesthesiology		4,844,332					53
54	Radiology-Diagnostic		7,810,547					54
56	Radioisotope		2,396,037					56
56.01	ULTRA SOUND		7,229,578					56.01
57	CT Scan		20,764,670					57
58	MRI		3,727,527					58
59	Cardiac Catheterization		7,258,397					59
60	Laboratory		30,281,750					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		1,914,938					63
65	Respiratory Therapy		4,263,194					65
66	Physical Therapy		6,538,827					66
67	Occupational Therapy		4,041,523					67
68	Speech Pathology		931,857					68
69	Electrocardiology		4,758,995					69
70	Electroencephalography		292,963					70
71	Medical Supplies Charged to Patients		7,763,010					71
72	Impl. Dev. Charged to Patients		5,134,520					72
73	Drugs Charged to Patients	100	39,137,033					73
74	Renal Dialysis		454,149					74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		30,957,481					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	312,385,287	100	100			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
194	MARKETING							194

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME			
		15	16	21	22			
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)	1,608,979	1,309,354		1,521			202
203	Unit Cost Multiplier (Wkst. B, Part I)	16,089.790000	0.004191		15.210000			203
204	Cost to be allocated (Per Wkst. B, Part II)	88,278	126,111		25			204
205	Unit Cost Multiplier (Wkst. B, Part II)	882.780000	0.000404		0.250000			205

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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	12,670,830		12,670,830	17,005	12,687,835	30
31	Intensive Care Unit	3,135,679		3,135,679		3,135,679	31
40	Subprovider - IPF	1,946,284		1,946,284	16,397	1,962,681	40
41	Subprovider - IRF	3,084,458		3,084,458	8,781	3,093,239	41
43	Nursery	1,732,471		1,732,471		1,732,471	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,336,275		5,336,275	17,360	5,353,635	50
50.01	GASTRO INTESTINAL SERVICES	532,363		532,363		532,363	50.01
51	Recovery Room	736,722		736,722		736,722	51
52	Delivery Room & Labor Room	2,846,842		2,846,842		2,846,842	52
53	Anesthesiology	228,702		228,702		228,702	53
54	Radiology-Diagnostic	2,273,403		2,273,403		2,273,403	54
56	Radioisotope	454,652		454,652		454,652	56
56.01	ULTRA SOUND	712,042		712,042		712,042	56.01
57	CT Scan	413,971		413,971		413,971	57
58	MRI	278,952		278,952		278,952	58
59	Cardiac Catheterization	890,956		890,956	11,396	902,352	59
60	Laboratory	3,077,871		3,077,871		3,077,871	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	153,719		153,719		153,719	63
65	Respiratory Therapy	931,784		931,784		931,784	65
66	Physical Therapy	1,474,054		1,474,054		1,474,054	66
67	Occupational Therapy	640,676		640,676		640,676	67
68	Speech Pathology	208,508		208,508		208,508	68
69	Electrocardiology	489,008		489,008		489,008	69
70	Electroencephalography	20,092		20,092		20,092	70
71	Medical Supplies Charged to Patients	2,679,160		2,679,160		2,679,160	71
72	Impl. Dev. Charged to Patients	2,515,151		2,515,151		2,515,151	72
73	Drugs Charged to Patients	3,716,900		3,716,900		3,716,900	73
74	Renal Dialysis	317,841		317,841		317,841	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	3,942,022		3,942,022		3,942,022	91
92	Observation Beds (Non-Distinct Part)	642,899		642,899		642,899	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	58,084,287		58,084,287	70,939	58,155,226	200
201	Less Observation Beds	642,899		642,899		642,899	201
202	Total (line 200 minus line 201)	57,441,388		57,441,388		57,512,327	202

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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	54,502,551		54,502,551				30
31	Intensive Care Unit	10,580,494		10,580,494				31
40	Subprovider - IPF	10,530,585		10,530,585				40
41	Subprovider - IRF	3,853,206		3,853,206				41
43	Nursery	2,950,703		2,950,703				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,392,207	12,986,332	21,378,539	0.249609	0.249609	0.250421	50
50.01	GASTRO INTESTINAL SERVICES	767,913	2,064,226	2,832,139	0.187972	0.187972	0.187972	50.01
51	Recovery Room	2,237,716	2,879,349	5,117,065	0.143974	0.143974	0.143974	51
52	Delivery Room & Labor Room	6,845,305	375,533	7,220,838	0.394254	0.394254	0.394254	52
53	Anesthesiology	1,963,052	2,881,280	4,844,332	0.047210	0.047210	0.047210	53
54	Radiology-Diagnostic	2,204,237	5,606,310	7,810,547	0.291068	0.291068	0.291068	54
56	Radioisotope	1,073,325	1,322,712	2,396,037	0.189752	0.189752	0.189752	56
56.01	ULTRA SOUND	1,714,141	5,515,437	7,229,578	0.098490	0.098490	0.098490	56.01
57	CT Scan	7,705,878	13,058,792	20,764,670	0.019936	0.019936	0.019936	57
58	MRI	1,345,903	2,381,624	3,727,527	0.074836	0.074836	0.074836	58
59	Cardiac Catheterization	4,754,358	2,504,039	7,258,397	0.122748	0.122748	0.124318	59
60	Laboratory	20,405,570	9,876,180	30,281,750	0.101641	0.101641	0.101641	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,576,147	338,791	1,914,938	0.080274	0.080274	0.080274	63
65	Respiratory Therapy	3,967,640	295,554	4,263,194	0.218565	0.218565	0.218565	65
66	Physical Therapy	3,759,976	2,778,851	6,538,827	0.225431	0.225431	0.225431	66
67	Occupational Therapy	3,687,484	354,039	4,041,523	0.158523	0.158523	0.158523	67
68	Speech Pathology	909,375	22,482	931,857	0.223755	0.223755	0.223755	68
69	Electrocardiology	2,463,534	2,295,461	4,758,995	0.102754	0.102754	0.102754	69
70	Electroencephalography	249,362	43,601	292,963	0.068582	0.068582	0.068582	70
71	Medical Supplies Charged to Patients	3,559,339	4,203,671	7,763,010	0.345119	0.345119	0.345119	71
72	Impl. Dev. Charged to Patients	3,970,725	1,163,795	5,134,520	0.489851	0.489851	0.489851	72
73	Drugs Charged to Patients	28,605,100	10,531,933	39,137,033	0.094971	0.094971	0.094971	73
74	Renal Dialysis	443,726	10,423	454,149	0.699861	0.699861	0.699861	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	8,142,240	22,815,241	30,957,481	0.127337	0.127337	0.127337	91
92	Observation Beds (Non-Distinct Part)	237,727	2,680,112	2,917,839	0.220334	0.220334	0.220334	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	203,399,519	108,985,768	312,385,287				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	203,399,519	108,985,768	312,385,287				202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,157,778		1,157,778	21,117	54.83	5,870	321,852	30
31	Intensive Care Unit	297,221		297,221	2,474	120.14	711	85,420	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	259,755		259,755	4,429	58.65	2,277	133,546	40
41	Subprovider - IRF	496,154		496,154	3,965	125.13	1,834	229,488	41
42	Subprovider I								42
43	Nursery	192,428		192,428	1,833	104.98			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,403,336		2,403,336	33,818		10,692	770,306	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0240** **WORKSHEET D PART II**

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

		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	509,405	21,378,539	0.023828	2,027,305	48,307	50
50.01	GASTRO INTESTINAL SERVICES	70,590	2,832,139	0.024925	345,195	8,604	50.01
51	Recovery Room	59,021	5,117,065	0.011534	543,047	6,264	51
52	Delivery Room & Labor Room	465,133	7,220,838	0.064415	8,163	526	52
53	Anesthesiology	18,592	4,844,332	0.003838	427,683	1,641	53
54	Radiology-Diagnostic	384,593	7,810,547	0.049240	935,448	46,061	54
56	Radioisotope	31,551	2,396,037	0.013168	430,039	5,663	56
56.01	ULTRA SOUND	30,602	7,229,578	0.004233	671,775	2,844	56.01
57	CT Scan	40,549	20,764,670	0.001953	2,770,512	5,411	57
58	MRI	29,922	3,727,527	0.008027	577,389	4,635	58
59	Cardiac Catheterization	130,978	7,258,397	0.018045	1,610,717	29,065	59
60	Laboratory	266,372	30,281,750	0.008796	6,781,361	59,649	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	11,449	1,914,938	0.005979	516,946	3,091	63
65	Respiratory Therapy	33,791	4,263,194	0.007926	1,124,468	8,913	65
66	Physical Therapy	219,376	6,538,827	0.033550	596,044	19,997	66
67	Occupational Therapy	9,226	4,041,523	0.002283	538,017	1,228	67
68	Speech Pathology	18,503	931,857	0.019856	127,545	2,533	68
69	Electrocardiology	76,902	4,758,995	0.016159	1,079,866	17,450	69
70	Electroencephalography	371	292,963	0.001266	113,608	144	70
71	Medical Supplies Charged to Pat	64,633	7,763,010	0.008326	817,300	6,805	71
72	Impl. Dev. Charged to Patients	60,014	5,134,520	0.011688	759,191	8,873	72
73	Drugs Charged to Patients	121,547	39,137,033	0.003106	7,342,994	22,807	73
74	Renal Dialysis	3,020	454,149	0.006650	207,996	1,383	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	438,542	30,957,481	0.014166	2,244,643	31,798	91
92	Observation Beds (Non-Distinct	58,665	2,917,839	0.020106	94,291	1,896	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,153,347	229,967,748		32,691,543	345,588	200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V
[XX] Title XVIII, Part A
[ ] Title XIX
[XX] 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)	21,117		5,870		30
31	Intensive Care Unit	2,474		711		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	4,429		2,277		40
41	Subprovider - IRF	3,965		1,834		41
42	Subprovider I					42
43	Nursery	1,833				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	33,818		10,692		200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0240** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0240** **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,378,539			2,027,305		2,719,084		50
50.01	GASTRO INTESTINAL SERVICES	2,832,139			345,195		520,298		50.01
51	Recovery Room	5,117,065			543,047		1,021,605		51
52	Delivery Room & Labor Room	7,220,838			8,163				52
53	Anesthesiology	4,844,332			427,683		539,122		53
54	Radiology-Diagnostic	7,810,547			935,448		1,101,509		54
56	Radioisotope	2,396,037			430,039		471,075		56
56.01	ULTRA SOUND	7,229,578			671,775		174,270		56.01
57	CT Scan	20,764,670			2,770,512		2,492,728		57
58	MRI	3,727,527			577,389		496,973		58
59	Cardiac Catheterization	7,258,397			1,610,717		905,328		59
60	Laboratory	30,281,750			6,781,361		1,341,774		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,914,938			516,946		23,897		63
65	Respiratory Therapy	4,263,194			1,124,468				65
66	Physical Therapy	6,538,827			596,044				66
67	Occupational Therapy	4,041,523			538,017				67
68	Speech Pathology	931,857			127,545				68
69	Electrocardiology	4,758,995			1,079,866		638,546		69
70	Electroencephalography	292,963			113,608		12,202		70
71	Medical Supplies Charged to Pat	7,763,010			817,300		775,752		71
72	Impl. Dev. Charged to Patients	5,134,520			759,191		869,176		72
73	Drugs Charged to Patients	39,137,033			7,342,994		1,721,461		73
74	Renal Dialysis	454,149			207,996		3,709		74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	30,957,481			2,244,643		2,206,874		91
92	Observation Beds (Non-Distinct	2,917,839			94,291		490,165		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	229,967,748			32,691,543		18,525,548		200

(A) Worksheet A line numbers

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**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.249609	2,719,084			678,708			50
50.01	GASTRO INTESTINAL SERVICES	0.187972	520,298			97,801			50.01
51	Recovery Room	0.143974	1,021,605			147,085			51
52	Delivery Room & Labor Room	0.394254							52
53	Anesthesiology	0.047210	539,122			25,452			53
54	Radiology-Diagnostic	0.291068	1,101,509			320,614			54
56	Radioisotope	0.189752	471,075			89,387			56
56.01	ULTRA SOUND	0.098490	174,270			17,164			56.01
57	CT Scan	0.019936	2,492,728			49,695			57
58	MRI	0.074836	496,973			37,191			58
59	Cardiac Catheterization	0.122748	905,328			111,127			59
60	Laboratory	0.101641	1,341,774			136,379			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.080274	23,897			1,918			63
65	Respiratory Therapy	0.218565							65
66	Physical Therapy	0.225431							66
67	Occupational Therapy	0.158523							67
68	Speech Pathology	0.223755							68
69	Electrocardiology	0.102754	638,546			65,613			69
70	Electroencephalography	0.068582	12,202			837			70
71	Medical Supplies Charged to Pat	0.345119	775,752			267,727			71
72	Impl. Dev. Charged to Patients	0.489851	869,176			425,767			72
73	Drugs Charged to Patients	0.094971	1,721,461		15,886	163,489		1,509	73
74	Renal Dialysis	0.699861	3,709			2,596			74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.127337	2,206,874			281,017			91
92	Observation Beds (Non-Distinct	0.220334	490,165			108,000			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		18,525,548		15,886	3,027,567		1,509	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		18,525,548		15,886	3,027,567		1,509	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S240** **WORKSHEET D PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	509,405	21,378,539	0.023828	495	12	50
50.01	GASTRO INTESTINAL SERVICES	70,590	2,832,139	0.024925			50.01
51	Recovery Room	59,021	5,117,065	0.011534	27,641	319	51
52	Delivery Room & Labor Room	465,133	7,220,838	0.064415			52
53	Anesthesiology	18,592	4,844,332	0.003838	55,079	211	53
54	Radiology-Diagnostic	384,593	7,810,547	0.049240	18,057	889	54
56	Radioisotope	31,551	2,396,037	0.013168	8,272	109	56
56.01	ULTRA SOUND	30,602	7,229,578	0.004233	9,901	42	56.01
57	CT Scan	40,549	20,764,670	0.001953	39,675	77	57
58	MRI	29,922	3,727,527	0.008027	9,431	76	58
59	Cardiac Catheterization	130,978	7,258,397	0.018045			59
60	Laboratory	266,372	30,281,750	0.008796	443,498	3,901	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	11,449	1,914,938	0.005979			63
65	Respiratory Therapy	33,791	4,263,194	0.007926	21,694	172	65
66	Physical Therapy	219,376	6,538,827	0.033550	14,209	477	66
67	Occupational Therapy	9,226	4,041,523	0.002283	2,368	5	67
68	Speech Pathology	18,503	931,857	0.019856	2,027	40	68
69	Electrocardiology	76,902	4,758,995	0.016159	73,189	1,183	69
70	Electroencephalography	371	292,963	0.001266			70
71	Medical Supplies Charged to Pat	64,633	7,763,010	0.008326	7,354	61	71
72	Impl. Dev. Charged to Patients	60,014	5,134,520	0.011688			72
73	Drugs Charged to Patients	121,547	39,137,033	0.003106	1,187,918	3,690	73
74	Renal Dialysis	3,020	454,149	0.006650			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	438,542	30,957,481	0.014166	216,250	3,063	91
92	Observation Beds (Non-Distinct		2,917,839				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,094,682	229,967,748		2,137,058	14,327	200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S240** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-S240** **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,378,539			495				50
50.01	GASTRO INTESTINAL SERVICES	2,832,139							50.01
51	Recovery Room	5,117,065			27,641				51
52	Delivery Room & Labor Room	7,220,838							52
53	Anesthesiology	4,844,332			55,079				53
54	Radiology-Diagnostic	7,810,547			18,057		4,894		54
56	Radioisotope	2,396,037			8,272				56
56.01	ULTRA SOUND	7,229,578			9,901		1,396		56.01
57	CT Scan	20,764,670			39,675		2,757		57
58	MRI	3,727,527			9,431				58
59	Cardiac Catheterization	7,258,397							59
60	Laboratory	30,281,750			443,498		9,099		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,914,938							63
65	Respiratory Therapy	4,263,194			21,694				65
66	Physical Therapy	6,538,827			14,209				66
67	Occupational Therapy	4,041,523			2,368				67
68	Speech Pathology	931,857			2,027				68
69	Electrocardiology	4,758,995			73,189		8,781		69
70	Electroencephalography	292,963							70
71	Medical Supplies Charged to Pat	7,763,010			7,354				71
72	Impl. Dev. Charged to Patients	5,134,520					1,760		72
73	Drugs Charged to Patients	39,137,033			1,187,918		7,186		73
74	Renal Dialysis	454,149							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	30,957,481			216,250		29,489		91
92	Observation Beds (Non-Distinct	2,917,839							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	229,967,748			2,137,058		65,362		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S240** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.249609							50
50.01	GASTRO INTESTINAL SERVICES	0.187972							50.01
51	Recovery Room	0.143974							51
52	Delivery Room & Labor Room	0.394254							52
53	Anesthesiology	0.047210							53
54	Radiology-Diagnostic	0.291068	4,894			1,424			54
56	Radioisotope	0.189752							56
56.01	ULTRA SOUND	0.098490	1,396			137			56.01
57	CT Scan	0.019936	2,757			55			57
58	MRI	0.074836							58
59	Cardiac Catheterization	0.122748							59
60	Laboratory	0.101641	9,099			925			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.080274							63
65	Respiratory Therapy	0.218565							65
66	Physical Therapy	0.225431							66
67	Occupational Therapy	0.158523							67
68	Speech Pathology	0.223755							68
69	Electrocardiology	0.102754	8,781			902			69
70	Electroencephalography	0.068582							70
71	Medical Supplies Charged to Pat	0.345119							71
72	Impl. Dev. Charged to Patients	0.489851	1,760			862			72
73	Drugs Charged to Patients	0.094971	7,186		1,558	682		148	73
74	Renal Dialysis	0.699861							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.127337	29,489			3,755			91
92	Observation Beds (Non-Distinct	0.220334							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		65,362		1,558	8,742		148	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		65,362		1,558	8,742		148	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T240** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V **[ ] Hospital** **[ ] SUB (Other)** **[XX] PPS**
[XX] Title XVIII, Part A **[ ] IPF** **[ ] TEFRA**
[ ] Title XIX **[XX] 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	509,405	21,378,539	0.023828	14,808	353	50
50.01	GASTRO INTESTINAL SERVICES	70,590	2,832,139	0.024925			50.01
51	Recovery Room	59,021	5,117,065	0.011534	3,582	41	51
52	Delivery Room & Labor Room	465,133	7,220,838	0.064415			52
53	Anesthesiology	18,592	4,844,332	0.003838			53
54	Radiology-Diagnostic	384,593	7,810,547	0.049240	36,404	1,793	54
56	Radioisotope	31,551	2,396,037	0.013168	2,222	29	56
56.01	ULTRA SOUND	30,602	7,229,578	0.004233	2,039	9	56.01
57	CT Scan	40,549	20,764,670	0.001953	60,190	118	57
58	MRI	29,922	3,727,527	0.008027			58
59	Cardiac Catheterization	130,978	7,258,397	0.018045			59
60	Laboratory	266,372	30,281,750	0.008796	550,043	4,838	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	11,449	1,914,938	0.005979	29,670	177	63
65	Respiratory Therapy	33,791	4,263,194	0.007926	85,706	679	65
66	Physical Therapy	219,376	6,538,827	0.033550	1,203,370	40,373	66
67	Occupational Therapy	9,226	4,041,523	0.002283	1,231,560	2,812	67
68	Speech Pathology	18,503	931,857	0.019856	331,105	6,574	68
69	Electrocardiology	76,902	4,758,995	0.016159	17,683	286	69
70	Electroencephalography	371	292,963	0.001266			70
71	Medical Supplies Charged to Pat	64,633	7,763,010	0.008326	585	5	71
72	Impl. Dev. Charged to Patients	60,014	5,134,520	0.011688			72
73	Drugs Charged to Patients	121,547	39,137,033	0.003106	851,633	2,645	73
74	Renal Dialysis	3,020	454,149	0.006650	50,431	335	74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	438,542	30,957,481	0.014166			91
92	Observation Beds (Non-Distinct		2,917,839				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,094,682	229,967,748		4,471,031	61,067	200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T240** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-T240** **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,378,539			14,808				50
50.01	GASTRO INTESTINAL SERVICES	2,832,139							50.01
51	Recovery Room	5,117,065			3,582				51
52	Delivery Room & Labor Room	7,220,838							52
53	Anesthesiology	4,844,332							53
54	Radiology-Diagnostic	7,810,547			36,404		884		54
56	Radioisotope	2,396,037			2,222				56
56.01	ULTRA SOUND	7,229,578			2,039				56.01
57	CT Scan	20,764,670			60,190				57
58	MRI	3,727,527							58
59	Cardiac Catheterization	7,258,397							59
60	Laboratory	30,281,750			550,043				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,914,938			29,670				63
65	Respiratory Therapy	4,263,194			85,706		158		65
66	Physical Therapy	6,538,827			1,203,370				66
67	Occupational Therapy	4,041,523			1,231,560				67
68	Speech Pathology	931,857			331,105				68
69	Electrocardiology	4,758,995			17,683				69
70	Electroencephalography	292,963							70
71	Medical Supplies Charged to Pat	7,763,010			585				71
72	Impl. Dev. Charged to Patients	5,134,520							72
73	Drugs Charged to Patients	39,137,033			851,633				73
74	Renal Dialysis	454,149			50,431				74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	30,957,481							91
92	Observation Beds (Non-Distinct	2,917,839							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	229,967,748			4,471,031		1,042		200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T240** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.249609							50
50.01	GASTRO INTESTINAL SERVICES	0.187972							50.01
51	Recovery Room	0.143974							51
52	Delivery Room & Labor Room	0.394254							52
53	Anesthesiology	0.047210							53
54	Radiology-Diagnostic	0.291068	884	884		257	257		54
56	Radioisotope	0.189752							56
56.01	ULTRA SOUND	0.098490							56.01
57	CT Scan	0.019936							57
58	MRI	0.074836							58
59	Cardiac Catheterization	0.122748							59
60	Laboratory	0.101641							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.080274							63
65	Respiratory Therapy	0.218565	158	158		35	35		65
66	Physical Therapy	0.225431							66
67	Occupational Therapy	0.158523							67
68	Speech Pathology	0.223755							68
69	Electrocardiology	0.102754							69
70	Electroencephalography	0.068582							70
71	Medical Supplies Charged to Pat	0.345119							71
72	Impl. Dev. Charged to Patients	0.489851							72
73	Drugs Charged to Patients	0.094971							73
74	Renal Dialysis	0.699861							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.127337							91
92	Observation Beds (Non-Distinct	0.220334							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		1,042	1,042		292	292		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		1,042	1,042		292	292		202

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,157,778		1,157,778	21,117	54.83	6,415	351,734	30
31	Intensive Care Unit	297,221		297,221	2,474	120.14	366	43,971	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	259,755		259,755	4,429	58.65			40
41	Subprovider - IRF	496,154		496,154	3,965	125.13	866	108,363	41
42	Subprovider I								42
43	Nursery	192,428		192,428	1,833	104.98	1,274	133,745	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	2,403,336		2,403,336	33,818		8,921	637,813	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-0240** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Hospital** **[ ] SUB (Other)** **[ ] Title XVIII, Part A** **[ ] IPF** **[XX] 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	509,405	21,378,539	0.023828			50
50.01	GASTRO INTESTINAL SERVICES	70,590	2,832,139	0.024925			50.01
51	Recovery Room	59,021	5,117,065	0.011534			51
52	Delivery Room & Labor Room	465,133	7,220,838	0.064415			52
53	Anesthesiology	18,592	4,844,332	0.003838			53
54	Radiology-Diagnostic	384,593	7,810,547	0.049240			54
56	Radioisotope	31,551	2,396,037	0.013168			56
56.01	ULTRA SOUND	30,602	7,229,578	0.004233			56.01
57	CT Scan	40,549	20,764,670	0.001953			57
58	MRI	29,922	3,727,527	0.008027			58
59	Cardiac Catheterization	130,978	7,258,397	0.018045			59
60	Laboratory	266,372	30,281,750	0.008796			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	11,449	1,914,938	0.005979			63
65	Respiratory Therapy	33,791	4,263,194	0.007926			65
66	Physical Therapy	219,376	6,538,827	0.033550			66
67	Occupational Therapy	9,226	4,041,523	0.002283			67
68	Speech Pathology	18,503	931,857	0.019856			68
69	Electrocardiology	76,902	4,758,995	0.016159			69
70	Electroencephalography	371	292,963	0.001266			70
71	Medical Supplies Charged to Pat	64,633	7,763,010	0.008326			71
72	Impl. Dev. Charged to Patients	60,014	5,134,520	0.011688			72
73	Drugs Charged to Patients	121,547	39,137,033	0.003106			73
74	Renal Dialysis	3,020	454,149	0.006650			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	438,542	30,957,481	0.014166			91
92	Observation Beds (Non-Distinct	58,665	2,917,839	0.020106			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,153,347	229,967,748				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	21,117		6,415		30
31	Intensive Care Unit	2,474		366		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	4,429				40
41	Subprovider - IRF	3,965		866		41
42	Subprovider I					42
43	Nursery	1,833		1,274		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	33,818		8,921		200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-0240** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS **COMPONENT CCN: 14-0240** **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,378,539							50
50.01	GASTRO INTESTINAL SERVICES	2,832,139							50.01
51	Recovery Room	5,117,065							51
52	Delivery Room & Labor Room	7,220,838							52
53	Anesthesiology	4,844,332							53
54	Radiology-Diagnostic	7,810,547							54
56	Radioisotope	2,396,037							56
56.01	ULTRA SOUND	7,229,578							56.01
57	CT Scan	20,764,670							57
58	MRI	3,727,527							58
59	Cardiac Catheterization	7,258,397							59
60	Laboratory	30,281,750							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,914,938							63
65	Respiratory Therapy	4,263,194							65
66	Physical Therapy	6,538,827							66
67	Occupational Therapy	4,041,523							67
68	Speech Pathology	931,857							68
69	Electrocardiology	4,758,995							69
70	Electroencephalography	292,963							70
71	Medical Supplies Charged to Pat	7,763,010							71
72	Impl. Dev. Charged to Patients	5,134,520							72
73	Drugs Charged to Patients	39,137,033							73
74	Renal Dialysis	454,149							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	30,957,481							91
92	Observation Beds (Non-Distinct	2,917,839							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	229,967,748							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-0240** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.249609							50
50.01	GASTRO INTESTINAL SERVICES	0.187972							50.01
51	Recovery Room	0.143974							51
52	Delivery Room & Labor Room	0.394254							52
53	Anesthesiology	0.047210							53
54	Radiology-Diagnostic	0.291068							54
56	Radioisotope	0.189752							56
56.01	ULTRA SOUND	0.098490							56.01
57	CT Scan	0.019936							57
58	MRI	0.074836							58
59	Cardiac Catheterization	0.122748							59
60	Laboratory	0.101641							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.080274							63
65	Respiratory Therapy	0.218565							65
66	Physical Therapy	0.225431							66
67	Occupational Therapy	0.158523							67
68	Speech Pathology	0.223755							68
69	Electrocardiology	0.102754							69
70	Electroencephalography	0.068582							70
71	Medical Supplies Charged to Pat	0.345119							71
72	Impl. Dev. Charged to Patients	0.489851							72
73	Drugs Charged to Patients	0.094971							73
74	Renal Dialysis	0.699861							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.127337							91
92	Observation Beds (Non-Distinct	0.220334							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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-S240** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other)
[ ] Title XVIII, Part A [XX] IPF
[XX] 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	509,405	21,378,539	0.023828			50
50.01	GASTRO INTESTINAL SERVICES	70,590	2,832,139	0.024925			50.01
51	Recovery Room	59,021	5,117,065	0.011534			51
52	Delivery Room & Labor Room	465,133	7,220,838	0.064415			52
53	Anesthesiology	18,592	4,844,332	0.003838			53
54	Radiology-Diagnostic	384,593	7,810,547	0.049240			54
56	Radioisotope	31,551	2,396,037	0.013168			56
56.01	ULTRA SOUND	30,602	7,229,578	0.004233			56.01
57	CT Scan	40,549	20,764,670	0.001953			57
58	MRI	29,922	3,727,527	0.008027			58
59	Cardiac Catheterization	130,978	7,258,397	0.018045			59
60	Laboratory	266,372	30,281,750	0.008796			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	11,449	1,914,938	0.005979			63
65	Respiratory Therapy	33,791	4,263,194	0.007926			65
66	Physical Therapy	219,376	6,538,827	0.033550			66
67	Occupational Therapy	9,226	4,041,523	0.002283			67
68	Speech Pathology	18,503	931,857	0.019856			68
69	Electrocardiology	76,902	4,758,995	0.016159			69
70	Electroencephalography	371	292,963	0.001266			70
71	Medical Supplies Charged to Pat	64,633	7,763,010	0.008326			71
72	Impl. Dev. Charged to Patients	60,014	5,134,520	0.011688			72
73	Drugs Charged to Patients	121,547	39,137,033	0.003106			73
74	Renal Dialysis	3,020	454,149	0.006650			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	438,542	30,957,481	0.014166			91
92	Observation Beds (Non-Distinct		2,917,839				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,094,682	229,967,748				200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-S240** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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

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** **[XX] Title XIX** **[ ] Hospital** **[XX] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,378,539							50
50.01	GASTRO INTESTINAL SERVICES	2,832,139							50.01
51	Recovery Room	5,117,065							51
52	Delivery Room & Labor Room	7,220,838							52
53	Anesthesiology	4,844,332							53
54	Radiology-Diagnostic	7,810,547							54
56	Radioisotope	2,396,037							56
56.01	ULTRA SOUND	7,229,578							56.01
57	CT Scan	20,764,670							57
58	MRI	3,727,527							58
59	Cardiac Catheterization	7,258,397							59
60	Laboratory	30,281,750							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,914,938							63
65	Respiratory Therapy	4,263,194							65
66	Physical Therapy	6,538,827							66
67	Occupational Therapy	4,041,523							67
68	Speech Pathology	931,857							68
69	Electrocardiology	4,758,995							69
70	Electroencephalography	292,963							70
71	Medical Supplies Charged to Pat	7,763,010							71
72	Impl. Dev. Charged to Patients	5,134,520							72
73	Drugs Charged to Patients	39,137,033							73
74	Renal Dialysis	454,149							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	30,957,481							91
92	Observation Beds (Non-Distinct	2,917,839							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	229,967,748							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-S240** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.249609							50
50.01	GASTRO INTESTINAL SERVICES	0.187972							50.01
51	Recovery Room	0.143974							51
52	Delivery Room & Labor Room	0.394254							52
53	Anesthesiology	0.047210							53
54	Radiology-Diagnostic	0.291068							54
56	Radioisotope	0.189752							56
56.01	ULTRA SOUND	0.098490							56.01
57	CT Scan	0.019936							57
58	MRI	0.074836							58
59	Cardiac Catheterization	0.122748							59
60	Laboratory	0.101641							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.080274							63
65	Respiratory Therapy	0.218565							65
66	Physical Therapy	0.225431							66
67	Occupational Therapy	0.158523							67
68	Speech Pathology	0.223755							68
69	Electrocardiology	0.102754							69
70	Electroencephalography	0.068582							70
71	Medical Supplies Charged to Pat	0.345119							71
72	Impl. Dev. Charged to Patients	0.489851							72
73	Drugs Charged to Patients	0.094971							73
74	Renal Dialysis	0.699861							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.127337							91
92	Observation Beds (Non-Distinct	0.220334							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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-T240** **WORKSHEET D PART II**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other)
[ ] Title XVIII, Part A [ ] IPF
[XX] Title XIX [XX] 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	509,405	21,378,539	0.023828			50
50.01	GASTRO INTESTINAL SERVICES	70,590	2,832,139	0.024925			50.01
51	Recovery Room	59,021	5,117,065	0.011534			51
52	Delivery Room & Labor Room	465,133	7,220,838	0.064415			52
53	Anesthesiology	18,592	4,844,332	0.003838			53
54	Radiology-Diagnostic	384,593	7,810,547	0.049240			54
56	Radioisotope	31,551	2,396,037	0.013168			56
56.01	ULTRA SOUND	30,602	7,229,578	0.004233			56.01
57	CT Scan	40,549	20,764,670	0.001953			57
58	MRI	29,922	3,727,527	0.008027			58
59	Cardiac Catheterization	130,978	7,258,397	0.018045			59
60	Laboratory	266,372	30,281,750	0.008796			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	11,449	1,914,938	0.005979			63
65	Respiratory Therapy	33,791	4,263,194	0.007926			65
66	Physical Therapy	219,376	6,538,827	0.033550			66
67	Occupational Therapy	9,226	4,041,523	0.002283			67
68	Speech Pathology	18,503	931,857	0.019856			68
69	Electrocardiology	76,902	4,758,995	0.016159			69
70	Electroencephalography	371	292,963	0.001266			70
71	Medical Supplies Charged to Pat	64,633	7,763,010	0.008326			71
72	Impl. Dev. Charged to Patients	60,014	5,134,520	0.011688			72
73	Drugs Charged to Patients	121,547	39,137,033	0.003106			73
74	Renal Dialysis	3,020	454,149	0.006650			74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	438,542	30,957,481	0.014166			91
92	Observation Beds (Non-Distinct		2,917,839				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,094,682	229,967,748				200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-T240** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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 [XX] Title XIX
[ ] Hospital [ ] IPF [XX] IRF
[ ] SUB (Other) [ ] SNF [ ] NF
[ ] ICF/IID
[ ] PPS [ ] TEFRA [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	21,378,539							50
50.01	GASTRO INTESTINAL SERVICES	2,832,139							50.01
51	Recovery Room	5,117,065							51
52	Delivery Room & Labor Room	7,220,838							52
53	Anesthesiology	4,844,332							53
54	Radiology-Diagnostic	7,810,547							54
56	Radioisotope	2,396,037							56
56.01	ULTRA SOUND	7,229,578							56.01
57	CT Scan	20,764,670							57
58	MRI	3,727,527							58
59	Cardiac Catheterization	7,258,397							59
60	Laboratory	30,281,750							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,914,938							63
65	Respiratory Therapy	4,263,194							65
66	Physical Therapy	6,538,827							66
67	Occupational Therapy	4,041,523							67
68	Speech Pathology	931,857							68
69	Electrocardiology	4,758,995							69
70	Electroencephalography	292,963							70
71	Medical Supplies Charged to Pat	7,763,010							71
72	Impl. Dev. Charged to Patients	5,134,520							72
73	Drugs Charged to Patients	39,137,033							73
74	Renal Dialysis	454,149							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	30,957,481							91
92	Observation Beds (Non-Distinct	2,917,839							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	229,967,748							200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-T240** **WORKSHEET D PART V**

Check Applicable Boxes:

[ ] Title V - O/P	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF
[ ] Title XVIII, Part B	[ ] IPF	[ ] SNF	[ ] Swing Bed NF
[XX] Title XIX - O/P	[XX] IRF	[ ] NF	[ ] ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.249609							50
50.01	GASTRO INTESTINAL SERVICES	0.187972							50.01
51	Recovery Room	0.143974							51
52	Delivery Room & Labor Room	0.394254							52
53	Anesthesiology	0.047210							53
54	Radiology-Diagnostic	0.291068							54
56	Radioisotope	0.189752							56
56.01	ULTRA SOUND	0.098490							56.01
57	CT Scan	0.019936							57
58	MRI	0.074836							58
59	Cardiac Catheterization	0.122748							59
60	Laboratory	0.101641							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.080274							63
65	Respiratory Therapy	0.218565							65
66	Physical Therapy	0.225431							66
67	Occupational Therapy	0.158523							67
68	Speech Pathology	0.223755							68
69	Electrocardiology	0.102754							69
70	Electroencephalography	0.068582							70
71	Medical Supplies Charged to Pat	0.345119							71
72	Impl. Dev. Charged to Patients	0.489851							72
73	Drugs Charged to Patients	0.094971							73
74	Renal Dialysis	0.699861							74
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.127337							91
92	Observation Beds (Non-Distinct	0.220334							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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0240** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,117	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,117	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)	20,047	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)	5,870	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)	12,687,835	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)	12,687,835	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)	12,687,835	37

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	2	3	4	5	
38	Adjusted general inpatient routine service cost per diem (see instructions)					600.84	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,526,931	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					3,526,931	41
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	3,135,679	2,474	1,267.45	711	901,157	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)	4,539,860	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	8,967,948	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	407,272	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	345,588	51
52	Total Program excludable cost (sum of lines 50 and 51)	752,860	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	8,215,088	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,070	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					600.84	88
89	Observation bed cost (line 87 x line 88) (see instructions)					642,899	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,157,778	12,687,835	0.091251	642,899	58,665	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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

Check	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[XX] 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)	4,429	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,429	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)	4,429	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)	2,277	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)	1,962,681	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)	1,962,681	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)	1,962,681	37

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[XX] PPS**
	[XX] Title XVIII, Part A	**[XX] IPF**		**[ ] TEFRA**
	[ ] 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)	443.14	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,009,030	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,009,030	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	220,267	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,229,297	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	133,546	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,327	51
52	Total Program excludable cost (sum of lines 50 and 51)	147,873	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,081,424	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T240** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,965	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,965	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)	3,965	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)	1,834	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)	3,093,239	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)	3,093,239	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)	3,093,239	37

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T240** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	780.14	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,430,777	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,430,777	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	752,452	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,183,229	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	229,488	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	61,067	51
52	Total Program excludable cost (sum of lines 50 and 51)	290,555	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,892,674	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0240** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,117	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,117	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)	20,047	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)	6,415	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)	1,833	15
16	Nursery days (title V or XIX only)	1,274	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)	12,670,830	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)	12,670,830	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)	12,670,830	37

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0240** **WORKSHEET D-1 PART II**

Check Applicable Boxes: **[ ] Title V - I/P** **[ ] Title XVIII, Part A** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[XX] 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)					600.03	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,849,192	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					3,849,192	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)	1,732,471	1,833	945.16	1,274	1,204,134	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	3,135,679	2,474	1,267.45	366	463,887	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)					5,517,213	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					529,450	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)					529,450	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,070	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,429	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,429	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)	4,429	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)		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)	1,946,284	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)	1,946,284	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)	1,946,284	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	439.44	38
39	Program general inpatient routine service cost (line 9 x line 38)		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)		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)		49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		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)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T240** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,965	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,965	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)	3,965	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)	866	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)	3,084,458	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)	3,084,458	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)	3,084,458	37

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-T240** **WORKSHEET D-1**
PART II

Check Applicable Boxes:	**[ ] Title V - I/P**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[XX] IRF**		**[XX] 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)	777.92	38
39	Program general inpatient routine service cost (line 9 x line 38)	673,679	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)	673,679	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)	673,679	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	108,363	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)	108,363	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0240** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[XX] PPS
[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[ ] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/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		18,028,841		30
31	Intensive Care Unit		3,102,069		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.250421	2,027,305	507,680	50
50.01	GASTRO INTESTINAL SERVICES	0.187972	345,195	64,887	50.01
51	Recovery Room	0.143974	543,047	78,185	51
52	Delivery Room & Labor Room	0.394254	8,163	3,218	52
53	Anesthesiology	0.047210	427,683	20,191	53
54	Radiology-Diagnostic	0.291068	935,448	272,279	54
56	Radioisotope	0.189752	430,039	81,601	56
56.01	ULTRA SOUND	0.098490	671,775	66,163	56.01
57	CT Scan	0.019936	2,770,512	55,233	57
58	MRI	0.074836	577,389	43,209	58
59	Cardiac Catheterization	0.124318	1,610,717	200,241	59
60	Laboratory	0.101641	6,781,361	689,264	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.080274	516,946	41,497	63
65	Respiratory Therapy	0.218565	1,124,468	245,769	65
66	Physical Therapy	0.225431	596,044	134,367	66
67	Occupational Therapy	0.158523	538,017	85,288	67
68	Speech Pathology	0.223755	127,545	28,539	68
69	Electrocardiology	0.102754	1,079,866	110,961	69
70	Electroencephalography	0.068582	113,608	7,791	70
71	Medical Supplies Charged to Patients	0.345119	817,300	282,066	71
72	Impl. Dev. Charged to Patients	0.489851	759,191	371,890	72
73	Drugs Charged to Patients	0.094971	7,342,994	697,371	73
74	Renal Dialysis	0.699861	207,996	145,568	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.127337	2,244,643	285,826	91
92	Observation Beds (Non-Distinct Part)	0.220334	94,291	20,776	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		32,691,543	4,539,860	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		32,691,543		202

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S240** **WORKSHEET D-3**

Check Applicable Boxes:

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		5,315,484		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.250421	495	124	50
50.01	GASTRO INTESTINAL SERVICES	0.187972			50.01
51	Recovery Room	0.143974	27,641	3,980	51
52	Delivery Room & Labor Room	0.394254			52
53	Anesthesiology	0.047210	55,079	2,600	53
54	Radiology-Diagnostic	0.291068	18,057	5,256	54
56	Radioisotope	0.189752	8,272	1,570	56
56.01	ULTRA SOUND	0.098490	9,901	975	56.01
57	CT Scan	0.019936	39,675	791	57
58	MRI	0.074836	9,431	706	58
59	Cardiac Catheterization	0.124318			59
60	Laboratory	0.101641	443,498	45,078	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.080274			63
65	Respiratory Therapy	0.218565	21,694	4,742	65
66	Physical Therapy	0.225431	14,209	3,203	66
67	Occupational Therapy	0.158523	2,368	375	67
68	Speech Pathology	0.223755	2,027	454	68
69	Electrocardiology	0.102754	73,189	7,520	69
70	Electroencephalography	0.068582			70
71	Medical Supplies Charged to Patients	0.345119	7,354	2,538	71
72	Impl. Dev. Charged to Patients	0.489851			72
73	Drugs Charged to Patients	0.094971	1,187,918	112,818	73
74	Renal Dialysis	0.699861			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.127337	216,250	27,537	91
92	Observation Beds (Non-Distinct Part)	0.220334			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,137,058	220,267	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,137,058		202

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T240** **WORKSHEET D-3**

Check Applicable Boxes:

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF		1,866,762		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.250421	14,808	3,708	50
50.01	GASTRO INTESTINAL SERVICES	0.187972			50.01
51	Recovery Room	0.143974	3,582	516	51
52	Delivery Room & Labor Room	0.394254			52
53	Anesthesiology	0.047210			53
54	Radiology-Diagnostic	0.291068	36,404	10,596	54
56	Radioisotope	0.189752	2,222	422	56
56.01	ULTRA SOUND	0.098490	2,039	201	56.01
57	CT Scan	0.019936	60,190	1,200	57
58	MRI	0.074836			58
59	Cardiac Catheterization	0.124318			59
60	Laboratory	0.101641	550,043	55,907	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.080274	29,670	2,382	63
65	Respiratory Therapy	0.218565	85,706	18,732	65
66	Physical Therapy	0.225431	1,203,370	271,277	66
67	Occupational Therapy	0.158523	1,231,560	195,231	67
68	Speech Pathology	0.223755	331,105	74,086	68
69	Electrocardiology	0.102754	17,683	1,817	69
70	Electroencephalography	0.068582			70
71	Medical Supplies Charged to Patients	0.345119	585	202	71
72	Impl. Dev. Charged to Patients	0.489851			72
73	Drugs Charged to Patients	0.094971	851,633	80,880	73
74	Renal Dialysis	0.699861	50,431	35,295	74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.127337			91
92	Observation Beds (Non-Distinct Part)	0.220334			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,471,031	752,452	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,471,031		202

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-0240** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] 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	0.249609			50
50.01	GASTRO INTESTINAL SERVICES	0.187972			50.01
51	Recovery Room	0.143974			51
52	Delivery Room & Labor Room	0.394254			52
53	Anesthesiology	0.047210			53
54	Radiology-Diagnostic	0.291068			54
56	Radioisotope	0.189752			56
56.01	ULTRA SOUND	0.098490			56.01
57	CT Scan	0.019936			57
58	MRI	0.074836			58
59	Cardiac Catheterization	0.122748			59
60	Laboratory	0.101641			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.080274			63
65	Respiratory Therapy	0.218565			65
66	Physical Therapy	0.225431			66
67	Occupational Therapy	0.158523			67
68	Speech Pathology	0.223755			68
69	Electrocardiology	0.102754			69
70	Electroencephalography	0.068582			70
71	Medical Supplies Charged to Patients	0.345119			71
72	Impl. Dev. Charged to Patients	0.489851			72
73	Drugs Charged to Patients	0.094971			73
74	Renal Dialysis	0.699861			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.127337			91
92	Observation Beds (Non-Distinct Part)	0.220334			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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-S240** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[ ] PPS
[ ] Title XVIII, Part A	[XX] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[XX] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/IID	[XX] 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	0.249609			50
50.01	GASTRO INTESTINAL SERVICES	0.187972			50.01
51	Recovery Room	0.143974			51
52	Delivery Room & Labor Room	0.394254			52
53	Anesthesiology	0.047210			53
54	Radiology-Diagnostic	0.291068			54
56	Radioisotope	0.189752			56
56.01	ULTRA SOUND	0.098490			56.01
57	CT Scan	0.019936			57
58	MRI	0.074836			58
59	Cardiac Catheterization	0.122748			59
60	Laboratory	0.101641			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.080274			63
65	Respiratory Therapy	0.218565			65
66	Physical Therapy	0.225431			66
67	Occupational Therapy	0.158523			67
68	Speech Pathology	0.223755			68
69	Electrocardiology	0.102754			69
70	Electroencephalography	0.068582			70
71	Medical Supplies Charged to Patients	0.345119			71
72	Impl. Dev. Charged to Patients	0.489851			72
73	Drugs Charged to Patients	0.094971			73
74	Renal Dialysis	0.699861			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.127337			91
92	Observation Beds (Non-Distinct Part)	0.220334			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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-T240** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V	[ ] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[ ] PPS
[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[XX] Title XIX	[XX] IRF	[ ] NF	[ ] ICF/IID	[XX] 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	0.249609			50
50.01	GASTRO INTESTINAL SERVICES	0.187972			50.01
51	Recovery Room	0.143974			51
52	Delivery Room & Labor Room	0.394254			52
53	Anesthesiology	0.047210			53
54	Radiology-Diagnostic	0.291068			54
56	Radioisotope	0.189752			56
56.01	ULTRA SOUND	0.098490			56.01
57	CT Scan	0.019936			57
58	MRI	0.074836			58
59	Cardiac Catheterization	0.122748			59
60	Laboratory	0.101641			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.080274			63
65	Respiratory Therapy	0.218565			65
66	Physical Therapy	0.225431			66
67	Occupational Therapy	0.158523			67
68	Speech Pathology	0.223755			68
69	Electrocardiology	0.102754			69
70	Electroencephalography	0.068582			70
71	Medical Supplies Charged to Patients	0.345119			71
72	Impl. Dev. Charged to Patients	0.489851			72
73	Drugs Charged to Patients	0.094971			73
74	Renal Dialysis	0.699861			74
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.127337			91
92	Observation Beds (Non-Distinct Part)	0.220334			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

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)	2,275,193			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,367,201			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)	12,979			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	2,615,896			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	130.07			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)	36.87			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).	-34.87			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)	2.00			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	0.34			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	0.34			12
13	Total allowable FTE count for the prior year	1.27			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	1.50			14
15	Sum of lines 12 through 14 divided by 3	1.04			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	1.04			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.007996			19
20	Prior year resident to bed ratio (see instructions)	0.009788			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.007996			21
22	IME payment adjustment (see instructions)	49,109			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)	-1.66			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)	49,109			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)	0.1336			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4595			31
32	Sum of lines 30 and 31	0.5931			32
33	Allowable disproportionate share percentage (see instructions)	0.3815			33
34	Disproportionate share adjustment (see instructions)	824,269			34
		Prior to	**On or after**		
	Uncompensated Care Adjustment	**October 1**	**October 1**		
35	Total uncompensated care amount (see instructions)	9,046,380,143			35
35.01	Factor 3 (see instructions)	0.000243510			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,202,884	1,924,455		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	555,248	1,439,386		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,994,634			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

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
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
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)	11,523,385			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)	11,523,385			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	855,098			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)	39,599			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)	12,418,082			59
60	Primary payer payments	16,679			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	12,401,403			61
62	Deductibles billed to program beneficiaries	899,108			62
63	Coinsurance billed to program beneficiaries	131,770			63
64	Allowable bad debts (see instructions)	569,357			64
65	Adjusted reimbursable bad debts (see instructions)	370,082			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	402,134			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	11,740,607			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
70.94	HRR adjustment amount (see instructions)	47,399			70.94
70.95	Recovery of accelerated depreciation	48,925			70.95
71	Amount due provider (see instructions)	11,739,081			71
71.01	Sequestration adjustment (see instructions)	234,782			71.01
72	Interim payments	11,308,650			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	195,649			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	256,776			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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0240** **WORKSHEET E PART B**

Check applicable box: [XX] 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)	1,509			1
2	Medical and other services reimbursed under OPPS (see instructions)	3,027,567			2
3	PPS payments	2,781,543			3
4	Outlier payment (see instructions)	8,492			4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	1,509			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	15,886			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)	15,886			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)	15,886			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	14,377			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	1,509			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	2,790,035			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	583,477			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)	2,208,067			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	9,710			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,217,777			30
31	Primary payer payments	6,970			31
32	Subtotal (line 30 minus line 31)	2,210,807			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)	371,296			34
35	Adjusted reimbursable bad debts (see instructions)	241,342			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	309,984			36
37	Subtotal (see instructions)	2,452,149			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)	2,452,149			40
40.01	Sequestration adjustment (see instructions)	49,043			40.01
41	Interim payments	2,671,694			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-268,588			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S240** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [XX] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	148			1
2	Medical and other services reimbursed under OPPS (see instructions)	8,742			2
3	PPS payments	9,392			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	148			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,558			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)	1,558			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)	1,558			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	1,410			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	148			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	9,392			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,889			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)	7,651			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)	7,651			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	7,651			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)	7,651			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)	7,651			40
40.01	Sequestration adjustment (see instructions)	153			40.01
41	Interim payments	7,352			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	146			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T240** **WORKSHEET E PART B**

Check applicable box: [ ] Hospital [ ] IPF [XX] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	292			1
2	Medical and other services reimbursed under OPPS (see instructions)	292			2
3	PPS payments	157			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	292			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,042			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)	1,042			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)	1,042			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	750			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	292			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	157			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	31			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)	418			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)	418			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	418			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)	418			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)	418			40
40.01	Sequestration adjustment (see instructions)	8			40.01
41	Interim payments	123			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	287			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

Check Applicable Boxes: **[XX] Hospital** **[ ] SUB (Other)** **[ ] IPF** **[ ] SNF** **[ ] 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				11,723,298		2,447,704	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					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	06/18/2015	95,736	06/18/2015	230,048	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	02/03/2015	510,384	02/03/2015	6,058	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		-414,648		223,990	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)				11,308,650		2,671,694	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		195,649			6.01
	based on the cost report (1)		.02				-268,588	6.02
7	Total Medicare program liability (see instructions)				11,504,299		2,403,106	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.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-S240** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [XX] IPF [ ] SNF [ ] 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				1,703,916		7,352	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					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)				1,703,916		7,352	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				146	6.01
	based on the cost report (1)		.02		-1			6.02
7	Total Medicare program liability (see instructions)				1,703,915		7,498	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.

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [XX] 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				2,431,789		123	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02	02/03/2015	146,831			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		146,831			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)				2,578,620		123	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				287	6.01
	based on the cost report (1)		.02		-196,851			6.02
7	Total Medicare program liability (see instructions)				2,381,769		410	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT **WORKSHEET E-1 PART II**

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	4,835	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	6,581	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,837	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	22,521	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	312,385,287	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	4,267,399	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	778,049	8
9	Sequestration adjustment amount (see instructions)	15,561	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	762,488	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	777,629	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-15,141	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S240** **WORKSHEET E-3 PART II**

Check Applicable Box: **[ ] Hospital** **[XX] Subprovider IPF**

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,860,612	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment	29,278	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)	12.134247	9
10	Teaching adjustment factor {((1 + (line 8/line 9)) 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)	1,889,890	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)	1,889,890	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,889,890	18
19	Deductibles	81,708	19
20	Subtotal (line 18 minus line 19)	1,808,182	20
21	Coinsurance	69,493	21
22	Subtotal (line 20 minus line 21)	1,738,689	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)	1,738,689	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)	1,738,689	31
31.01	Sequestration adjustment (see instructions)	34,774	31.01
32	Interim payments	1,703,916	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	-1	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

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T240** **WORKSHEET E-3 PART III**

Check Applicable Box: **[ ] Hospital** **[XX] Subprovider IRF**

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	2,281,989		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.046000		2
3	Inpatient Rehabilitation LIP payments (see instructions)	176,626		3
4	Outlier payments	5,206		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 excludnig 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)	10.863014		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	2,463,821		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)	2,463,821		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	2,463,821		19
20	Deductibles	9,929		20
21	Subtotal (line 19 minus line 20)	2,453,892		21
22	Coinsurance	23,515		22
23	Subtotal (line 21 minus line 22)	2,430,377		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)	2,430,377		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)	2,430,377		32
32.01	Sequestration adjustment (see instructions)	48,608		32.01
33	Interim payments	2,578,620		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	-196,851		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (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

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	5,517,213		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	5,517,213		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	5,517,213		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 cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			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)	5,517,213		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)	5,517,213		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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-S240** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] NF**	**[ ] PPS**
	[XX] Title XIX	**[XX] Subprovider IPF**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			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 cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			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)			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)			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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-T240** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	**[ ] Title V**	**[ ] Hospital**	**[ ] NF**	**[ ] PPS**
	[XX] Title XIX	**[XX] Subprovider IRF**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	673,679		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	673,679		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	673,679		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 cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			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)	673,679		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)	673,679		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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

Check Applicable Box:
[ ] Title V
[XX] Title XVIII
[ ] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			36.33	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			-34.33	4
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			2.00	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)			0.32	6
7	Enter the lesser of line 5 or line 6			0.32	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.32	0.00	0.32	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.32	0.00	0.32	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.32	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.27	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.50	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	1.03	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	1.03	0.00		17
18	Per resident amount	114,107.10	111,042.03		18
19	Approved amount for resident costs	117,530		117,530	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			117,530	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	10,692	2,783		26
27	Total inpatient days (see instructions)	31,181	31,181		27
28	Ratio of inpatient days to total inpatient days	0.342901	0.089253		28
29	Program direct GME amount	40,301	10,490		29
30	Reduction for direct GME payments for Medicare Advantage		1,482		30
31	Net Program direct GME amount			49,309	31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			454,149	33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)			12,380,474	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)			16,679	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			12,363,795	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			3,038,550	42
43	Primary payer payments (see instructions)			6,970	43
44	Total Part B reasonable cost (line 42 minus line 43)			3,031,580	44
45	Total reasonable cost (sum of lines 41 and 44)			15,395,375	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.803085	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.196915	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			49,309	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			39,599	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			9,710	50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS **WORKSHEET E-4**

Check Applicable Box:
[ ] Title V
[ ] Title XVIII
[XX] Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for teh current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	7,647	3,258		26
27	Total inpatient days (see instructions)	31,181	31,181		27
28	Ratio of inpatient days to total inpatient days	0.245246	0.104487		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	-121,571				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	14,108,745				4
5	Other receivables	482,417				5
6	Allowances for uncollectible notes and accounts receivable	-2,130,669				6
7	Inventory	1,608,296				7
8	Prepaid expenses	146,625				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	14,093,843				11
	FIXED ASSETS					
12	Land	9,300,000				12
13	Land improvements	260,000				13
14	Accumulated depreciation					14
15	Buildings	18,133,055				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	2,411,223				23
24	Accumulated depreciation	-3,873,437				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	17,598				29
30	Total fixed assets (sum of lines 12-29)	26,248,439				30
	OTHER ASSETS					
31	Investments	299,330				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)	299,330				35
36	Total assets (sum of lines 11, 30 and 35)	40,641,612				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable					37
38	Salaries, wages and fees payable	3,544,015				38
39	Payroll taxes payable	3,829,713				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	971,577				43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	8,345,305				45
	LONG TERM LIABILITIES					
46	Mortgage payable	62,153,702				46
47	Notes payable	1,647,738				47
48	Unsecured loans					48
49	Other long term liabilities	1,418,110				49
50	Total long term liabilities (sum of lines 46 thru 49)	65,219,550				50
51	Total liabilities (sum of lines 45 and 50)	73,564,855				51
	CAPITAL ACCOUNTS					
52	General fund balance	-32,923,243				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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
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)	-32,923,243				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	40,641,612				60

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		-28,610,702			1
2	Net income (loss) (from Worksheet G-3, line 29)		-4,312,541			2
3	Total (sum of line 1 and line 2)		-32,923,243			3
4	Additions (credit adjustments) (specify)					4
5	RECONCILING ITEM					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)		-32,923,243			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-32,923,243			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	RECONCILING ITEM					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	57,453,254		57,453,254	1
2	Subprovider IPF	10,530,585		10,530,585	2
3	Subprovider IRF	3,853,206		3,853,206	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)	71,837,045		71,837,045	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	10,580,494		10,580,494	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)	10,580,494		10,580,494	16
17	Total inpatient routine care services (sum of lines 10 and 16)	82,417,539		82,417,539	17
18	Ancillary services	112,602,013	83,490,416	196,092,429	18
19	Outpatient services	8,379,967	25,495,353	33,875,320	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)	203,399,519	108,985,769	312,385,288	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		68,435,912	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)		68,435,912	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	312,385,288	1
2	Less contractual allowances and discounts on patients' accounts	250,042,155	2
3	Net patient revenues (line 1 minus line 2)	62,343,133	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	68,435,912	4
5	Net income from service to patients (line 3 minus line 4)	-6,092,779	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	9,392	21
22	Rental of hosptial space	1,055,528	22
23	Governmental appropriations		23
24	Other (HOSPICE BED RENTAL REVENUE)	205,403	24
24.01	Other (OTHER OPERATING REVENUE)	509,915	24.01
25	Total other income (sum of lines 6-24)	1,780,238	25
26	Total (line 5 plus line 25)	-4,312,541	26
29	Net income (or loss) for the period (line 26 minus line 28)	-4,312,541	29

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-0240** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	690,872	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	72,824	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)	62.43	3
4	Number of interns & residents (see instructions)	1.04	4
5	Indirect medical education percentage (see instructions)	0.47	5
6	Indirect medical education adjustment (see instructions)	3,247	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1336	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4595	8
9	Sum of lines 7 and 8	0.5931	9
10	Allowable disproportionate share percentage (see instructions)	0.1276	10
11	Disproportionate share adjustment (see instructions)	88,155	11
12	Total prospective capital payments (see instructions)	855,098	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

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
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
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	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
192	Physicians' Private Offices							192
194	MARKETING							194
194.02	COMMUNITY RELATIONS							194.02

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/17/2015 Run Time: 16:02 Version: 2015.10 (11/17/2015)

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		
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