

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

**WORKSHEET S
PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 11/15/2016 Time: 10:16	
	2. <input type="checkbox"/> Manually submitted cost report	
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report	
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WESTLAKE COMMUNITY HOSPITAL (14-0240) (Provider Name(s) and Number(s)) for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX
		1	2	3	4	5
1	HOSPITAL		587,172	19,751	-36,041	1
2	SUBPROVIDER - IPF		5	127		2
3	SUBPROVIDER - IRF		-16,013	14,779		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		571,164	34,657	-36,041	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number 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.

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Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 1225 SUPERIOR STREET	P.O. Box:		1	
2	City: MELROSE PARK	State: IL	ZIP Code: 60160	County: COOK	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 / 2015	To: 06 / 30 / 2016	20
21	Type of control (see instructions)	4		21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,058	3,455			3,946	172	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.	878						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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**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
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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**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)	Y	N	40	
		V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital	I	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

		1	2	3	
	Teaching Hospitals				
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 as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
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 received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64

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

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

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 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

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**WORKSHEET S-2
PART I**

Title V and XIX Services		V	XIX	
		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 elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		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:				118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

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 certified 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 certified 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

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PART I**

All Providers

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)	1 Y	2 HB0557	140
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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	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	0.50				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01 / 01 / 2015	03 / 31 / 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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation					
1	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	
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					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	C	12/31/2015	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				
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 instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

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

		Y/N	
Bed Complement			
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					
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	10/03/2016	Y	10/03/2016
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	
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	
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	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

Capital Related Cost			
22	Have assets been relieved 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

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

Cost Report Preparer Contact Information				
41	First name: BETH	Last name: SLOAN	Title: DIRECTOR OF OPERATIONS REI	41
42	Employer: TENET HEALTHCARE			42
43	Phone number: 606-451-1228	E-mail Address: BETH1.SLOAN@TENETHEALTH.COM		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Total All Patients
						Title V	Title XVIII	Title XIX		
						5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	109	39,894		5,060	5,045	18,066	1	
2	HMO and other (see instructions)					1,509	3,946		2	
3	HMO IPF Subprovider					550			3	
4	HMO IRF Subprovider					415			4	
5	Hospital Adults & Peds. Swing Bed SNF								5	
6	Hospital Adults & Peds. Swing Bed NF								6	
7	Total Adults & Peds. (exclude observation beds) (see instructions)		109	39,894		5,060	5,045	18,066	7	
8	Intensive Care Unit	31	12	4,392		669	320	2,320	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					1,148	2,268	13	
14	Total (see instructions)		121	44,286		5,729	6,513	22,654	14	
15	CAH Visits								15	
16	Subprovider - IPF	40	17	6,222		2,278		4,265	16	
17	Subprovider - IRF	41	20	7,320		1,916	878	4,003	17	
18	Subprovider I	42							18	
19	Skilled Nursing Facility	44							19	
20	Nursing Facility	45							20	
21	Other Long Term Care	46							21	
22	Home Health Agency	101							22	
23	ASC (Distinct Part)	115							23	
24	Hospice (Distinct Part)	116							24	
24.10	Hospice (non-distinct part)	30							24.10	
25	CMHC	99							25	
26	RHC	88							26	
27	Total (sum of lines 14-26)		158						27	
28	Observation Bed Days							1,766	28	
29	Ambulance Trips								29	
30	Employee discount days (see instructions)								30	
31	Employee discount days-IRF								31	
32	Labor & delivery (see instructions)						172	296	32	
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01	
33	LTCH non-covered days								33	

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					975	734	4,532	1
2	HMO and other (see instructions)					276			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)	0.60	433.58			975	734	4,532	14
15	CAH Visits								15
16	Subprovider - IPF		14.44			164	23	411	16
17	Subprovider - IRF		19.21			144	25	283	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)	0.60	467.23						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

KPMG LLP Compu-Max 2552-10

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HOSPITAL WAGE INDEX INFORMATION

**WORKSHEET S-3
PARTS II-III**

Part II - Wage Data

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
SALARIES								
1	Total salaries (see instructions)	200	30,859,355		30,859,355	971,850.00	31.75	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)		2,466,170	125,574	2,591,744	77,246.00	33.55	10
OTHER WAGES & RELATED COSTS								
11	Contract labor (see instructions)		179,452		179,452	2,543.00	70.57	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		224,346		224,346	1,789.00	125.40	13
14	Home office salaries & wage-related costs		2,280,216		2,280,216	47,935.00	47.57	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)		5,524,059		5,524,059			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		510,182		510,182			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		364,167	26,145	390,312	13,184.00	29.60	26
27	Administrative & General		4,485,003	-537,108	3,947,895	107,278.00	36.80	27
28	Administrative & General under contract (see instructions)		102,211		102,211	1,670.00	61.20	28
29	Maintenance & Repairs							29
30	Operation of Plant		1,085,750		1,085,750	43,167.00	25.15	30
31	Laundry & Linen Service							31
32	Housekeeping		839,700		839,700	61,900.00	13.57	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		866,245		866,245	53,688.00	16.13	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		723,266		723,266	16,034.00	45.11	38
39	Central Services and Supply		198,843		198,843	10,776.00	18.45	39
40	Pharmacy		974,267	113,395	1,087,662	24,893.00	43.69	40
41	Medical Records & Medical Records Library		199,734	271,994	471,728	20,681.00	22.81	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		30,961,566		30,961,566	973,520.00	31.80	1
2	Excluded area salaries (see instructions)		2,466,170	125,574	2,591,744	77,246.00	33.55	2
3	Subtotal salaries (line 1 minus line 2)		28,495,396	-125,574	28,369,822	896,274.00	31.65	3
4	Subtotal other wages & related costs (see instructions)		2,684,014		2,684,014	52,267.00	51.35	4
5	Subtotal wage-related costs (see instructions)		5,524,059		5,524,059		19.47%	5
6	Total (sum of lines 3 through 5)		36,703,469	-125,574	36,577,895	948,541.00	38.56	6
7	Total overhead cost (see instructions)		9,839,186	-125,574	9,713,612	353,271.00	27.50	7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	434,955	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)	2,067,884	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	18,823	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	36,300	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	408,021	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	1,930,212	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	557,978	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	69,886	23
24	Total Wage Related cost (Sum of lines 1-23)	5,524,059	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTS (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	320,814	6,074,627	1
2	Hospital	316,910	6,074,627	2
3	Subprovider - IPF	3,904		3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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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)	0.179468	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	10,040,597	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	10,284,045	5
6	Medicaid charges	140,206,131	6
7	Medicaid cost (line 1 times line 6)	25,162,514	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.	4,837,872	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 fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,837,872	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	4,574,517	14,141	4,588,658	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	820,979	2,538	823,517	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	820,979	2,538	823,517	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)	4,459,488	26
27	Medicare bad debts for the entire hospital complex (see instructions)	568,174	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,891,314	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	698,366	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,521,883	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,359,755	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	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				3,490,926	3,490,926	1,212,623	4,703,549	1
2	00200	Cap Rel Costs-Mvble Equip				736,125	736,125	1,788,279	2,524,404	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	364,167	6,141,525	6,505,692	30,143	6,535,835	-510,882	6,024,953	4
5	00500	Administrative & General	4,485,003	9,785,861	14,270,864	-4,544,124	9,726,740	310,734	10,037,474	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,085,750	3,686,564	4,772,314	-57,625	4,714,689	-16,949	4,697,740	7
8	00800	Laundry & Linen Service		381,176	381,176	74,475	455,651		455,651	8
9	00900	Housekeeping	839,700	360,715	1,200,415	-898	1,199,517		1,199,517	9
10	01000	Dietary	866,245	402,400	1,268,645	-1,236	1,267,409	-146,000	1,121,409	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	723,266	8,363	731,629	-379	731,250	-675	730,575	13
14	01400	Central Services & Supply	198,843	395,491	594,334	-18,432	575,902	-5,259	570,643	14
15	01500	Pharmacy	974,267	2,613,511	3,587,778	-1,617,951	1,969,827	-260,725	1,709,102	15
16	01600	Medical Records & Library	199,734	184,190	383,924	374,107	758,031	-25,681	732,350	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		2,661	2,661		2,661		2,661	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	6,665,474	814,309	7,479,783	-952,761	6,527,022	-421,697	6,105,325	30
31	03100	Intensive Care Unit	1,407,454	131,647	1,539,101	-81,291	1,457,810	-15,000	1,442,810	31
40	04000	Subprovider - IPF	911,474	76,983	988,457	-6,622	981,835	-27,197	954,638	40
41	04100	Subprovider - IRF	1,266,555	164,950	1,431,505	-34,037	1,397,468	-28,465	1,369,003	41
43	04300	Nursery	448,759	421,485	870,244	583,778	1,454,022	-370,127	1,083,895	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,829,460	3,933,439	5,762,899	-2,786,266	2,976,633	-128,469	2,848,164	50
50.01	03340	GASTRO INTESTINAL SERVICES	190,842	90,638	281,480	-40,089	241,391		241,391	50.01
51	05100	Recovery Room	391,272	15,449	406,721	-8,572	398,149		398,149	51
52	05200	Delivery Room & Labor Room	1,277,085	691,838	1,968,923	-363	1,968,560	-580,511	1,388,049	52
53	05300	Anesthesiology	116,025	605,690	721,715	-127,052	594,663	-437,707	156,956	53
54	05400	Radiology-Diagnostic	966,745	133,859	1,100,604	-30,310	1,070,294	-3,713	1,066,581	54
56	05600	Radioisotope	116,373	179,718	296,091	-931	295,160		295,160	56
56.01	03630	ULTRA SOUND	445,161	10,317	455,478	-5,782	449,696		449,696	56.01
57	05700	CT Scan	153,817	49,445	203,262	-34,598	168,664		168,664	57
58	05800	MRI	129,928	8,896	138,824	-3,585	135,239		135,239	58
59	05900	Cardiac Catheterization	402,404	796,810	1,199,214	-662,662	536,552	-124,607	411,945	59
60	06000	Laboratory	134,271	1,913,417	2,047,688	827	2,048,515	-22,476	2,026,039	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.		130,884	130,884	-92	130,792	-3,144	127,648	63
65	06500	Respiratory Therapy	624,298	188,925	813,223	-88,464	724,759	-69,842	654,917	65
66	06600	Physical Therapy	736,369	87,167	823,536	-2,166	821,370	-84,486	736,884	66
67	06700	Occupational Therapy	448,147	19,559	467,706	-92	467,614		467,614	67
68	06800	Speech Pathology	120,568	1,786	122,354		122,354		122,354	68
69	06900	Electrocardiology	203,951	23,521	227,472	-4,045	223,427	-3,270	220,157	69
70	07000	Electroencephalography	13,005	-4,792	8,213		8,213		8,213	70
71	07100	Medical Supplies Charged to Patients				2,289,509	2,289,509		2,289,509	71
72	07200	Impl. Dev. Charged to Patients				1,748,105	1,748,105		1,748,105	72
73	07300	Drugs Charged to Patients				1,845,372	1,845,372		1,845,372	73
74	07400	Renal Dialysis		430,720	430,720		430,720		430,720	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	1,834,802	1,275,623	3,110,425	-188,285	2,922,140	-977,981	1,944,159	91
92	09200	Observation Beds (Non-Distinct Part)								92
		SPECIAL REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	30,571,214	36,154,740	66,725,954	-125,343	66,600,611	-953,227	65,647,384	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		6,854	6,854		6,854		6,854	190

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	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	94,196	171,066	265,262	78,188	343,450		343,450	194
194.0	07952	COMMUNITY RELATIONS	147,227	25,112	172,339		172,339		172,339	194.0
2										2
194.0	07953	SENIOR CENTER		37,695	37,695	-756	36,939		36,939	194.0
3										3
194.0	07954	PHYSICIAN CLINICS				59,547	59,547		59,547	194.0
4										4
194.0	07955	POB		243,809	243,809	-11,636	232,173		232,173	194.0
5										5
194.0	07956	TRITON HLTH CAREER SCHOLARSHIP PROG	46,718	33	46,751		46,751		46,751	194.0
6										6
194.0	07957	GUEST TRAYS & CATERING MEALS								194.0
7										7
194.0	07958	HOSPICE								194.0
8										8
200		TOTAL (sum of lines 118-199)	30,859,355	36,639,309	67,498,664		67,498,664	-953,227	66,545,437	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRECIATION EXPENSE	A	Cap Rel Costs-Bldg & Fixt	1		1,857,851	1
2	DEPRECIATION EXPENSE	A	Cap Rel Costs-Mvble Equip	2		444,379	2
500	Total reclassifications					2,302,230	500
	Code Letter - A						
1	RENTS	B	Cap Rel Costs-Bldg & Fixt	1		210,744	1
2	RENTS	B	Cap Rel Costs-Mvble Equip	2		291,746	2
3	RENTS	B	GASTRO INTESTINAL SERVICES	50.01		299	3
4	RENTS	B	Laboratory	60		303	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					19
20	RENTS	B					20
21	RENTS	B					21
22	RENTS	B					22
23	RENTS	B					23
24	RENTS	B					24
500	Total reclassifications					503,092	500
	Code Letter - B						
1	PROPERTY TAXES	C	Cap Rel Costs-Bldg & Fixt	1		1,406,749	1
500	Total reclassifications					1,406,749	500
	Code Letter - C						
1	INSURANCE	D	Cap Rel Costs-Bldg & Fixt	1		15,582	1
500	Total reclassifications					15,582	500
	Code Letter - D						
1	PHARMACY COGS	E	Drugs Charged to Patients	73		1,845,372	1
2	PHARMACY COGS	E					2
3	PHARMACY COGS	E					3
4	PHARMACY COGS	E					4
5	PHARMACY COGS	E					5
6	PHARMACY COGS	E					6
7	PHARMACY COGS	E					7
8	PHARMACY COGS	E					8
9	PHARMACY COGS	E					9
10	PHARMACY COGS	E					10
11	PHARMACY COGS	E					11
12	PHARMACY COGS	E					12
13	PHARMACY COGS	E					13
14	PHARMACY COGS	E					14
15	PHARMACY COGS	E					15
16	PHARMACY COGS	E					16
17	PHARMACY COGS	E					17
18	PHARMACY COGS	E					18
19	PHARMACY COGS	E					19
20	PHARMACY COGS	E					20
21	PHARMACY COGS	E					21
22	PHARMACY COGS	E					22
23	PHARMACY COGS	E					23
500	Total reclassifications					1,845,372	500
	Code Letter - E						
1	LAUNDRY	F	Laundry & Linen Service	8		74,475	1
2	LAUNDRY	F					2
3	LAUNDRY	F					3
4	LAUNDRY	F					4

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
5	LAUNDRY	F					5
6	LAUNDRY	F					6
7	LAUNDRY	F					7
8	LAUNDRY	F					8
9	LAUNDRY	F					9
10	LAUNDRY	F					10
11	LAUNDRY	F					11
12	LAUNDRY	F					12
13	LAUNDRY	F					13
500	Total reclassifications					74,475	500
	Code Letter - F						
1	MEDICAL SUPPLIES COGS	G	Medical Supplies Charged to P	71		2,289,509	1
2	MEDICAL SUPPLIES COGS	G	Central Services & Supply	14		104,101	2
3	MEDICAL SUPPLIES COGS	G	Laboratory	60		524	3
4	MEDICAL SUPPLIES COGS	G					4
5	MEDICAL SUPPLIES COGS	G					5
6	MEDICAL SUPPLIES COGS	G					6
7	MEDICAL SUPPLIES COGS	G					7
8	MEDICAL SUPPLIES COGS	G					8
9	MEDICAL SUPPLIES COGS	G					9
10	MEDICAL SUPPLIES COGS	G					10
11	MEDICAL SUPPLIES COGS	G					11
12	MEDICAL SUPPLIES COGS	G					12
13	MEDICAL SUPPLIES COGS	G					13
14	MEDICAL SUPPLIES COGS	G					14
15	MEDICAL SUPPLIES COGS	G					15
16	MEDICAL SUPPLIES COGS	G					16
17	MEDICAL SUPPLIES COGS	G					17
18	MEDICAL SUPPLIES COGS	G					18
19	MEDICAL SUPPLIES COGS	G					19
20	MEDICAL SUPPLIES COGS	G					20
21	MEDICAL SUPPLIES COGS	G					21
22	MEDICAL SUPPLIES COGS	G					22
23	MEDICAL SUPPLIES COGS	G					23
24	MEDICAL SUPPLIES COGS	G					24
25	MEDICAL SUPPLIES COGS	G					25
26	MEDICAL SUPPLIES COGS	G					26
27	MEDICAL SUPPLIES COGS	G					27
500	Total reclassifications					2,394,134	500
	Code Letter - G						
1	IMPLANTABLE DEVICES	H	Impl. Dev. Charged to Patient	72		1,748,105	1
2	IMPLANTABLE DEVICES	H	Operation of Plant	7		765	2
3	IMPLANTABLE DEVICES	H	Adults & Pediatrics	30		20	3
4	IMPLANTABLE DEVICES	H					4
5	IMPLANTABLE DEVICES	H					5
6	IMPLANTABLE DEVICES	H					6
7	IMPLANTABLE DEVICES	H					7
500	Total reclassifications					1,748,890	500
	Code Letter - H						
1	NURSERY	I	Nursery	43	586,026	36,004	1
500	Total reclassifications				586,026	36,004	500
	Code Letter - I						
1	HOSPITAL SPACE IN POB	J	Employee Benefits Department	4		2,059	1
2	HOSPITAL SPACE IN POB	J	Radiology-Diagnostic	54		9,577	2
500	Total reclassifications					11,636	500
	Code Letter - J						
1	REGIONAL CORP ALLOCATION	K	Employee Benefits Department	4	26,145	4,117	1
2	REGIONAL CORP ALLOCATION	K	Pharmacy	15	113,395	5,666	2
3	REGIONAL CORP ALLOCATION	K	Medical Records & Library	16	271,994	102,986	3
4	REGIONAL CORP ALLOCATION	K	MARKETING	194	60,272	18,193	4
5	REGIONAL CORP ALLOCATION	K	PHYSICIAN CLINICS	194.04	65,302		5
500	Total reclassifications				537,108	130,962	500
	Code Letter - K						
	GRAND TOTAL (Increases)				1,123,134	10,469,126	

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RECLASSIFICATIONS

WORKSHEET A-6

			INCREASES				
EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER		
	1	2	3	4	5		

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES							
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.		
		1	6	7	8	9	10		
1	DEPRECIATION EXPENSE	A	Administrative & General	5		2,302,230	9	1	
2	DEPRECIATION EXPENSE	A					9	2	
500	Total reclassifications					2,302,230		500	
	Code letter - A								
1	RENTS	B	Employee Benefits Department	4		1,712	10	1	
2	RENTS	B	Administrative & General	5		150,752	10	2	
3	RENTS	B	Operation of Plant	7		57,983		3	
4	RENTS	B	Dietary	10		683		4	
5	RENTS	B	Nursing Administration	13		330		5	
6	RENTS	B	Central Services & Supply	14		122,457		6	
7	RENTS	B	Pharmacy	15		10,385		7	
8	RENTS	B	Medical Records & Library	16		873		8	
9	RENTS	B	Adults & Pediatrics	30		330		9	
10	RENTS	B	Intensive Care Unit	31		92		10	
11	RENTS	B	Subprovider - IPF	40		92		11	
12	RENTS	B	Nursery	43		1,165		12	
13	RENTS	B	Operating Room	50		33,225		13	
14	RENTS	B	Recovery Room	51		92		14	
15	RENTS	B	Anesthesiology	53		66,406		15	
16	RENTS	B	Radiology-Diagnostic	54		32,785		16	
17	RENTS	B	Cardiac Catheterization	59		92		17	
18	RENTS	B	Blood Storing, Processing & T	63		92		18	
19	RENTS	B	Respiratory Therapy	65		22,332		19	
20	RENTS	B	Physical Therapy	66		92		20	
21	RENTS	B	Occupational Therapy	67		92		21	
22	RENTS	B	Electrocardiology	69		92		22	
23	RENTS	B	Emergency	91		661		23	
24	RENTS	B	MARKETING	194		277		24	
500	Total reclassifications					503,092		500	
	Code letter - B								
1	PROPERTY TAXES	C	Administrative & General	5		1,406,749	13	1	
500	Total reclassifications					1,406,749		500	
	Code letter - C								
1	INSURANCE	D	Administrative & General	5		15,582	12	1	
500	Total reclassifications					15,582		500	
	Code letter - D								
1	PHARMACY COGS	E	Employee Benefits Department	4		380		1	
2	PHARMACY COGS	E	Administrative & General	5		4,124		2	
3	PHARMACY COGS	E	Central Services & Supply	14		76		3	
4	PHARMACY COGS	E	Pharmacy	15		1,691,756		4	
5	PHARMACY COGS	E	Adults & Pediatrics	30		28,845		5	
6	PHARMACY COGS	E	Intensive Care Unit	31		12,129		6	
7	PHARMACY COGS	E	Subprovider - IPF	40		132		7	
8	PHARMACY COGS	E	Subprovider - IRF	41		1,582		8	
9	PHARMACY COGS	E	Nursery	43		833		9	
10	PHARMACY COGS	E	Operating Room	50		35,592		10	
11	PHARMACY COGS	E	GASTRO INTESTINAL SERVICES	50.01		1,457		11	
12	PHARMACY COGS	E	Recovery Room	51		42		12	
13	PHARMACY COGS	E	Anesthesiology	53		1,982		13	
14	PHARMACY COGS	E	Radiology-Diagnostic	54		582		14	
15	PHARMACY COGS	E	Radioisotope	56		396		15	
16	PHARMACY COGS	E	ULTRA SOUND	56.01		38		16	
17	PHARMACY COGS	E	CT Scan	57		4,013		17	
18	PHARMACY COGS	E	MRI	58		2,157		18	
19	PHARMACY COGS	E	Cardiac Catheterization	59		3,694		19	
20	PHARMACY COGS	E	Respiratory Therapy	65		412		20	
21	PHARMACY COGS	E	Electrocardiology	69		76		21	
22	PHARMACY COGS	E	Emergency	91		54,318		22	
23	PHARMACY COGS	E	SENIOR CENTER	194.03		756		23	
500	Total reclassifications					1,845,372		500	
	Code letter - E								
1	LAUNDRY	F	Pharmacy	15		78		1	
2	LAUNDRY	F	Adults & Pediatrics	30		9,819		2	
3	LAUNDRY	F	Intensive Care Unit	31		817		3	

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9	10	
4	LAUNDRY	F	Subprovider - IPF	40		1,235	4	
5	LAUNDRY	F	Subprovider - IRF	41		1,087	5	
6	LAUNDRY	F	Operating Room	50		55,373	6	
7	LAUNDRY	F	GASTRO INTESTINAL SERVICES	50.01		13	7	
8	LAUNDRY	F	Anesthesiology	53		736	8	
9	LAUNDRY	F	Radiology-Diagnostic	54		526	9	
10	LAUNDRY	F	CT Scan	57		14	10	
11	LAUNDRY	F	Cardiac Catheterization	59		2,575	11	
12	LAUNDRY	F	Electrocardiology	69		4	12	
13	LAUNDRY	F	Emergency	91		2,198	13	
500	Total reclassifications					74,475	500	
	Code letter - F							
1	MEDICAL SUPPLIES COGS	G	Employee Benefits Department	4		86	1	
2	MEDICAL SUPPLIES COGS	G	Administrative & General	5		2,372	2	
3	MEDICAL SUPPLIES COGS	G	Operation of Plant	7		407	3	
4	MEDICAL SUPPLIES COGS	G	Housekeeping	9		451	4	
5	MEDICAL SUPPLIES COGS	G	Dietary	10		15	5	
6	MEDICAL SUPPLIES COGS	G	Nursing Administration	13		49	6	
7	MEDICAL SUPPLIES COGS	G	Pharmacy	15		32,057	7	
8	MEDICAL SUPPLIES COGS	G	Adults & Pediatrics	30		291,757	8	
9	MEDICAL SUPPLIES COGS	G	Intensive Care Unit	31		68,253	9	
10	MEDICAL SUPPLIES COGS	G	Subprovider - IPF	40		5,163	10	
11	MEDICAL SUPPLIES COGS	G	Subprovider - IRF	41		31,368	11	
12	MEDICAL SUPPLIES COGS	G	Nursery	43		36,254	12	
13	MEDICAL SUPPLIES COGS	G	Operating Room	50		1,282,113	13	
14	MEDICAL SUPPLIES COGS	G	GASTRO INTESTINAL SERVICES	50.01		38,341	14	
15	MEDICAL SUPPLIES COGS	G	Recovery Room	51		8,438	15	
16	MEDICAL SUPPLIES COGS	G	Delivery Room & Labor Room	52		363	16	
17	MEDICAL SUPPLIES COGS	G	Anesthesiology	53		57,928	17	
18	MEDICAL SUPPLIES COGS	G	Radiology-Diagnostic	54		5,994	18	
19	MEDICAL SUPPLIES COGS	G	Radioisotope	56		535	19	
20	MEDICAL SUPPLIES COGS	G	ULTRA SOUND	56.01		5,744	20	
21	MEDICAL SUPPLIES COGS	G	CT Scan	57		30,571	21	
22	MEDICAL SUPPLIES COGS	G	MRI	58		1,428	22	
23	MEDICAL SUPPLIES COGS	G	Cardiac Catheterization	59		291,859	23	
24	MEDICAL SUPPLIES COGS	G	Respiratory Therapy	65		65,720	24	
25	MEDICAL SUPPLIES COGS	G	Physical Therapy	66		2,074	25	
26	MEDICAL SUPPLIES COGS	G	Electrocardiology	69		3,873	26	
27	MEDICAL SUPPLIES COGS	G	Emergency	91		130,921	27	
500	Total reclassifications					2,394,134	500	
	Code letter - G							
1	IMPLANTABLE DEVICES	H	Housekeeping	9		447	1	
2	IMPLANTABLE DEVICES	H	Dietary	10		538	2	
3	IMPLANTABLE DEVICES	H	Pharmacy	15		2,736	3	
4	IMPLANTABLE DEVICES	H	Operating Room	50		1,379,963	4	
5	IMPLANTABLE DEVICES	H	GASTRO INTESTINAL SERVICES	50.01		577	5	
6	IMPLANTABLE DEVICES	H	Cardiac Catheterization	59		364,442	6	
7	IMPLANTABLE DEVICES	H	Emergency	91		187	7	
500	Total reclassifications					1,748,890	500	
	Code letter - H							
1	NURSERY	I	Adults & Pediatrics	30	586,026	36,004	1	
500	Total reclassifications				586,026	36,004	500	
	Code letter - I							
1	HOSPITAL SPACE IN POB	J	POB	194.05		11,636	1	
2	HOSPITAL SPACE IN POB	J					2	
500	Total reclassifications					11,636	500	
	Code letter - J							
1	REGIONAL CORP ALLOCATION	K	Administrative & General	5	537,108	125,207	1	
2	REGIONAL CORP ALLOCATION	K	PHYSICIAN CLINICS	194.04		5,755	2	
3	REGIONAL CORP ALLOCATION	K					3	
4	REGIONAL CORP ALLOCATION	K					4	
5	REGIONAL CORP ALLOCATION	K					5	
500	Total reclassifications				537,108	130,962	500	
	Code letter - K							

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10		
	1	6	7	8	9	10		
GRAND TOTAL (Decreases)				1,123,134	10,469,126			

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

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	4,187,868					4,187,868		1
2	Land Improvements	4,893,624					4,893,624		2
3	Buildings and Fixtures	66,106,726	743,163		743,163		66,849,889		3
4	Building Improvements	6,039,774	125,112		125,112		6,164,886		4
5	Fixed Equipment	4,124,706					4,124,706		5
6	Movable Equipment	73,933,936	951,236		951,236		74,885,172		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	159,286,634	1,819,511		1,819,511		161,106,145		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	159,286,634	1,819,511		1,819,511		161,106,145		10

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

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

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

have been included in Worksheet A, column 2, lines 1 and 2.

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	77,908,399		77,908,399	0.496490					1
2	Cap Rel Costs-Mvble Equip	79,009,878		79,009,878	0.503510					2
3	Total (sum of lines 1-2)	156,918,277		156,918,277	1.000000					3

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	2,562,650	210,744		15,582	1,914,573		4,703,549	1	
2	Cap Rel Costs-Mvble Equip	2,232,658	291,746					2,524,404	2	
3	Total (sum of lines 1-2)	4,795,308	502,490		15,582	1,914,573		7,227,953	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications,

Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	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	-3,815,487			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-522,776			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-135,109	Dietary	10	14
15	Rental of quarters to employees & others	B	-390,669	Adults & Pediatrics	30	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	-7,906	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines	B	-8,707	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	-58,459	Cap Rel Costs-Bldg & Fixt	1	9 26
27	Depreciation--movable equipment	A	1,848,287	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	-40,220	Administrative & General	5	33
33.01	PBX SALARY	A	-19,986	Administrative & General	5	33.01
33.02	PBX BENEFITS	A	-17,928	Employee Benefits Department	4	33.02
33.03	TELEVISION CABLE/SATELITE & DEPREC	A	-60,008	Cap Rel Costs-Mvble Equip	2	9 33.03
33.04	EMPLOYEE BADGES	B	-297	Employee Benefits Department	4	33.04
33.05	RENTAL INCOME	B	-30,581	Administrative & General	5	33.05
33.06	ADMIN SVCS	B	-48,510	Administrative & General	5	33.06
33.07	CHAPEL FUNDS	B	-78	Administrative & General	5	33.07
33.08	HEALTHWAYS	B	-5,618	Administrative & General	5	33.08
33.09	DRUG SCREENS	B	-73,478	Administrative & General	5	33.09
33.10	GRANT REVENUE	B	-89,166	Administrative & General	5	33.10
33.11	SEASON HOSPICE	B	-5,259	Central Services & Supply	14	33.11
33.12	SEASON HOSPICE	B	-224,269	Pharmacy	15	33.12
33.13	BARIATRIC PHONE LINE	B	-4,386	Operating Room	50	33.13
33.14	MISC	B	-1	Delivery Room & Labor Room	52	33.14
33.15	SEASON HOSPICE	B	-3,713	Radiology-Diagnostic	54	33.15
33.16	SEASON HOSPICE	B	-15,541	Cardiac Catheterization	59	33.16
33.17	SEASON HOSPICE	B	-8,419	Laboratory	60	33.17
33.18	SEASON HOSPICE	B	-3,144	Blood Storing, Processing & Trans.	63	33.18
33.19	SEASON HOSPICE	B	-16,177	Respiratory Therapy	65	33.19
33.20	FITNESS CENTER REVENUE	B	-84,486	Physical Therapy	66	33.20
33.21	WEST TOWNS PHO-SPECIALTY FEES	B	-163	Emergency	91	33.21
33.22	ADVERTISING	A	-10,624	Administrative & General	5	33.22
33.23	ADVERTISING	A	-232	Medical Records & Library	16	33.23
33.24	ADVERTISING	A	-1,331	Operating Room	50	33.24

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
33.25	PURCHASED SVCS	A	-30,023	Administrative & General	5	33.25
33.26	PURCHASED SVCS	A	-16,871	Operation of Plant	7	33.26
33.27	PURCHASED SVCS	A	-2,184	Dietary	10	33.27
33.28	PURCHASED SVCS	A	-36,456	Pharmacy	15	33.28
33.29	PURCHASED SVCS	A	-17,543	Medical Records & Library	16	33.29
33.30	PURCHASED SVCS	A	-46	Subprovider - IRF	41	33.30
33.31	PURCHASED SVCS	A	-39,120	Operating Room	50	33.31
33.32	PURCHASED SVCS	A	-14,057	Laboratory	60	33.32
33.33	PHYSICIAN RECRUITMENT	A	-194	Administrative & General	5	33.33
33.34	PHYSICIAN CONTINUING	A	-313	Administrative & General	5	33.34
33.35	PHYSICIAN RELOCATION	A	5,257	Administrative & General	5	33.35
33.36	TRAVEL	A	-55	Subprovider - IRF	41	33.36
33.37	ALCOHOL	A	-517	Administrative & General	5	33.37
33.38	ALCOHOL	A	-7	Subprovider - IRF	41	33.38
33.39	MEALS	A	-1,196	Administrative & General	5	33.39
33.40	PROPERTY TAXES	A	507,824	Cap Rel Costs-Bldg & Fixt	1	13 33.40
33.41	DONATIONS/CONTRIBUTIONS	A	-26,467	Administrative & General	5	33.41
33.42	DUES & SUBSCRIPTION	A	-3,835	Administrative & General	5	33.42
33.43	LOBBYING	A	-28,329	Administrative & General	5	33.43
33.44	PATIENT TRANSPORTATION	A	-1,700	Administrative & General	5	33.44
33.45	PATIENT TRANSPORTATION	A	-675	Nursing Administration	13	33.45
33.46	PATIENT TRANSPORTATION	A	-202	Subprovider - IRF	41	33.46
33.47	LEGAL	A	-113,860	Administrative & General	5	33.47
33.48	LEGAL	A	-78	Operation of Plant	7	33.48
33.49	IDPA TAX ASSESSMENT	A	5,252	Administrative & General	5	33.49
33.50	H.O. WORKER COMPENSATION	A	-389,564	Employee Benefits Department	4	33.50
33.51	PERIOD 13 ADJUSTMENTS	A	-103,093	Employee Benefits Department	4	33.51
33.52	PERIOD 13 ADJUSTMENTS	A	3,209,266	Administrative & General	5	33.52
34						34
35						35
36						36
37						37
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-953,227			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 subscripsts thereof.

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

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

WORKSHEET A-8-1

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
1	2	3	4	5	6	7		
1	1	Cap Rel Costs-Bldg & Fixt	TENET DIRECT ALLOC.- CAPITAL	352,270		352,270	9	1
2	1	Cap Rel Costs-Bldg & Fixt	TENET POOL ALLOC.- CAPITAL	410,988		410,988	9	2
3	5	Administrative & General	TENET POOL/DIRECT ALLOC.-NON CAPITAL	1,245,483		1,245,483		3
4	5	Administrative & General	PERIOD 13 ADJ - IC OVERHEAD ALLOC		2,531,517	-2,531,517		4
4.01	1	Cap Rel Costs-Bldg & Fixt	REGIONAL ALLOCATION	117,729	117,729		10	4.01
4.02	2	Cap Rel Costs-Mvble Equip	REGIONAL ALLOCATION	3,490	3,490		10	4.02
4.03	4	Employee Benefits Department	REGIONAL ALLOCATION	30,262	30,262			4.03
4.04	5	Administrative & General	REGIONAL ALLOCATION	3,374,770	3,374,770			4.04
4.05	15	Pharmacy	REGIONAL ALLOCATION	119,060	119,060			4.05
4.06	16	Medical Records & Library	REGIONAL ALLOCATION	374,980	374,980			4.06
4.07	71	Medical Supplies Charged to Patients	REGIONAL ALLOCATION	61	61			4.07
4.08	194	MARKETING	REGIONAL ALLOCATION	78,465	78,465			4.08
4.09	194.04	PHYSICIAN CLINICS	REGIONAL ALLOCATION	59,547	59,547			4.09
4.10	60	Laboratory	GENESIS LAB	1,934,686	1,934,686			4.10
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			8,101,791	8,624,567	-522,776		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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership		Type of Business
	1	2	3	4	5	6	
6	B			TENET HLTHCARE	100.00	HLTHCARE	6
7	G			GENESIS	1.00	LAB	7
8	G			REGIONAL	1.00	HLTHCARE	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	1,125,829	1,094,413	31,416	177,200	323	27,517	1,376	1
2	30	Adults & Pediatrics ADULTS & PEDIAT	47,179	14,479	32,700	154,100	218	16,151	808	2
3	31	Intensive Care Unit INTENSIVE CARE	15,000	15,000						3
4	40	Subprovider - IPF SUBPROVIDER - I	43,200	10,800	32,400	154,100	216	16,003	800	4
5	41	Subprovider - IRF SUBPROVIDER - I	95,798	16,400	79,398	177,200	794	67,643	3,382	5
6	43	Nursery NURSERY	370,127	370,127						6
7	50	Operating Room OPERATING ROOM	100,232	65,800	34,432	208,000	166	16,600	830	7
8	52	Delivery Room & Labo LABOR ROOM & DE	580,510	580,510						8
9	53	Anesthesiology ANESTHESIOLOGY	437,707	437,707						9
10	59	Cardiac Catheterizat CARDIAC CATHETE	115,200	101,200	14,000	177,200	72	6,134	307	10
11	65	Respiratory Therapy RESPIRATORY THE	53,665	53,665						11
12	69	Electrocardiology ELECTRO CARDIOL	3,270	3,270						12
13	91	Emergency EMERGENCY	977,818	977,818						13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	3,965,535	3,741,189	224,346		1,789	150,048	7,503	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowanc e	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen ADMINISTRATIVE					27,517	3,899	1,098,312	1
2	30	Adults & Pediatrics ADULTS & PEDIAT					16,151	16,549	31,028	2
3	31	Intensive Care Unit INTENSIVE CARE							15,000	3
4	40	Subprovider - IPF SUBPROVIDER - I					16,003	16,397	27,197	4
5	41	Subprovider - IRF SUBPROVIDER - I					67,643	11,755	28,155	5
6	43	Nursery NURSERY							370,127	6
7	50	Operating Room OPERATING ROOM					16,600	17,832	83,632	7
8	52	Delivery Room & Labo LABOR ROOM & DE							580,510	8
9	53	Anesthesiology ANESTHESIOLOGY							437,707	9
10	59	Cardiac Catheterizat CARDIAC CATHETE					6,134	7,866	109,066	10
11	65	Respiratory Therapy RESPIRATORY THE							53,665	11
12	69	Electrocardiology ELECTRO CARDIOL							3,270	12
13	91	Emergency EMERGENCY							977,818	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					150,048	74,298	3,815,487	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	4,703,549	4,703,549					1
2	Cap Rel Costs-Mvble Equip	2,524,404		2,524,404				2
4	Employee Benefits Department	6,024,953			6,024,953			4
5	Administrative & General	10,037,474	308,741	165,702	780,657	11,292,574	11,292,574	5
6	Maintenance & Repairs							6
7	Operation of Plant	4,697,740	639,748	343,354	214,696	5,895,538	1,204,930	7
8	Laundry & Linen Service	455,651	25,302	13,580		494,533	101,073	8
9	Housekeeping	1,199,517	41,020	22,016	166,042	1,428,595	291,976	9
10	Dietary	1,121,409	161,500	86,677	171,291	1,540,877	314,924	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	730,575	22,825	12,250	143,019	908,669	185,714	13
14	Central Services & Supply	570,643	31,229	16,761	39,319	657,952	134,472	14
15	Pharmacy	1,709,102	30,419	16,326	215,074	1,970,921	402,817	15
16	Medical Records & Library	732,350	48,304	25,925	93,279	899,858	183,913	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	2,661				2,661	544	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,105,325	351,693	188,754	1,202,153	7,847,925	1,603,953	30
31	Intensive Care Unit	1,442,810	102,285	54,896	278,310	1,878,301	383,887	31
40	Subprovider - IPF	954,638	87,805	47,125	180,235	1,269,803	259,522	40
41	Subprovider - IRF	1,369,003	188,778	101,317	250,449	1,909,547	390,273	41
43	Nursery	1,083,895	74,402	39,932	204,618	1,402,847	286,714	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,848,164	188,881	101,373	361,757	3,500,175	715,366	50
50.01	GASTRO INTESTINAL SERVICES	241,391	27,720	14,878	37,737	321,726	65,754	50.01
51	Recovery Room	398,149	20,348	10,921	77,370	506,788	103,577	51
52	Delivery Room & Labor Room	1,388,049	221,320	118,783	252,531	1,980,683	404,812	52
53	Anesthesiology	156,956	5,868	3,150	22,943	188,917	38,611	53
54	Radiology-Diagnostic	1,066,581	153,774	82,531	191,164	1,494,050	305,354	54
56	Radioisotope	295,160	11,427	6,133	23,012	335,732	68,617	56
56.01	ULTRA SOUND	449,696	8,699	4,669	88,026	551,090	112,632	56.01
57	CT Scan	168,664	12,238	6,568	30,416	217,886	44,532	57
58	MRI	135,239	11,162	5,991	25,692	178,084	36,397	58
59	Cardiac Catheterization	411,945	51,445	27,610	79,571	570,571	116,613	59
60	Laboratory	2,026,039	98,141	52,673	26,551	2,203,404	450,332	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	127,648	4,084	2,192		133,924	27,371	63
65	Respiratory Therapy	654,917	8,758	4,701	123,449	791,825	161,833	65
66	Physical Therapy	736,884	86,198	46,263	145,610	1,014,955	207,437	66
67	Occupational Therapy	467,614			88,617	556,231	113,682	67
68	Speech Pathology	122,354	6,901	3,704	23,841	156,800	32,047	68
69	Electrocardiology	220,157	30,389	16,310	40,329	307,185	62,782	69
70	Electroencephalography	8,213			2,572	10,785	2,204	70
71	Medical Supplies Charged to Patients	2,289,509				2,289,509	467,930	71
72	Impl. Dev. Charged to Patients	1,748,105				1,748,105	357,278	72
73	Drugs Charged to Patients	1,845,372				1,845,372	377,157	73
74	Renal Dialysis	430,720				430,720	88,031	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	1,944,159	162,886	87,421	362,814	2,557,280	522,657	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	65,647,384	3,224,290	1,730,486	5,943,144	63,292,398	10,627,718	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	6,854	2,728	1,464		11,046	2,258	190
192	Physicians' Private Offices							192
194	MARKETING	343,450	8,655	4,645	30,545	387,295	79,155	194

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & GENERAL	
		0	1	2	4	4A	5	
194.0 2	COMMUNITY RELATIONS	172,339	7,417	3,981	29,113	212,850	43,502	194.0 2
194.0 3	SENIOR CENTER	36,939				36,939	7,550	194.0 3
194.0 4	PHYSICIAN CLINICS	59,547	18,519	9,939	12,913	100,918	20,626	194.0 4
194.0 5	POB	232,173	1,372,566	736,656		2,341,395	478,534	194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG	46,751			9,238	55,989	11,443	194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS							194.0 7
194.0 8	HOSPICE		69,374	37,233		106,607	21,788	194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	66,545,437	4,703,549	2,524,404	6,024,953	66,545,437	11,292,574	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		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	7,100,468						7
8	Laundry & Linen Service	47,844	643,450					8
9	Housekeeping	77,565	7,291	1,805,427				9
10	Dietary	305,381		79,045	2,240,227			10
11	Cafeteria				762,582	762,582		11
12	Maintenance of Personnel							12
13	Nursing Administration	43,160		11,172		17,590	1,166,305	13
14	Central Services & Supply	59,052		15,285		11,818		14
15	Pharmacy	57,519		14,888		27,308		15
16	Medical Records & Library	91,338		23,642		22,677		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		136					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	665,019	311,234	172,134	691,920	216,298	461,777	30
31	Intensive Care Unit	193,411	37,062	50,063	88,840	40,541	86,550	31
40	Subprovider - IPF	166,032	43,097	42,976	163,352	33,035	70,526	40
41	Subprovider - IRF	356,961	31,718	92,396	153,319	43,826	93,564	41
43	Nursery	140,688		36,416		27,468	58,642	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	357,156	52,836	92,446		56,830	121,326	50
50.01	GASTRO INTESTINAL SERVICES	52,416		13,567		4,563	9,741	50.01
51	Recovery Room	38,476	19,830	9,959		9,331	19,921	51
52	Delivery Room & Labor Room	418,495		108,323		38,807	82,848	52
53	Anesthesiology	11,097		2,872		5,818	12,420	53
54	Radiology-Diagnostic	290,772	43,320	75,263		34,130		54
56	Radioisotope	21,608		5,593		2,555		56
56.01	ULTRA SOUND	16,450		4,258		11,270		56.01
57	CT Scan	23,141		5,990		4,312		57
58	MRI	21,106		5,463		3,034		58
59	Cardiac Catheterization	97,277		25,179		8,989	19,190	59
60	Laboratory	185,576	110	48,035		8,487		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	7,723		1,999				63
65	Respiratory Therapy	16,561	5,704	4,287		22,175		65
66	Physical Therapy	162,993	29,988	42,189		25,575		66
67	Occupational Therapy		752			13,985		67
68	Speech Pathology	13,048		3,377		3,445		68
69	Electrocardiology	57,463		14,874		6,707	14,319	69
70	Electroencephalography					570	1,218	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	308,002	58,318	79,723		53,499	114,263	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,303,330	641,396	1,081,414	1,860,013	754,643	1,166,305	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,158		1,335				190
192	Physicians' Private Offices				352,709			192
194	MARKETING	16,366		4,236		3,947		194
194.0	COMMUNITY RELATIONS	14,024		3,630		2,281		194.0
2								2

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
194.0 3	SENIOR CENTER							194.0 3
194.0 4	PHYSICIAN CLINICS	35,019		9,064		1,711		194.0 4
194.0 5	POB	2,595,391	2,054	671,793				194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG							194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS				8,108			194.0 7
194.0 8	HOSPICE	131,180		33,955	19,397			194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	7,100,468	643,450	1,805,427	2,240,227	762,582	1,166,305	202

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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	878,579						14
15	Pharmacy		2,473,453					15
16	Medical Records & Library			1,221,428				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				3,341			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			208,872	3,341	12,182,473	-3,341	30
31	Intensive Care Unit			38,940		2,797,595		31
40	Subprovider - IPF			39,364		2,087,707		40
41	Subprovider - IRF			15,108		3,086,712		41
43	Nursery			15,551		1,968,326		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			83,422		4,979,557		50
50.01	GASTRO INTESTINAL SERVICES			11,074		478,841		50.01
51	Recovery Room			19,579		727,461		51
52	Delivery Room & Labor Room			32,043		3,066,011		52
53	Anesthesiology			20,999		280,734		53
54	Radiology-Diagnostic			30,835		2,273,724		54
56	Radioisotope			9,009		443,114		56
56.01	ULTRA SOUND			28,976		724,676		56.01
57	CT Scan			94,698		390,559		57
58	MRI			12,972		257,056		58
59	Cardiac Catheterization			24,421		862,240		59
60	Laboratory			110,615		3,006,559		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			7,422		178,439		63
65	Respiratory Therapy			16,202		1,018,587		65
66	Physical Therapy			26,678		1,509,815		66
67	Occupational Therapy			16,671		701,321		67
68	Speech Pathology			4,434		213,151		68
69	Electrocardiology			18,635		481,965		69
70	Electroencephalography			918		15,695		70
71	Medical Supplies Charged to Patients	498,154		34,225		3,289,818		71
72	Impl. Dev. Charged to Patients	380,425		20,911		2,506,719		72
73	Drugs Charged to Patients		2,473,453	150,710		4,846,692		73
74	Renal Dialysis			3,489		522,240		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			124,655		3,818,397		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	878,579	2,473,453	1,221,428	3,341	58,716,184	-3,341	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					19,797		190
192	Physicians' Private Offices					352,709		192
194	MARKETING					490,999		194
194.0	COMMUNITY RELATIONS					276,287		194.0
2								2

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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	
194.0 3	SENIOR CENTER					44,489		194.0 3
194.0 4	PHYSICIAN CLINICS					167,338		194.0 4
194.0 5	POB					6,089,167		194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG					67,432		194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS					8,108		194.0 7
194.0 8	HOSPICE					312,927		194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	878,579	2,473,453	1,221,428	3,341	66,545,437	-3,341	202

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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	12,179,132					30
31	Intensive Care Unit	2,797,595					31
40	Subprovider - IPF	2,087,707					40
41	Subprovider - IRF	3,086,712					41
43	Nursery	1,968,326					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,979,557					50
50.01	GASTRO INTESTINAL SERVICES	478,841					50.01
51	Recovery Room	727,461					51
52	Delivery Room & Labor Room	3,066,011					52
53	Anesthesiology	280,734					53
54	Radiology-Diagnostic	2,273,724					54
56	Radioisotope	443,114					56
56.01	ULTRA SOUND	724,676					56.01
57	CT Scan	390,559					57
58	MRI	257,056					58
59	Cardiac Catheterization	862,240					59
60	Laboratory	3,006,559					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	178,439					63
65	Respiratory Therapy	1,018,587					65
66	Physical Therapy	1,509,815					66
67	Occupational Therapy	701,321					67
68	Speech Pathology	213,151					68
69	Electrocardiology	481,965					69
70	Electroencephalography	15,695					70
71	Medical Supplies Charged to Patients	3,289,818					71
72	Impl. Dev. Charged to Patients	2,506,719					72
73	Drugs Charged to Patients	4,846,692					73
74	Renal Dialysis	522,240					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	3,818,397					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	58,712,843					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	19,797					190
192	Physicians' Private Offices	352,709					192
194	MARKETING	490,999					194
194.0	COMMUNITY RELATIONS	276,287					194.0
2							2

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
194.0 3	SENIOR CENTER	44,489						194.0 3
194.0 4	PHYSICIAN CLINICS	167,338						194.0 4
194.0 5	POB	6,089,167						194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG	67,432						194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS	8,108						194.0 7
194.0 8	HOSPICE	312,927						194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	66,542,096						202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		308,741	165,702	474,443	474,443		5
6	Maintenance & Repairs							6
7	Operation of Plant		639,748	343,354	983,102	50,625	1,033,727	7
8	Laundry & Linen Service		25,302	13,580	38,882	4,247	6,965	8
9	Housekeeping		41,020	22,016	63,036	12,267	11,292	9
10	Dietary		161,500	86,677	248,177	13,232	44,459	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		22,825	12,250	35,075	7,803	6,283	13
14	Central Services & Supply		31,229	16,761	47,990	5,650	8,597	14
15	Pharmacy		30,419	16,326	46,745	16,924	8,374	15
16	Medical Records & Library		48,304	25,925	74,229	7,727	13,298	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					23		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		351,693	188,754	540,447	67,377	96,817	30
31	Intensive Care Unit		102,285	54,896	157,181	16,129	28,158	31
40	Subprovider - IPF		87,805	47,125	134,930	10,904	24,172	40
41	Subprovider - IRF		188,778	101,317	290,095	16,397	51,968	41
43	Nursery		74,402	39,932	114,334	12,046	20,482	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		188,881	101,373	290,254	30,056	51,997	50
50.01	GASTRO INTESTINAL SERVICES		27,720	14,878	42,598	2,763	7,631	50.01
51	Recovery Room		20,348	10,921	31,269	4,352	5,602	51
52	Delivery Room & Labor Room		221,320	118,783	340,103	17,008	60,927	52
53	Anesthesiology		5,868	3,150	9,018	1,622	1,616	53
54	Radiology-Diagnostic		153,774	82,531	236,305	12,829	42,332	54
56	Radioisotope		11,427	6,133	17,560	2,883	3,146	56
56.01	ULTRA SOUND		8,699	4,669	13,368	4,732	2,395	56.01
57	CT Scan		12,238	6,568	18,806	1,871	3,369	57
58	MRI		11,162	5,991	17,153	1,529	3,073	58
59	Cardiac Catheterization		51,445	27,610	79,055	4,899	14,162	59
60	Laboratory		98,141	52,673	150,814	18,921	27,017	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		4,084	2,192	6,276	1,150	1,124	63
65	Respiratory Therapy		8,758	4,701	13,459	6,799	2,411	65
66	Physical Therapy		86,198	46,263	132,461	8,715	23,729	66
67	Occupational Therapy						4,776	67
68	Speech Pathology		6,901	3,704	10,605	1,346	1,900	68
69	Electrocardiology		30,389	16,310	46,699	2,638	8,366	69
70	Electroencephalography					93		70
71	Medical Supplies Charged to Patients					19,660		71
72	Impl. Dev. Charged to Patients					15,011		72
73	Drugs Charged to Patients					15,846		73
74	Renal Dialysis					3,699		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		162,886	87,421	250,307	21,959	44,841	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		3,224,290	1,730,486	4,954,776	446,508	626,503	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,728	1,464	4,192	95	751	190
192	Physicians' Private Offices							192
194	MARKETING		8,655	4,645	13,300	3,326	2,383	194
194.0	COMMUNITY RELATIONS							194.0
2			7,417	3,981	11,398	1,828	2,042	2

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
194.0 3	SENIOR CENTER					317		194.0 3
194.0 4	PHYSICIAN CLINICS		18,519	9,939	28,458	867	5,098	194.0 4
194.0 5	POB		1,372,566	736,656	2,109,222	20,106	377,852	194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG					481		194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS							194.0 7
194.0 8	HOSPICE		69,374	37,233	106,607	915	19,098	194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		4,703,549	2,524,404	7,227,953	474,443	1,033,727	202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	50,094						8
9	Housekeeping	568	87,163					9
10	Dietary		3,816	309,684				10
11	Cafeteria			105,418	105,418			11
12	Maintenance of Personnel							12
13	Nursing Administration		539			2,432	52,132	13
14	Central Services & Supply		738			1,634	64,609	14
15	Pharmacy		719			3,775		15
16	Medical Records & Library		1,141			3,135		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	11						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,229	8,310	95,650	29,901	20,643		30
31	Intensive Care Unit	2,885	2,417	12,281	5,604	3,869		31
40	Subprovider - IPF	3,355	2,075	22,581	4,567	3,152		40
41	Subprovider - IRF	2,469	4,461	21,194	6,058	4,182		41
43	Nursery		1,758		3,797	2,621		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,113	4,463		7,856	5,423		50
50.01	GASTRO INTESTINAL SERVICES		655		631	435		50.01
51	Recovery Room	1,544	481		1,290	890		51
52	Delivery Room & Labor Room		5,230		5,365	3,703		52
53	Anesthesiology		139		804	555		53
54	Radiology-Diagnostic	3,373	3,634		4,718			54
56	Radioisotope		270		353			56
56.01	ULTRA SOUND		206		1,558			56.01
57	CT Scan		289		596			57
58	MRI		264		419			58
59	Cardiac Catheterization		1,216		1,243	858		59
60	Laboratory	9	2,319		1,173			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		97					63
65	Respiratory Therapy	444	207		3,065			65
66	Physical Therapy	2,335	2,037		3,535			66
67	Occupational Therapy	59			1,933			67
68	Speech Pathology		163		476			68
69	Electrocardiology		718		927	640		69
70	Electroencephalography				79	54		70
71	Medical Supplies Charged to Patients						36,633	71
72	Impl. Dev. Charged to Patients						27,976	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	4,540	3,849		7,396	5,107		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	49,934	52,211	257,124	104,320	52,132	64,609	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		64					190
192	Physicians' Private Offices			48,758				192
194	MARKETING		205		546			194
194.0	COMMUNITY RELATIONS		175		315			194.0
2								2

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
194.0 3	SENIOR CENTER							194.0 3
194.0 4	PHYSICIAN CLINICS		438		237			194.0 4
194.0 5	POB	160	32,431					194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG							194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS			1,121				194.0 7
194.0 8	HOSPICE		1,639	2,681				194.0 8
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	50,094	87,163	309,684	105,418	52,132	64,609	202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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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	76,537						15
16	Medical Records & Library		99,530					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			34				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		17,094		900,468		900,468	30
31	Intensive Care Unit		3,170		231,694		231,694	31
40	Subprovider - IPF		3,205		208,941		208,941	40
41	Subprovider - IRF		1,230		398,054		398,054	41
43	Nursery		1,266		156,304		156,304	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		6,792		400,954		400,954	50
50.01	GASTRO INTESTINAL SERVICES		902		55,615		55,615	50.01
51	Recovery Room		1,594		47,022		47,022	51
52	Delivery Room & Labor Room		2,609		434,945		434,945	52
53	Anesthesiology		1,710		15,464		15,464	53
54	Radiology-Diagnostic		2,510		305,701		305,701	54
56	Radioisotope		733		24,945		24,945	56
56.01	ULTRA SOUND		2,359		24,618		24,618	56.01
57	CT Scan		7,710		32,641		32,641	57
58	MRI		1,056		23,494		23,494	58
59	Cardiac Catheterization		1,988		103,421		103,421	59
60	Laboratory		9,006		209,259		209,259	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		604		9,251		9,251	63
65	Respiratory Therapy		1,319		27,704		27,704	65
66	Physical Therapy		2,172		174,984		174,984	66
67	Occupational Therapy		1,357		8,125		8,125	67
68	Speech Pathology		361		14,851		14,851	68
69	Electrocardiology		1,517		61,505		61,505	69
70	Electroencephalography		75		301		301	70
71	Medical Supplies Charged to Patients		2,786		59,079		59,079	71
72	Impl. Dev. Charged to Patients		1,702		44,689		44,689	72
73	Drugs Charged to Patients	76,537	12,270		104,653		104,653	73
74	Renal Dialysis		284		3,983		3,983	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		10,149		348,148		348,148	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	76,537	99,530		4,430,813		4,430,813	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				5,102		5,102	190
192	Physicians' Private Offices				48,758		48,758	192
194	MARKETING				19,760		19,760	194
194.0	COMMUNITY RELATIONS				15,758		15,758	194.0
2								2

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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	
194.0 3	SENIOR CENTER				317		317	194.0 3
194.0 4	PHYSICIAN CLINICS				35,098		35,098	194.0 4
194.0 5	POB				2,539,771		2,539,771	194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG				481		481	194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS				1,121		1,121	194.0 7
194.0 8	HOSPICE				130,940		130,940	194.0 8
200	Cross Foot Adjustments			34	34		34	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	76,537	99,530	34	7,227,953		7,227,953	202

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WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT T GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & 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			30,469,043				4
5	Administrative & General	20,939	20,939	3,947,895	-11,292,574	55,252,863		5
6	Maintenance & Repairs							6
7	Operation of Plant	43,388	43,388	1,085,750		5,895,538	254,670	7
8	Laundry & Linen Service	1,716	1,716			494,533	1,716	8
9	Housekeeping	2,782	2,782	839,700		1,428,595	2,782	9
10	Dietary	10,953	10,953	866,245		1,540,877	10,953	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,548	1,548	723,266		908,669	1,548	13
14	Central Services & Supply	2,118	2,118	198,843		657,952	2,118	14
15	Pharmacy	2,063	2,063	1,087,662		1,970,921	2,063	15
16	Medical Records & Library	3,276	3,276	471,728		899,858	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					2,661		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	23,852	23,852	6,079,448		7,847,925	23,852	30
31	Intensive Care Unit	6,937	6,937	1,407,454		1,878,301	6,937	31
40	Subprovider - IPF	5,955	5,955	911,474		1,269,803	5,955	40
41	Subprovider - IRF	12,803	12,803	1,266,555		1,909,547	12,803	41
43	Nursery	5,046	5,046	1,034,785		1,402,847	5,046	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,810	12,810	1,829,460		3,500,175	12,810	50
50.01	GASTRO INTESTINAL SERVICES	1,880	1,880	190,842		321,726	1,880	50.01
51	Recovery Room	1,380	1,380	391,272		506,788	1,380	51
52	Delivery Room & Labor Room	15,010	15,010	1,277,085		1,980,683	15,010	52
53	Anesthesiology	398	398	116,025		188,917	398	53
54	Radiology-Diagnostic	10,429	10,429	966,745		1,494,050	10,429	54
56	Radioisotope	775	775	116,373		335,732	775	56
56.01	ULTRA SOUND	590	590	445,161		551,090	590	56.01
57	CT Scan	830	830	153,817		217,886	830	57
58	MRI	757	757	129,928		178,084	757	58
59	Cardiac Catheterization	3,489	3,489	402,404		570,571	3,489	59
60	Laboratory	6,656	6,656	134,271		2,203,404	6,656	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	277	277			133,924	277	63
65	Respiratory Therapy	594	594	624,298		791,825	594	65
66	Physical Therapy	5,846	5,846	736,369		1,014,955	5,846	66
67	Occupational Therapy			448,147		556,231		67
68	Speech Pathology	468	468	120,568		156,800	468	68
69	Electrocardiology	2,061	2,061	203,951		307,185	2,061	69
70	Electroencephalography			13,005		10,785		70
71	Medical Supplies Charged to Patients					2,289,509		71
72	Impl. Dev. Charged to Patients					1,748,105		72
73	Drugs Charged to Patients					1,845,372		73
74	Renal Dialysis					430,720		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	1,834,802		2,557,280	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)	218,673	218,673	30,055,328	-11,292,574	51,999,824	154,346	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	185	185			11,046	185	190
192	Physicians' Private Offices							192
194	MARKETING	587	587	154,468		387,295	587	194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
194.0 2	COMMUNITY RELATIONS	503	503	147,227		212,850	503	194.0 2
194.0 3	SENIOR CENTER					36,939		194.0 3
194.0 4	PHYSICIAN CLINICS	1,256	1,256	65,302		100,918	1,256	194.0 4
194.0 5	POB	93,088	93,088			2,341,395	93,088	194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG			46,718		55,989		194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS							194.0 7
194.0 8	HOSPICE	4,705	4,705			106,607	4,705	194.0 8
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,703,549	2,524,404	6,024,953		11,292,574	7,100,468	202
203	Unit Cost Multiplier (Wkst. B, Part I)	14.744806	7.913567	0.197740		0.204380	27.881054	203
204	Cost to be allocated (Per Wkst. B, Part II)					474,443	1,033,727	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.008587	4.059084	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	NURSING ADMINISTRATION (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	646,367						8
9	Housekeeping	7,324	250,172					9
10	Dietary		10,953	237,336				10
11	Cafeteria			80,790	33,426			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,548		771	23,946		13
14	Central Services & Supply		2,118		518		10,000	14
15	Pharmacy		2,063		1,197			15
16	Medical Records & Library		3,276		994			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	137						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	312,645	23,852	73,304	9,481	9,481		30
31	Intensive Care Unit	37,230	6,937	9,412	1,777	1,777		31
40	Subprovider - IPF	43,292	5,955	17,306	1,448	1,448		40
41	Subprovider - IRF	31,862	12,803	16,243	1,921	1,921		41
43	Nursery		5,046		1,204	1,204		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	53,076	12,810		2,491	2,491		50
50.01	GASTRO INTESTINAL SERVICES		1,880		200	200		50.01
51	Recovery Room	19,920	1,380		409	409		51
52	Delivery Room & Labor Room		15,010		1,701	1,701		52
53	Anesthesiology		398		255	255		53
54	Radiology-Diagnostic	43,516	10,429		1,496			54
56	Radioisotope		775		112			56
56.01	ULTRA SOUND		590		494			56.01
57	CT Scan		830		189			57
58	MRI		757		133			58
59	Cardiac Catheterization		3,489		394	394		59
60	Laboratory	111	6,656		372			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		277					63
65	Respiratory Therapy	5,730	594		972			65
66	Physical Therapy	30,124	5,846		1,121			66
67	Occupational Therapy	755			613			67
68	Speech Pathology		468		151			68
69	Electrocardiology		2,061		294	294		69
70	Electroencephalography				25	25		70
71	Medical Supplies Charged to Patients						5,670	71
72	Impl. Dev. Charged to Patients						4,330	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	58,582	11,047		2,345	2,346		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	644,304	149,848	197,055	33,078	23,946	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		185					190
192	Physicians' Private Offices			37,367				192
194	MARKETING		587		173			194
194.0	COMMUNITY RELATIONS		503		100			194.0
2								2

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS		1,256		75			194.04
194.05	POB	2,063	93,088					194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS			859				194.07
194.08	HOSPICE		4,705	2,055				194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	643,450	1,805,427	2,240,227	762,582	1,166,305	878,579	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.995487	7.216743	9.439053	22.814037	48.705629	87.857900	203
204	Cost to be allocated (Per Wkst. B, Part II)	50,094	87,163	309,684	105,418	52,132	64,609	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.077501	0.348412	1.304834	3.153773	2.177065	6.460900	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHAR GES	I&R PROGRAM COSTS ASSIGNED TIME				
	15	16	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		327,149,245				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			60			22
23	Paramed Ed Prgm-(specify)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		55,976,881	60			30
31	Intensive Care Unit		10,428,615				31
40	Subprovider - IPF		10,542,004				40
41	Subprovider - IRF		4,045,990				41
43	Nursery		4,164,801				43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		22,341,153				50
50.01	GASTRO INTESTINAL SERVICES		2,965,753				50.01
51	Recovery Room		5,243,466				51
52	Delivery Room & Labor Room		8,581,338				52
53	Anesthesiology		5,623,818				53
54	Radiology-Diagnostic		8,257,873				54
56	Radioisotope		2,412,716				56
56.01	ULTRA SOUND		7,760,018				56.01
57	CT Scan		25,361,129				57
58	MRI		3,473,915				58
59	Cardiac Catheterization		6,540,056				59
60	Laboratory		29,623,830				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		1,987,723				63
65	Respiratory Therapy		4,339,131				65
66	Physical Therapy		7,144,638				66
67	Occupational Therapy		4,464,767				67
68	Speech Pathology		1,187,489				68
69	Electrocardiology		4,990,669				69
70	Electroencephalography		245,806				70
71	Medical Supplies Charged to Patients		9,165,823				71
72	Impl. Dev. Charged to Patients		5,600,254				72
73	Drugs Charged to Patients	100	40,361,410				73
74	Renal Dialysis		934,444				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		33,383,735				91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	327,149,245	60			118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
194	MARKETING						194

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHAR GES	I&R PROGRAM COSTS ASSIGNED TIME				
		15	16	22				
194.0 2	COMMUNITY RELATIONS							194.0 2
194.0 3	SENIOR CENTER							194.0 3
194.0 4	PHYSICIAN CLINICS							194.0 4
194.0 5	POB							194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG							194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS							194.0 7
194.0 8	HOSPICE							194.0 8
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,473,453	1,221,428	3,341				202
203	Unit Cost Multiplier (Wkst. B, Part I)	24,734.530000	0.003734	55.683333				203
204	Cost to be allocated (Per Wkst. B, Part II)	76,537	99,530	34				204
205	Unit Cost Multiplier (Wkst. B, Part II)	765.370000	0.000304	0.566667				205

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POST STEPDOWN ADJUSTMENTS**WORKSHEET B-2**

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		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	12,179,132		12,179,132	16,549	12,195,681	30
31	Intensive Care Unit	2,797,595		2,797,595		2,797,595	31
40	Subprovider - IPF	2,087,707		2,087,707	16,397	2,104,104	40
41	Subprovider - IRF	3,086,712		3,086,712	11,755	3,098,467	41
43	Nursery	1,968,326		1,968,326		1,968,326	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,979,557		4,979,557	17,832	4,997,389	50
50.01	GASTRO INTESTINAL SERVICES	478,841		478,841		478,841	50.01
51	Recovery Room	727,461		727,461		727,461	51
52	Delivery Room & Labor Room	3,066,011		3,066,011		3,066,011	52
53	Anesthesiology	280,734		280,734		280,734	53
54	Radiology-Diagnostic	2,273,724		2,273,724		2,273,724	54
56	Radioisotope	443,114		443,114		443,114	56
56.01	ULTRA SOUND	724,676		724,676		724,676	56.01
57	CT Scan	390,559		390,559		390,559	57
58	MRI	257,056		257,056		257,056	58
59	Cardiac Catheterization	862,240		862,240	7,866	870,106	59
60	Laboratory	3,006,559		3,006,559		3,006,559	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	178,439		178,439		178,439	63
65	Respiratory Therapy	1,018,587		1,018,587		1,018,587	65
66	Physical Therapy	1,509,815		1,509,815		1,509,815	66
67	Occupational Therapy	701,321		701,321		701,321	67
68	Speech Pathology	213,151		213,151		213,151	68
69	Electrocardiology	481,965		481,965		481,965	69
70	Electroencephalography	15,695		15,695		15,695	70
71	Medical Supplies Charged to Patients	3,289,818		3,289,818		3,289,818	71
72	Impl. Dev. Charged to Patients	2,506,719		2,506,719		2,506,719	72
73	Drugs Charged to Patients	4,846,692		4,846,692		4,846,692	73
74	Renal Dialysis	522,240		522,240		522,240	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	3,818,397		3,818,397		3,818,397	91
92	Observation Beds (Non-Distinct Part)	1,086,002		1,086,002		1,086,002	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	59,798,845		59,798,845	70,399	59,869,244	200
201	Less Observation Beds	1,086,002		1,086,002		1,086,002	201
202	Total (line 200 minus line 201)	58,712,843		58,712,843		58,783,242	202

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COMPUTATION OF RATIO OF COST TO CHARGES

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	50,937,574		50,937,574				30
31	Intensive Care Unit	10,428,615		10,428,615				31
40	Subprovider - IPF	10,542,004		10,542,004				40
41	Subprovider - IRF	4,045,990		4,045,990				41
43	Nursery	4,164,801		4,164,801				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,271,436	13,069,717	22,341,153	0.222887	0.222887	0.223685	50
50.01	GASTRO INTESTINAL SERVICES	825,967	2,139,786	2,965,753	0.161457	0.161457	0.161457	50.01
51	Recovery Room	2,415,052	2,828,414	5,243,466	0.138737	0.138737	0.138737	51
52	Delivery Room & Labor Room	8,092,505	488,833	8,581,338	0.357288	0.357288	0.357288	52
53	Anesthesiology	1,845,634	3,778,184	5,623,818	0.049919	0.049919	0.049919	53
54	Radiology-Diagnostic	2,180,018	6,077,855	8,257,873	0.275340	0.275340	0.275340	54
56	Radioisotope	880,542	1,532,174	2,412,716	0.183658	0.183658	0.183658	56
56.01	ULTRA SOUND	1,559,866	6,200,152	7,760,018	0.093386	0.093386	0.093386	56.01
57	CT Scan	7,989,348	17,371,781	25,361,129	0.015400	0.015400	0.015400	57
58	MRI	1,112,630	2,361,285	3,473,915	0.073996	0.073996	0.073996	58
59	Cardiac Catheterization	4,081,943	2,458,113	6,540,056	0.131840	0.131840	0.133043	59
60	Laboratory	18,316,130	11,307,700	29,623,830	0.101491	0.101491	0.101491	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,624,711	363,012	1,987,723	0.089771	0.089771	0.089771	63
65	Respiratory Therapy	4,039,319	299,812	4,339,131	0.234744	0.234744	0.234744	65
66	Physical Therapy	4,103,947	3,040,691	7,144,638	0.211321	0.211321	0.211321	66
67	Occupational Therapy	3,849,448	615,319	4,464,767	0.157079	0.157079	0.157079	67
68	Speech Pathology	1,161,945	25,544	1,187,489	0.179497	0.179497	0.179497	68
69	Electrocardiology	2,246,050	2,744,619	4,990,669	0.096573	0.096573	0.096573	69
70	Electroencephalography	180,546	65,260	245,806	0.063851	0.063851	0.063851	70
71	Medical Supplies Charged to Patients	4,417,271	4,748,552	9,165,823	0.358922	0.358922	0.358922	71
72	Impl. Dev. Charged to Patients	4,331,531	1,268,723	5,600,254	0.447608	0.447608	0.447608	72
73	Drugs Charged to Patients	27,785,496	12,575,914	40,361,410	0.120082	0.120082	0.120082	73
74	Renal Dialysis	906,016	28,428	934,444	0.558878	0.558878	0.558878	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	6,325,644	27,058,091	33,383,735	0.114379	0.114379	0.114379	91
92	Observation Beds (Non-Distinct Part)	263,050	4,776,257	5,039,307	0.215506	0.215506	0.215506	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	199,925,029	127,224,216	327,149,245				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	199,925,029	127,224,216	327,149,245				202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	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)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	900,468		900,468	19,832	45.40	5,060	229,724	30
31	Intensive Care Unit	231,694		231,694	2,320	99.87	669	66,813	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	208,941		208,941	4,265	48.99	2,278	111,599	40
41	Subprovider - IRF	398,054		398,054	4,003	99.44	1,916	190,527	41
42	Subprovider I								42
43	Nursery	156,304		156,304	2,268	68.92			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,895,461		1,895,461	32,688		9,923	598,663	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
6		7		8	9
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	19,832		5,060	30
31	Intensive Care Unit	2,320		669	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	4,265		2,278	40
41	Subprovider - IRF	4,003		1,916	41
42	Subprovider I				42
43	Nursery	2,268			43
44	Skilled Nursing Facility				44
45	Nursing Facility				45
200	Total (lines 30-199)	32,688		9,923	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,341,153			1,951,030		2,623,650		50
50.01	GASTRO INTESTINAL SERVICES	2,965,753			328,605		602,076		50.01
51	Recovery Room	5,243,466			510,902		906,479		51
52	Delivery Room & Labor Room	8,581,338			6,119				52
53	Anesthesiology	5,623,818			429,780		539,416		53
54	Radiology-Diagnostic	8,257,873			786,207		926,968		54
56	Radioisotope	2,412,716			379,853		554,616		56
56.01	ULTRA SOUND	7,760,018			587,516		188,499		56.01
57	CT Scan	25,361,129			2,750,567		3,051,693		57
58	MRI	3,473,915			422,107		580,477		58
59	Cardiac Catheterization	6,540,056			1,593,948		906,787		59
60	Laboratory	29,623,830			6,166,284		1,741,742		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,987,723			413,773		24,754		63
65	Respiratory Therapy	4,339,131			1,014,981		46,389		65
66	Physical Therapy	7,144,638			577,295		24,745		66
67	Occupational Therapy	4,464,767			572,358		22,361		67
68	Speech Pathology	1,187,489			108,832		1,636		68
69	Electrocardiology	4,990,669			1,008,875		1,067,860		69
70	Electroencephalography	245,806			65,096		21,424		70
71	Medical Supplies Charged to Pat	9,165,823			848,040		869,152		71
72	Impl. Dev. Charged to Patients	5,600,254			947,001		574,164		72
73	Drugs Charged to Patients	40,361,410			6,847,635		1,939,817		73
74	Renal Dialysis	934,444			265,075		15,620		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	33,383,735			2,062,218		2,979,616		91
92	Observation Beds (Non-Distinct	5,039,307			83,250		907,713		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	247,030,261			30,727,347		21,117,654		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0240

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
1	2	3	4	5	6	7			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.222887	2,623,650			584,777		50	
50.01	GASTRO INTESTINAL SERVICES	0.161457	602,076			97,209		50.01	
51	Recovery Room	0.138737	906,479			125,762		51	
52	Delivery Room & Labor Room	0.357288						52	
53	Anesthesiology	0.049919	539,416			26,927		53	
54	Radiology-Diagnostic	0.275340	926,968			255,231		54	
56	Radioisotope	0.183658	554,616			101,860		56	
56.01	ULTRA SOUND	0.093386	188,499			17,603		56.01	
57	CT Scan	0.015400	3,051,693			46,996		57	
58	MRI	0.073996	580,477			42,953		58	
59	Cardiac Catheterization	0.131840	906,787			119,551		59	
60	Laboratory	0.101491	1,741,742			176,771		60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
63	Blood Storing, Processing & Tra	0.089771	24,754			2,222		63	
65	Respiratory Therapy	0.234744	46,389			10,890		65	
66	Physical Therapy	0.211321	24,745			5,229		66	
67	Occupational Therapy	0.157079	22,361			3,512		67	
68	Speech Pathology	0.179497	1,636			294		68	
69	Electrocardiology	0.096573	1,067,860			103,126		69	
70	Electroencephalography	0.063851	21,424			1,368		70	
71	Medical Supplies Charged to Pat	0.358922	869,152			311,958		71	
72	Impl. Dev. Charged to Patients	0.447608	574,164			257,000		72	
73	Drugs Charged to Patients	0.120082	1,939,817		33,433	232,937	4,015	73	
74	Renal Dialysis	0.558878	15,620			8,730		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	0.114379	2,979,616			340,805		91	
92	Observation Beds (Non-Distinct	0.215506	907,713			195,618		92	
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		21,117,654		33,433	3,069,329	4,015	200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)		21,117,654		33,433	3,069,329	4,015	202	

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S240

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: 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	400,954	22,341,153	0.017947	1,020	18	50
50.01	GASTRO INTESTINAL SERVICES	55,615	2,965,753	0.018752			50.01
51	Recovery Room	47,022	5,243,466	0.008968	5,014	45	51
52	Delivery Room & Labor Room	434,945	8,581,338	0.050685			52
53	Anesthesiology	15,464	5,623,818	0.002750	50,416	139	53
54	Radiology-Diagnostic	305,701	8,257,873	0.037019	14,990	555	54
56	Radioisotope	24,945	2,412,716	0.010339			56
56.01	ULTRA SOUND	24,618	7,760,018	0.003172	4,278	14	56.01
57	CT Scan	32,641	25,361,129	0.001287	4,485	6	57
58	MRI	23,494	3,473,915	0.006763	6,320	43	58
59	Cardiac Catheterization	103,421	6,540,056	0.015813			59
60	Laboratory	209,259	29,623,830	0.007064	259,229	1,831	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	9,251	1,987,723	0.004654			63
65	Respiratory Therapy	27,704	4,339,131	0.006385	24,810	158	65
66	Physical Therapy	174,984	7,144,638	0.024492	13,258	325	66
67	Occupational Therapy	8,125	4,464,767	0.001820	6,163	11	67
68	Speech Pathology	14,851	1,187,489	0.012506	563	7	68
69	Electrocardiology	61,505	4,990,669	0.012324	58,056	715	69
70	Electroencephalography	301	245,806	0.001225	3,193	4	70
71	Medical Supplies Charged to Pat	59,079	9,165,823	0.006446	1,095	7	71
72	Impl. Dev. Charged to Patients	44,689	5,600,254	0.007980			72
73	Drugs Charged to Patients	104,653	40,361,410	0.002593	990,426	2,568	73
74	Renal Dialysis	3,983	934,444	0.004262			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	348,148	33,383,735	0.010429	2,339	24	91
92	Observation Beds (Non-Distinct		5,039,307				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,535,352	247,030,261		1,445,655	6,470	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,341,153			1,020				50
50.01	GASTRO INTESTINAL SERVICES	2,965,753							50.01
51	Recovery Room	5,243,466			5,014				51
52	Delivery Room & Labor Room	8,581,338							52
53	Anesthesiology	5,623,818			50,416				53
54	Radiology-Diagnostic	8,257,873			14,990		2,686		54
56	Radioisotope	2,412,716							56
56.01	ULTRA SOUND	7,760,018			4,278		2,016		56.01
57	CT Scan	25,361,129			4,485		4,485		57
58	MRI	3,473,915			6,320		10,308		58
59	Cardiac Catheterization	6,540,056							59
60	Laboratory	29,623,830			259,229				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,987,723							63
65	Respiratory Therapy	4,339,131			24,810				65
66	Physical Therapy	7,144,638			13,258				66
67	Occupational Therapy	4,464,767			6,163				67
68	Speech Pathology	1,187,489			563				68
69	Electrocardiology	4,990,669			58,056		3,778		69
70	Electroencephalography	245,806			3,193		2,163		70
71	Medical Supplies Charged to Pat	9,165,823			1,095		917		71
72	Impl. Dev. Charged to Patients	5,600,254							72
73	Drugs Charged to Patients	40,361,410			990,426		3,316		73
74	Renal Dialysis	934,444							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	33,383,735			2,339				91
92	Observation Beds (Non-Distinct	5,039,307							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	247,030,261			1,445,655		29,669		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S240

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.222887							50
50.01	GASTRO INTESTINAL SERVICES	0.161457							50.01
51	Recovery Room	0.138737							51
52	Delivery Room & Labor Room	0.357288							52
53	Anesthesiology	0.049919							53
54	Radiology-Diagnostic	0.275340	2,686			740			54
56	Radioisotope	0.183658							56
56.01	ULTRA SOUND	0.093386	2,016			188			56.01
57	CT Scan	0.015400	4,485			69			57
58	MRI	0.073996	10,308			763			58
59	Cardiac Catheterization	0.131840							59
60	Laboratory	0.101491							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.089771							63
65	Respiratory Therapy	0.234744							65
66	Physical Therapy	0.211321							66
67	Occupational Therapy	0.157079							67
68	Speech Pathology	0.179497							68
69	Electrocardiology	0.096573	3,778			365			69
70	Electroencephalography	0.063851	2,163			138			70
71	Medical Supplies Charged to Pat	0.358922	917			329			71
72	Impl. Dev. Charged to Patients	0.447608							72
73	Drugs Charged to Patients	0.120082	3,316		1,401	398		168	73
74	Renal Dialysis	0.558878							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	0.114379							91
92	Observation Beds (Non-Distinct)	0.215506							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		29,669		1,401	2,990		168	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		29,669		1,401	2,990		168	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T240

**WORKSHEET D
PART II**

Check Title V Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: 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	400,954	22,341,153	0.017947	30,382	545	50
50.01	GASTRO INTESTINAL SERVICES	55,615	2,965,753	0.018752			50.01
51	Recovery Room	47,022	5,243,466	0.008968	2,037	18	51
52	Delivery Room & Labor Room	434,945	8,581,338	0.050685			52
53	Anesthesiology	15,464	5,623,818	0.002750	1,270	3	53
54	Radiology-Diagnostic	305,701	8,257,873	0.037019	71,640	2,652	54
56	Radioisotope	24,945	2,412,716	0.010339	5,960	62	56
56.01	ULTRA SOUND	24,618	7,760,018	0.003172	2,638	8	56.01
57	CT Scan	32,641	25,361,129	0.001287	36,739	47	57
58	MRI	23,494	3,473,915	0.006763	9,825	66	58
59	Cardiac Catheterization	103,421	6,540,056	0.015813	8,669	137	59
60	Laboratory	209,259	29,623,830	0.007064	589,288	4,163	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	9,251	1,987,723	0.004654	19,064	89	63
65	Respiratory Therapy	27,704	4,339,131	0.006385	187,734	1,199	65
66	Physical Therapy	174,984	7,144,638	0.024492	1,423,462	34,863	66
67	Occupational Therapy	8,125	4,464,767	0.001820	1,334,509	2,429	67
68	Speech Pathology	14,851	1,187,489	0.012506	464,828	5,813	68
69	Electrocardiology	61,505	4,990,669	0.012324	12,395	153	69
70	Electroencephalography	301	245,806	0.001225			70
71	Medical Supplies Charged to Pat	59,079	9,165,823	0.006446	15,305	99	71
72	Impl. Dev. Charged to Patients	44,689	5,600,254	0.007980	789	6	72
73	Drugs Charged to Patients	104,653	40,361,410	0.002593	1,254,546	3,253	73
74	Renal Dialysis	3,983	934,444	0.004262	107,313	457	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	348,148	33,383,735	0.010429			91
92	Observation Beds (Non-Distinct		5,039,307				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,535,352	247,030,261		5,578,393	56,062	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-T240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-T240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,341,153			30,382				50
50.01	GASTRO INTESTINAL SERVICES	2,965,753							50.01
51	Recovery Room	5,243,466			2,037				51
52	Delivery Room & Labor Room	8,581,338							52
53	Anesthesiology	5,623,818			1,270				53
54	Radiology-Diagnostic	8,257,873			71,640		2,574		54
56	Radioisotope	2,412,716			5,960				56
56.01	ULTRA SOUND	7,760,018			2,638		1,709		56.01
57	CT Scan	25,361,129			36,739		2,877		57
58	MRI	3,473,915			9,825				58
59	Cardiac Catheterization	6,540,056			8,669				59
60	Laboratory	29,623,830			589,288				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,987,723			19,064				63
65	Respiratory Therapy	4,339,131			187,734		1,326		65
66	Physical Therapy	7,144,638			1,423,462				66
67	Occupational Therapy	4,464,767			1,334,509				67
68	Speech Pathology	1,187,489			464,828				68
69	Electrocardiology	4,990,669			12,395		1,278		69
70	Electroencephalography	245,806							70
71	Medical Supplies Charged to Pat	9,165,823			15,305				71
72	Impl. Dev. Charged to Patients	5,600,254			789				72
73	Drugs Charged to Patients	40,361,410			1,254,546		10,584		73
74	Renal Dialysis	934,444			107,313				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	33,383,735							91
92	Observation Beds (Non-Distinct	5,039,307							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	247,030,261			5,578,393		20,348		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T240

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.222887						50
50.01	GASTRO INTESTINAL SERVICES	0.161457						50.01
51	Recovery Room	0.138737						51
52	Delivery Room & Labor Room	0.357288						52
53	Anesthesiology	0.049919						53
54	Radiology-Diagnostic	0.275340	2,574			709		54
56	Radioisotope	0.183658						56
56.01	ULTRA SOUND	0.093386	1,709			160		56.01
57	CT Scan	0.015400	2,877			44		57
58	MRI	0.073996						58
59	Cardiac Catheterization	0.131840						59
60	Laboratory	0.101491						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.089771						63
65	Respiratory Therapy	0.234744	1,326			311		65
66	Physical Therapy	0.211321						66
67	Occupational Therapy	0.157079						67
68	Speech Pathology	0.179497						68
69	Electrocardiology	0.096573	1,278			123		69
70	Electroencephalography	0.063851						70
71	Medical Supplies Charged to Pat	0.358922						71
72	Impl. Dev. Charged to Patients	0.447608						72
73	Drugs Charged to Patients	0.120082	10,584			1,271		73
74	Renal Dialysis	0.558878						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	0.114379						91
92	Observation Beds (Non-Distinct	0.215506						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)		20,348			2,618		200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		20,348			2,618		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title v
 Applicable Title XVIII, Part A
 Boxes: Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	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)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	900,468		900,468	19,832	45.40	5,045	229,043	30
31	Intensive Care Unit	231,694		231,694	2,320	99.87	320	31,958	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	208,941		208,941	4,265	48.99			40
41	Subprovider - IRF	398,054		398,054	4,003	99.44	878	87,308	41
42	Subprovider I								42
43	Nursery	156,304		156,304	2,268	68.92	1,148	79,120	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,895,461		1,895,461	32,688		7,391	427,429	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0240

**WORKSHEET D
PART II**

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

(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	400,954	22,341,153	0.017947		50
50.01	GASTRO INTESTINAL SERVICES	55,615	2,965,753	0.018752		50.01
51	Recovery Room	47,022	5,243,466	0.008968		51
52	Delivery Room & Labor Room	434,945	8,581,338	0.050685		52
53	Anesthesiology	15,464	5,623,818	0.002750		53
54	Radiology-Diagnostic	305,701	8,257,873	0.037019		54
56	Radioisotope	24,945	2,412,716	0.010339		56
56.01	ULTRA SOUND	24,618	7,760,018	0.003172		56.01
57	CT Scan	32,641	25,361,129	0.001287		57
58	MRI	23,494	3,473,915	0.006763		58
59	Cardiac Catheterization	103,421	6,540,056	0.015813		59
60	Laboratory	209,259	29,623,830	0.007064		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	Blood Storing, Processing & Tra	9,251	1,987,723	0.004654		63
65	Respiratory Therapy	27,704	4,339,131	0.006385		65
66	Physical Therapy	174,984	7,144,638	0.024492		66
67	Occupational Therapy	8,125	4,464,767	0.001820		67
68	Speech Pathology	14,851	1,187,489	0.012506		68
69	Electrocardiology	61,505	4,990,669	0.012324		69
70	Electroencephalography	301	245,806	0.001225		70
71	Medical Supplies Charged to Pat	59,079	9,165,823	0.006446		71
72	Impl. Dev. Charged to Patients	44,689	5,600,254	0.007980		72
73	Drugs Charged to Patients	104,653	40,361,410	0.002593		73
74	Renal Dialysis	3,983	934,444	0.004262		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	348,148	33,383,735	0.010429		91
92	Observation Beds (Non-Distinct	80,185	5,039,307	0.015912		92
	OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-199)	2,615,537	247,030,261			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

Check Title v PPS
 Applicable Title XVIII, Part A TEFRA
 Boxes: Title XIX Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
6		7		8	9
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	19,832		5,045	30
31	Intensive Care Unit	2,320		320	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	4,265			40
41	Subprovider - IRF	4,003		878	41
42	Subprovider I				42
43	Nursery	2,268		1,148	43
44	Skilled Nursing Facility				44
45	Nursing Facility				45
200	Total (lines 30-199)	32,688		7,391	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	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)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,341,153							50
50.01	GASTRO INTESTINAL SERVICES	2,965,753							50.01
51	Recovery Room	5,243,466							51
52	Delivery Room & Labor Room	8,581,338							52
53	Anesthesiology	5,623,818							53
54	Radiology-Diagnostic	8,257,873							54
56	Radioisotope	2,412,716							56
56.01	ULTRA SOUND	7,760,018							56.01
57	CT Scan	25,361,129							57
58	MRI	3,473,915							58
59	Cardiac Catheterization	6,540,056							59
60	Laboratory	29,623,830							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,987,723							63
65	Respiratory Therapy	4,339,131							65
66	Physical Therapy	7,144,638							66
67	Occupational Therapy	4,464,767							67
68	Speech Pathology	1,187,489							68
69	Electrocardiology	4,990,669							69
70	Electroencephalography	245,806							70
71	Medical Supplies Charged to Pat	9,165,823							71
72	Impl. Dev. Charged to Patients	5,600,254							72
73	Drugs Charged to Patients	40,361,410							73
74	Renal Dialysis	934,444							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	33,383,735							91
92	Observation Beds (Non-Distinct	5,039,307							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	247,030,261							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0240

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.222887						50
50.01	GASTRO INTESTINAL SERVICES	0.161457						50.01
51	Recovery Room	0.138737						51
52	Delivery Room & Labor Room	0.357288						52
53	Anesthesiology	0.049919						53
54	Radiology-Diagnostic	0.275340						54
56	Radioisotope	0.183658						56
56.01	ULTRA SOUND	0.093386						56.01
57	CT Scan	0.015400						57
58	MRI	0.073996						58
59	Cardiac Catheterization	0.131840						59
60	Laboratory	0.101491						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.089771						63
65	Respiratory Therapy	0.234744						65
66	Physical Therapy	0.211321						66
67	Occupational Therapy	0.157079						67
68	Speech Pathology	0.179497						68
69	Electrocardiology	0.096573						69
70	Electroencephalography	0.063851						70
71	Medical Supplies Charged to Pat	0.358922						71
72	Impl. Dev. Charged to Patients	0.447608						72
73	Drugs Charged to Patients	0.120082						73
74	Renal Dialysis	0.558878						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	0.114379						91
92	Observation Beds (Non-Distinct)	0.215506						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S240

**WORKSHEET D
PART II**

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

(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	400,954	22,341,153	0.017947			50
50.01	GASTRO INTESTINAL SERVICES	55,615	2,965,753	0.018752			50.01
51	Recovery Room	47,022	5,243,466	0.008968			51
52	Delivery Room & Labor Room	434,945	8,581,338	0.050685			52
53	Anesthesiology	15,464	5,623,818	0.002750			53
54	Radiology-Diagnostic	305,701	8,257,873	0.037019			54
56	Radioisotope	24,945	2,412,716	0.010339			56
56.01	ULTRA SOUND	24,618	7,760,018	0.003172			56.01
57	CT Scan	32,641	25,361,129	0.001287			57
58	MRI	23,494	3,473,915	0.006763			58
59	Cardiac Catheterization	103,421	6,540,056	0.015813			59
60	Laboratory	209,259	29,623,830	0.007064			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	9,251	1,987,723	0.004654			63
65	Respiratory Therapy	27,704	4,339,131	0.006385			65
66	Physical Therapy	174,984	7,144,638	0.024492			66
67	Occupational Therapy	8,125	4,464,767	0.001820			67
68	Speech Pathology	14,851	1,187,489	0.012506			68
69	Electrocardiology	61,505	4,990,669	0.012324			69
70	Electroencephalography	301	245,806	0.001225			70
71	Medical Supplies Charged to Pat	59,079	9,165,823	0.006446			71
72	Impl. Dev. Charged to Patients	44,689	5,600,254	0.007980			72
73	Drugs Charged to Patients	104,653	40,361,410	0.002593			73
74	Renal Dialysis	3,983	934,444	0.004262			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	348,148	33,383,735	0.010429			91
92	Observation Beds (Non-Distinct		5,039,307				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,535,352	247,030,261				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,341,153							50
50.01	GASTRO INTESTINAL SERVICES	2,965,753							50.01
51	Recovery Room	5,243,466							51
52	Delivery Room & Labor Room	8,581,338							52
53	Anesthesiology	5,623,818							53
54	Radiology-Diagnostic	8,257,873							54
56	Radioisotope	2,412,716							56
56.01	ULTRA SOUND	7,760,018							56.01
57	CT Scan	25,361,129							57
58	MRI	3,473,915							58
59	Cardiac Catheterization	6,540,056							59
60	Laboratory	29,623,830							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,987,723							63
65	Respiratory Therapy	4,339,131							65
66	Physical Therapy	7,144,638							66
67	Occupational Therapy	4,464,767							67
68	Speech Pathology	1,187,489							68
69	Electrocardiology	4,990,669							69
70	Electroencephalography	245,806							70
71	Medical Supplies Charged to Pat	9,165,823							71
72	Impl. Dev. Charged to Patients	5,600,254							72
73	Drugs Charged to Patients	40,361,410							73
74	Renal Dialysis	934,444							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	33,383,735							91
92	Observation Beds (Non-Distinct	5,039,307							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	247,030,261							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S240

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.222887							50
50.01	GASTRO INTESTINAL SERVICES	0.161457							50.01
51	Recovery Room	0.138737							51
52	Delivery Room & Labor Room	0.357288							52
53	Anesthesiology	0.049919							53
54	Radiology-Diagnostic	0.275340							54
56	Radioisotope	0.183658							56
56.01	ULTRA SOUND	0.093386							56.01
57	CT Scan	0.015400							57
58	MRI	0.073996							58
59	Cardiac Catheterization	0.131840							59
60	Laboratory	0.101491							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.089771							63
65	Respiratory Therapy	0.234744							65
66	Physical Therapy	0.211321							66
67	Occupational Therapy	0.157079							67
68	Speech Pathology	0.179497							68
69	Electrocardiology	0.096573							69
70	Electroencephalography	0.063851							70
71	Medical Supplies Charged to Pat	0.358922							71
72	Impl. Dev. Charged to Patients	0.447608							72
73	Drugs Charged to Patients	0.120082							73
74	Renal Dialysis	0.558878							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	0.114379							91
92	Observation Beds (Non-Distinct)	0.215506							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-T240

**WORKSHEET D
PART II**

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

(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	400,954	22,341,153	0.017947			50
50.01	GASTRO INTESTINAL SERVICES	55,615	2,965,753	0.018752			50.01
51	Recovery Room	47,022	5,243,466	0.008968			51
52	Delivery Room & Labor Room	434,945	8,581,338	0.050685			52
53	Anesthesiology	15,464	5,623,818	0.002750			53
54	Radiology-Diagnostic	305,701	8,257,873	0.037019			54
56	Radioisotope	24,945	2,412,716	0.010339			56
56.01	ULTRA SOUND	24,618	7,760,018	0.003172			56.01
57	CT Scan	32,641	25,361,129	0.001287			57
58	MRI	23,494	3,473,915	0.006763			58
59	Cardiac Catheterization	103,421	6,540,056	0.015813			59
60	Laboratory	209,259	29,623,830	0.007064			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	9,251	1,987,723	0.004654			63
65	Respiratory Therapy	27,704	4,339,131	0.006385			65
66	Physical Therapy	174,984	7,144,638	0.024492			66
67	Occupational Therapy	8,125	4,464,767	0.001820			67
68	Speech Pathology	14,851	1,187,489	0.012506			68
69	Electrocardiology	61,505	4,990,669	0.012324			69
70	Electroencephalography	301	245,806	0.001225			70
71	Medical Supplies Charged to Pat	59,079	9,165,823	0.006446			71
72	Impl. Dev. Charged to Patients	44,689	5,600,254	0.007980			72
73	Drugs Charged to Patients	104,653	40,361,410	0.002593			73
74	Renal Dialysis	3,983	934,444	0.004262			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	348,148	33,383,735	0.010429			91
92	Observation Beds (Non-Distinct		5,039,307				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,535,352	247,030,261				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-T240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-T240

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	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)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,341,153							50
50.01	GASTRO INTESTINAL SERVICES	2,965,753							50.01
51	Recovery Room	5,243,466							51
52	Delivery Room & Labor Room	8,581,338							52
53	Anesthesiology	5,623,818							53
54	Radiology-Diagnostic	8,257,873							54
56	Radioisotope	2,412,716							56
56.01	ULTRA SOUND	7,760,018							56.01
57	CT Scan	25,361,129							57
58	MRI	3,473,915							58
59	Cardiac Catheterization	6,540,056							59
60	Laboratory	29,623,830							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	1,987,723							63
65	Respiratory Therapy	4,339,131							65
66	Physical Therapy	7,144,638							66
67	Occupational Therapy	4,464,767							67
68	Speech Pathology	1,187,489							68
69	Electrocardiology	4,990,669							69
70	Electroencephalography	245,806							70
71	Medical Supplies Charged to Pat	9,165,823							71
72	Impl. Dev. Charged to Patients	5,600,254							72
73	Drugs Charged to Patients	40,361,410							73
74	Renal Dialysis	934,444							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	33,383,735							91
92	Observation Beds (Non-Distinct	5,039,307							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	247,030,261							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-T240

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.222887						50
50.01	GASTRO INTESTINAL SERVICES	0.161457						50.01
51	Recovery Room	0.138737						51
52	Delivery Room & Labor Room	0.357288						52
53	Anesthesiology	0.049919						53
54	Radiology-Diagnostic	0.275340						54
56	Radioisotope	0.183658						56
56.01	ULTRA SOUND	0.093386						56.01
57	CT Scan	0.015400						57
58	MRI	0.073996						58
59	Cardiac Catheterization	0.131840						59
60	Laboratory	0.101491						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Tra	0.089771						63
65	Respiratory Therapy	0.234744						65
66	Physical Therapy	0.211321						66
67	Occupational Therapy	0.157079						67
68	Speech Pathology	0.179497						68
69	Electrocardiology	0.096573						69
70	Electroencephalography	0.063851						70
71	Medical Supplies Charged to Pat	0.358922						71
72	Impl. Dev. Charged to Patients	0.447608						72
73	Drugs Charged to Patients	0.120082						73
74	Renal Dialysis	0.558878						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	0.114379						91
92	Observation Beds (Non-Distinct)	0.215506						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,832	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,832	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)	18,066	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)	5,060	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)	12,195,681	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)	12,195,681	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)	12,195,681	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)					614.95	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,111,647	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)					3,111,647	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,797,595	2,320	1,205.86	669	806,720	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)					4,397,505	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					8,315,872	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					296,537	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					249,509	51
52	Total Program excludable cost (sum of lines 50 and 51)					546,046	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					7,769,826	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

**WORKSHEET D-1
PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,766	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					614.95	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,086,002	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	900,468	12,195,681	0.073835	1,086,002	80,185	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S240

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,265	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,265	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)	4,265	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)	2,278	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)	2,104,104	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)	2,104,104	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)	2,104,104	37

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S240

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	493.34	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,123,829	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)	1,123,829	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	169,913	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,293,742	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	111,599	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	6,470	51
52	Total Program excludable cost (sum of lines 50 and 51)	118,069	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,175,673	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T240

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,003	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,003	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)	4,003	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)	1,916	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)	3,098,467	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)	3,098,467	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)	3,098,467	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T240

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	774.04	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,483,061	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)	1,483,061	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	947,772	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,430,833	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	190,527	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	56,062	51
52	Total Program excludable cost (sum of lines 50 and 51)	246,589	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,184,244	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	19,832	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	19,832	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)	18,066	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)	5,045	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)	2,268	15
16	Nursery days (title V or XIX only)	1,148	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)	12,179,132	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)	12,179,132	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)	12,179,132	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)					614.12	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,098,235	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)					3,098,235	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)	1,968,326	2,268	867.87	1,148	996,315	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,797,595	2,320	1,205.86	320	385,875	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)					4,480,425	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					340,121	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)					340,121	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

**WORKSHEET D-1
PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,766	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S240

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,265	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,265	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)	4,265	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)	2,087,707	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)	2,087,707	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)	2,087,707	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S240

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	489.50	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 enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T240

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,003	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,003	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)	4,003	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)	878	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)	3,086,712	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)	3,086,712	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)	3,086,712	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-T240

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	771.10	38
39	Program general inpatient routine service cost (line 9 x line 38)	677,026	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)	677,026	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)	677,026	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	87,308	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)	87,308	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0240

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		16,131,103		30
31	Intensive Care Unit		3,131,691		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.223685	1,951,030	436,416	50
50.01	GASTRO INTESTINAL SERVICES	0.161457	328,605	53,056	50.01
51	Recovery Room	0.138737	510,902	70,881	51
52	Delivery Room & Labor Room	0.357288	6,119	2,186	52
53	Anesthesiology	0.049919	429,780	21,454	53
54	Radiology-Diagnostic	0.275340	786,207	216,474	54
56	Radioisotope	0.183658	379,853	69,763	56
56.01	ULTRA SOUND	0.093386	587,516	54,866	56.01
57	CT Scan	0.015400	2,750,567	42,359	57
58	MRI	0.073996	422,107	31,234	58
59	Cardiac Catheterization	0.133043	1,593,948	212,064	59
60	Laboratory	0.101491	6,166,284	625,822	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.089771	413,773	37,145	63
65	Respiratory Therapy	0.234744	1,014,981	238,261	65
66	Physical Therapy	0.211321	577,295	121,995	66
67	Occupational Therapy	0.157079	572,358	89,905	67
68	Speech Pathology	0.179497	108,832	19,535	68
69	Electrocardiology	0.096573	1,008,875	97,430	69
70	Electroencephalography	0.063851	65,096	4,156	70
71	Medical Supplies Charged to Patients	0.358922	848,040	304,380	71
72	Impl. Dev. Charged to Patients	0.447608	947,001	423,885	72
73	Drugs Charged to Patients	0.120082	6,847,635	822,278	73
74	Renal Dialysis	0.558878	265,075	148,145	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	0.114379	2,062,218	235,874	91
92	Observation Beds (Non-Distinct Part)	0.215506	83,250	17,941	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		30,727,347	4,397,505	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		30,727,347		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S240

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		5,544,840		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.223685	1,020	228	50
50.01	GASTRO INTESTINAL SERVICES	0.161457			50.01
51	Recovery Room	0.138737	5,014	696	51
52	Delivery Room & Labor Room	0.357288			52
53	Anesthesiology	0.049919	50,416	2,517	53
54	Radiology-Diagnostic	0.275340	14,990	4,127	54
56	Radioisotope	0.183658			56
56.01	ULTRA SOUND	0.093386	4,278	400	56.01
57	CT Scan	0.015400	4,485	69	57
58	MRI	0.073996	6,320	468	58
59	Cardiac Catheterization	0.133043			59
60	Laboratory	0.101491	259,229	26,309	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.089771			63
65	Respiratory Therapy	0.234744	24,810	5,824	65
66	Physical Therapy	0.211321	13,258	2,802	66
67	Occupational Therapy	0.157079	6,163	968	67
68	Speech Pathology	0.179497	563	101	68
69	Electrocardiology	0.096573	58,056	5,607	69
70	Electroencephalography	0.063851	3,193	204	70
71	Medical Supplies Charged to Patients	0.358922	1,095	393	71
72	Impl. Dev. Charged to Patients	0.447608			72
73	Drugs Charged to Patients	0.120082	990,426	118,932	73
74	Renal Dialysis	0.558878			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	0.114379	2,339	268	91
92	Observation Beds (Non-Distinct Part)	0.215506			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,445,655	169,913	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,445,655		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T240

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF		2,026,827		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.223685	30,382	6,796	50
50.01	GASTRO INTESTINAL SERVICES	0.161457			50.01
51	Recovery Room	0.138737	2,037	283	51
52	Delivery Room & Labor Room	0.357288			52
53	Anesthesiology	0.049919	1,270	63	53
54	Radiology-Diagnostic	0.275340	71,640	19,725	54
56	Radioisotope	0.183658	5,960	1,095	56
56.01	ULTRA SOUND	0.093386	2,638	246	56.01
57	CT Scan	0.015400	36,739	566	57
58	MRI	0.073996	9,825	727	58
59	Cardiac Catheterization	0.133043	8,669	1,153	59
60	Laboratory	0.101491	589,288	59,807	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.089771	19,064	1,711	63
65	Respiratory Therapy	0.234744	187,734	44,069	65
66	Physical Therapy	0.211321	1,423,462	300,807	66
67	Occupational Therapy	0.157079	1,334,509	209,623	67
68	Speech Pathology	0.179497	464,828	83,435	68
69	Electrocardiology	0.096573	12,395	1,197	69
70	Electroencephalography	0.063851			70
71	Medical Supplies Charged to Patients	0.358922	15,305	5,493	71
72	Impl. Dev. Charged to Patients	0.447608	789	353	72
73	Drugs Charged to Patients	0.120082	1,254,546	150,648	73
74	Renal Dialysis	0.558878	107,313	59,975	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	0.114379			91
92	Observation Beds (Non-Distinct Part)	0.215506			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,578,393	947,772	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,578,393		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0240

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		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	0.222887			50
50.01	GASTRO INTESTINAL SERVICES	0.161457			50.01
51	Recovery Room	0.138737			51
52	Delivery Room & Labor Room	0.357288			52
53	Anesthesiology	0.049919			53
54	Radiology-Diagnostic	0.275340			54
56	Radioisotope	0.183658			56
56.01	ULTRA SOUND	0.093386			56.01
57	CT Scan	0.015400			57
58	MRI	0.073996			58
59	Cardiac Catheterization	0.131840			59
60	Laboratory	0.101491			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.089771			63
65	Respiratory Therapy	0.234744			65
66	Physical Therapy	0.211321			66
67	Occupational Therapy	0.157079			67
68	Speech Pathology	0.179497			68
69	Electrocardiology	0.096573			69
70	Electroencephalography	0.063851			70
71	Medical Supplies Charged to Patients	0.358922			71
72	Impl. Dev. Charged to Patients	0.447608			72
73	Drugs Charged to Patients	0.120082			73
74	Renal Dialysis	0.558878			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	0.114379			91
92	Observation Beds (Non-Distinct Part)	0.215506			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S240

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.222887			50
50.01	GASTRO INTESTINAL SERVICES	0.161457			50.01
51	Recovery Room	0.138737			51
52	Delivery Room & Labor Room	0.357288			52
53	Anesthesiology	0.049919			53
54	Radiology-Diagnostic	0.275340			54
56	Radioisotope	0.183658			56
56.01	ULTRA SOUND	0.093386			56.01
57	CT Scan	0.015400			57
58	MRI	0.073996			58
59	Cardiac Catheterization	0.131840			59
60	Laboratory	0.101491			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.089771			63
65	Respiratory Therapy	0.234744			65
66	Physical Therapy	0.211321			66
67	Occupational Therapy	0.157079			67
68	Speech Pathology	0.179497			68
69	Electrocardiology	0.096573			69
70	Electroencephalography	0.063851			70
71	Medical Supplies Charged to Patients	0.358922			71
72	Impl. Dev. Charged to Patients	0.447608			72
73	Drugs Charged to Patients	0.120082			73
74	Renal Dialysis	0.558878			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	0.114379			91
92	Observation Beds (Non-Distinct Part)	0.215506			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T240

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		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	0.222887			50
50.01	GASTRO INTESTINAL SERVICES	0.161457			50.01
51	Recovery Room	0.138737			51
52	Delivery Room & Labor Room	0.357288			52
53	Anesthesiology	0.049919			53
54	Radiology-Diagnostic	0.275340			54
56	Radioisotope	0.183658			56
56.01	ULTRA SOUND	0.093386			56.01
57	CT Scan	0.015400			57
58	MRI	0.073996			58
59	Cardiac Catheterization	0.131840			59
60	Laboratory	0.101491			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.089771			63
65	Respiratory Therapy	0.234744			65
66	Physical Therapy	0.211321			66
67	Occupational Therapy	0.157079			67
68	Speech Pathology	0.179497			68
69	Electrocardiology	0.096573			69
70	Electroencephalography	0.063851			70
71	Medical Supplies Charged to Patients	0.358922			71
72	Impl. Dev. Charged to Patients	0.447608			72
73	Drugs Charged to Patients	0.120082			73
74	Renal Dialysis	0.558878			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	0.114379			91
92	Observation Beds (Non-Distinct Part)	0.215506			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	2,016,784			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,869,347			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)	3,545			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	2,103,803			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	116.17			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	0.60			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	0.60			12
13	Total allowable FTE count for the prior year	0.34			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	1.27			14
15	Sum of lines 12 through 14 divided by 3	0.74			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	0.74			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.006370			19
20	Prior year resident to bed ratio (see instructions)	0.002614			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.002614			21
22	IME payment adjustment (see instructions)	11,261			22
22.01	IME payment adjustment - Managed Care (see instructions)	3,004			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)	-1.40			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)	11,261			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	3,004			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1133			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4632			31
32	Sum of lines 30 and 31	0.5765			32
33	Allowable disproportionate share percentage (see instructions)	0.3678			33
34	Disproportionate share adjustment (see instructions)	725,130			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,924,455		1,705,944	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	485,069		1,277,128	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,762,197			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

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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)	10,388,264			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)	10,391,268			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	713,206			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)	27,905			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)	11,132,379			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	11,132,379			61
62	Deductibles billed to program beneficiaries	771,204			62
63	Coinsurance billed to program beneficiaries	148,694			63
64	Allowable bad debts (see instructions)	607,622			64
65	Adjusted reimbursable bad debts (see instructions)	394,954			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	431,253			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	10,607,435			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	-30,139			70.93
70.94	HRR adjustment amount (see instructions)	-35,506			70.94
70.99	HAC adjustment amount (see instructions)	28,479			70.99
71	Amount due provider (see instructions)	10,513,311			71
71.01	Sequestration adjustment (see instructions)	210,266			71.01
72	Interim payments	9,715,873			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	587,172			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	245,489			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
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HVBP Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION

EXHIBIT 5

	(Amt. from Wkst. E, Pt. A or L Pt. I)	Prior to 10/1		On or after 10/1		Total (cols. 2 and 3)	
	(1)	(2)	(2.01)	(3)	(3.01)	(4)	
1	DRG Amounts Other Than Outlier Payments						1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	2,016,784	2,016,784			2,016,784	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	5,869,347		5,869,347		5,869,347	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1						1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1						1.04
2	Outlier payments for discharges	3,545		3,545		3,545	2
2.01	Outlier payment for discharges for Model 4 BPCI						2.01
3	Operating outlier reconciliation						3
4	Managed Care Simulated Payments	2,103,803	436,264	1,667,539		2,103,803	4
	Indirect Medical Education Adjustment						
5	Amount from Worksheet E Part A, line 21	0.002614	0.002614	0.002614			5
6	IME payment adjustment	11,261	2,880	8,381		11,261	6
6.01	IME payment adjustment for managed care	3,004	623	2,381		3,004	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7	IME payment adjustment factor						7
8	IME add-on adjustment amount						8
8.01	IME payment adjustment add-on for managed care						8.01
9	Total IME payment (sum of lines 6 and 8)	11,261	2,880	8,381		11,261	9
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	3,004	623	2,381		3,004	9.01
	Disproportionate Share Adjustment						
10	Allowable disproportionate share percentage	0.3678	0.3678	0.3678	0.3678	0.3678	10
11	Disproportionate share adjustment	725,130	185,443	539,687		725,130	11
11.01	Uncompensated care payments	1,762,197	485,069	1,277,128		1,762,197	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12	Total ESRD additional payment						12
13	Subtotal	10,388,264	2,690,176	7,698,088		10,388,264	13
14	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.)						14
15	Total payment for inpatient operating costs SCH and MDH only	10,391,268	2,690,799	7,700,469		10,391,268	15
16	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	713,206	181,800	531,406		713,206	16
17	Special add-on payments for new technologies						17
17.01	Net organ acquisition cost (Wkst. D-4 Pt. III, col 1, line 69)						17.01
17.02	Credits received from manufacturers for replaced devices applicable to MS-DRG						17.02
18	Capital outlier reconciliation adjustment amount						18
19	SUBTOTAL		2,872,599	8,231,875		11,104,474	19
20	Capital DRG other than outlier	632,036	161,241	470,795		632,036	20
20.01	Model 4 BPCI Capital DRG other than outlier						20.01
21	Capital DRG outlier payments	585		585		585	21
21.01	Model 4 BPCI Capital DRG outlier payments						21.01
22	Indirect medical education percentage	0.3700	0.3700	0.3700			22
23	Indirect medical education adjustment	2,339	597	1,742		2,339	23
24	Allowable disproportionate share percentage	0.1238	0.1238	0.1238			24
25	Disproportionate share adjustment	78,246	19,962	58,284		78,246	25
26	Total prospective capital payments	713,206	181,800	531,406		713,206	26
27							27
28	Low volume adjustment prior to October 1						28
29	Low volume adjustment on or after October 1						29
30	HVBP payment adjustment	-30,139	-14,979	-15,160		-30,139	30
30.01	HVBP payment adjustment for HSP bonus payment						30.01
31	HRR adjustment	-35,506	-9,681	-25,825		-35,506	31
31.01	HRR adjustment for HSP bonus payment						31.01
32	HAC Reduction Program adjustment		28,479			28,479	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0240

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	4,015			1
2	Medical and other services reimbursed under OPPS (see instructions)	3,069,329			2
3	PPS payments	2,909,510			3
4	Outlier payment (see instructions)	1,620			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)	4,015			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	33,433			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)	33,433			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)	33,433			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	29,418			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)	4,015			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)	2,911,130			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	597,682			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)	2,317,463			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	7,123			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,324,586			30
31	Primary payer payments	5,791			31
32	Subtotal (line 30 minus line 31)	2,318,795			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)	266,493			34
35	Adjusted reimbursable bad debts (see instructions)	173,220			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	201,819			36
37	Subtotal (see instructions)	2,492,015			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)	2,492,015			40
40.01	Sequestration adjustment (see instructions)	49,840			40.01
41	Interim payments	2,422,424			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	19,751			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S240

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	168			1
2	Medical and other services reimbursed under OPPS (see instructions)	2,990			2
3	PPS payments	3,284			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)	168			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	1,401			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)	1,401			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)	1,401			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	1,233			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)	168			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)	3,284			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	757			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)	2,695			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)	2,695			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,695			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)	2,695			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)	2,695			40
40.01	Sequestration adjustment (see instructions)	54			40.01
41	Interim payments	2,514			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	127			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T240

**WORKSHEET E
PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)	2,618			2
3	PPS payments	1,604			3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	1,604			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	355			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,249			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,249			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	1,249			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	1,249			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,249			40
40.01	Sequestration adjustment (see instructions)	25			40.01
41	Interim payments	-13,555			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	14,779			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0240

**WORKSHEET E-1
PART I**

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

		INPATIENT PART A		PART B			
DESCRIPTION		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	Total interim payments paid to provider		10,182,017		2,651,385	1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01				3.01	
		.02				3.02	
	Program	.03				3.03	
	to	.04				3.04	
	Provider	.05				3.05	
		.06				3.06	
		.07				3.07	
		.08				3.08	
		.09				3.09	
		.10				3.10	
		.50	01/29/2016	415,574	01/29/2016	153,219	3.50
		.51	06/16/2016	50,570	06/16/2016	75,742	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		-466,144		-228,961	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)			9,715,873		2,422,424	4
TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01				5.01	
		.02				5.02	
	Program	.03				5.03	
	to	.04				5.04	
	Provider	.05				5.05	
		.06				5.06	
		.07				5.07	
		.08				5.08	
		.09				5.09	
		.10				5.10	
		.50				5.50	
		.51				5.51	
	Provider	.52				5.52	
	to	.53				5.53	
	Program	.54				5.54	
		.55				5.55	
		.56				5.56	
		.57				5.57	
		.58				5.58	
		.59				5.59	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99	
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		587,172		19,751	6.01
		.02					6.02
7	Total Medicare program liability (see instructions)			10,303,045		2,442,175	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.

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S240

**WORKSHEET E-1
PART I**

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		1,700,627		2,514	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,700,627		2,514	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	5		127	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		1,700,632		2,641	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.

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-T240

**WORKSHEET E-1
PART I**

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		2,758,847		1,224	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50		01/26/2016	14,779	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			-14,779	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)		2,758,847		-13,555	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
		.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			14,779	6.01
		.02		-16,013		6.02
7	Total Medicare program liability (see instructions)		2,742,834		1,224	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.

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT**WORKSHEET E-1
PART II**

Check Hospital CAH
applicable box:

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)	4,532	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	5,729	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,509	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	20,386	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	327,149,245	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	4,588,658	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)	481,922	8
9	Sequestration adjustment amount (see instructions)	9,638	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	472,284	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	508,325	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-36,041	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.

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S240

**WORKSHEET E-3
PART II**

Check Hospital
Applicable Subprovider IPF
Box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,869,244	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment	19,479	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)	11.653005	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)	1,888,723	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)	1,888,723	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,888,723	18
19	Deductibles	105,616	19
20	Subtotal (line 18 minus line 19)	1,783,107	20
21	Coinsurance	47,768	21
22	Subtotal (line 20 minus line 21)	1,735,339	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)	1,735,339	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)	1,735,339	31
31.01	Sequestration adjustment (see instructions)	34,707	31.01
32	Interim payments	1,700,627	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	5	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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T240

**WORKSHEET E-3
PART III**

Check Hospital
Applicable Subprovider IRF
Box:

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	2,573,017		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.053300		2
3	Inpatient Rehabilitation LIP payments (see instructions)	204,812		3
4	Outlier payments	65,683		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	10,937,158		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	2,843,512		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)	2,843,512		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	2,843,512		19
20	Deductibles	11,396		20
21	Subtotal (line 19 minus line 20)	2,832,116		21
22	Coinsurance	33,306		22
23	Subtotal (line 21 minus line 22)	2,798,810		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)	2,798,810		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)	2,798,810		32
32.01	Sequestration adjustment (see instructions)	55,976		32.01
33	Interim payments	2,758,847		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	-16,013		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	8,748		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)	65,683		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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0240

**WORKSHEET E-3
PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services	4,480,425		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	4,480,425		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	4,480,425		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 charge 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)	4,480,425		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)	4,480,425		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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/15/2016 Run Time: 10:16 Version: 2016.05 (11/01/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S240

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services			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 cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T240

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services	677.026		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	677.026		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	677.026		7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
CUSTOMARY CHARGES				
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	677.026		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)	677.026		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check [] Title V
 Applicable [XX] Title XVIII
 Box: [] 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 cap (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 the current year from your records (see instructions)			0.60	6
7	Enter the lesser of line 5 or line 6			0.60	7
		Primary Care 1	Other 2	Total 3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.60	0.00	0.60	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	0.60	0.00	0.60	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
11	Total weighted FTE count	0.60	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.32	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.27	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.73	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	0.73	0.00		17
18	Per resident amount	115,305.23	112,208.28		18
19	Approved amount for resident costs	84,173		84,173	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)			84,173	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	9,923	2,474		26
27	Total inpatient days (see instructions)	28,950	28,950		27
28	Ratio of inpatient days to total inpatient days	0.342763	0.085458		28
29	Program direct GME amount	28,851	7,193		29
30	Reduction for direct GME payments for Medicare Advantage		1,016		30
31	Net Program direct GME amount			35,028	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)			934,444	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)			12,040,447	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)			12,040,447	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			3,079,120	42
43	Primary payer payments (see instructions)			5,791	43
44	Total Part B reasonable cost (line 42 minus line 43)			3,073,329	44
45	Total reasonable cost (sum of lines 41 and 44)			15,113,776	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.796654	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.203346	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			35,028	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			27,905	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			7,123	50

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

Check [] Title V
 Applicable [] Title XVIII
 Box: [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 cap (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 the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care 1	Other 2	Total 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					
26	Inpatient days (see instructions)	6,415	3,946		26
27	Total inpatient days (see instructions)	28,950	28,950		27
28	Ratio of inpatient days to total inpatient days	0.221589	0.136304		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

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	-124,373				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	14,982,608				4
5	Other receivables	115,592				5
6	Allowances for uncollectible notes and accounts receivable	-2,003,429				6
7	Inventory	1,385,053				7
8	Prepaid expenses	88,104				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	14,443,555				11
FIXED ASSETS						
12	Land	9,300,000				12
13	Land improvements	260,000				13
14	Accumulated depreciation					14
15	Buildings	19,001,330				15
16	Accumulated depreciation					16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	3,375,445				23
24	Accumulated depreciation	-6,175,667				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	35,189				29
30	Total fixed assets (sum of lines 12-29)	25,796,297				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	299,331				34
35	Total other assets (sum of lines 31-34)	299,331				35
36	Total assets (sum of lines 11, 30 and 35)	40,539,183				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	3,072,848				37
38	Salaries, wages and fees payable	4,489,718				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	-1,135,490				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	6,427,076				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	71,439,500				47
48	Unsecured loans					48
49	Other long term liabilities	2,118,366				49
50	Total long term liabilities (sum of lines 46 thru 49)	73,557,866				50
51	Total liabilities (sum of lines 45 and 50)	79,984,942				51
CAPITAL ACCOUNTS						
52	General fund balance	-39,445,759				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

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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets					
	(Omit Cents)	1	2	3	4	
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)	-39,445,759				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	40,539,183				60

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		-32,923,243		
2	Net income (loss) (from Worksheet G-3, line 29)		-3,416,343		
3	Total (sum of line 1 and line 2)		-36,339,586		
4	Additions (credit adjustments) (specify)				
5					
6					
7					
8					
9					
10	Total additions (sum of lines 4-9)				
11	Subtotal (line 3 plus line 10)		-36,339,586		
12	Deductions (debit adjustments) (specify)	3,106,173			
13					
14					
15					
16					
17					
18	Total deductions (sum of lines 12-17)		3,106,173		
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-39,445,759		

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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	55,102,375		55,102,375	1
2	Subprovider IPF	10,542,004		10,542,004	2
3	Subprovider IRF	4,045,990		4,045,990	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)	69,690,369		69,690,369	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	10,428,615		10,428,615	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)	10,428,615		10,428,615	16
17	Total inpatient routine care services (sum of lines 10 and 16)	80,118,984		80,118,984	17
18	Ancillary services	113,217,351	95,389,867	208,607,218	18
19	Outpatient services	6,588,694	31,834,348	38,423,042	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)	199,925,029	127,224,215	327,149,244	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		67,498,664	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)		67,498,664	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	327,149,244	1
2	Less contractual allowances and discounts on patients' accounts	264,931,096	2
3	Net patient revenues (line 1 minus line 2)	62,218,148	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	67,498,664	4
5	Net income from service to patients (line 3 minus line 4)	-5,280,516	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	8,707	21
22	Rental of hosptial space	1,175,964	22
23	Governmental appropriations		23
24	Other (HOSPICE BED RENTAL REVENUE)	81,669	24
24.0	Other (OTHER OPERATING REVENUE)	597,833	24.0
1			1
25	Total other income (sum of lines 6-24)	1,864,173	25
26	Total (line 5 plus line 25)	-3,416,343	26
29	Net income (or loss) for the period (line 26 minus line 28)	-3,416,343	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0240

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	632,036	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	585	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)	56.51	3
4	Number of interns & residents (see instructions)	0.74	4
5	Indirect medical education percentage (see instructions)	0.37	5
6	Indirect medical education adjustment (see instructions)	2,339	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1133	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4632	8
9	Sum of lines 7 and 8	0.5765	9
10	Allowable disproportionate share percentage (see instructions)	0.1238	10
11	Disproportionate share adjustment (see instructions)	78,246	11
12	Total prospective capital payments (see instructions)	713,206	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY 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
194.0	COMMUNITY RELATIONS						194.0
2							2

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
194.0 3	SENIOR CENTER						194.0 3
194.0 4	PHYSICIAN CLINICS						194.0 4
194.0 5	POB						194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG						194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS						194.0 7
194.0 8	HOSPICE						194.0 8
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202