

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 11/16/2017 Time: 12:08	
	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 07/01/2016 and ending 06/30/2017, 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		551,000	14,124	-3,295		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF		13,923				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		564,926	14,124	-3,295		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

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 / 2016	To: 06 / 30 / 2017	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.	2,167	674	3		7,122	193	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.	949						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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2		
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39	
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40	
		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

		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				1.27	67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 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:	1,351,309			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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**WORKSHEET S-2
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)	0.25			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07 / 01 / 2016	09 / 28 / 2016		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	C	12/31/2016	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	09/30/2017	Y	09/30/2017
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 relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

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

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

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

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				
						Title V	Title XVIII	Title XIX	Total All Patients	
						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	39,785		4,598	2,272	15,941	1	
2	HMO and other (see instructions)					1,243	7,122		2	
3	HMO IPF Subprovider					941	3,933		3	
4	HMO IRF Subprovider					432			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	39,785		4,598	2,272	15,941	7	
8	Intensive Care Unit	31	12	4,380		551	119	1,882	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					453	2,378	13	
14	Total (see instructions)		121	44,165		5,149	2,844	20,201	14	
15	CAH Visits								15	
16	Subprovider - IPF	40	17	6,205		1,826	2,057	4,108	16	
17	Subprovider - IRF	41	20	7,300		1,684	949	3,636	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							1,603	28	
29	Ambulance Trips								29	
30	Employee discount days (see instructions)								30	
31	Employee discount days-IRF								31	
32	Labor & delivery (see instructions)						193	300	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

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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)					881	463	3,930	1
2	HMO and other (see instructions)					259	1,318		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)	0.61	413.58			881	463	3,930	14
15	CAH Visits								15
16	Subprovider - IPF		19.83			131	14	364	16
17	Subprovider - IRF		15.94			124	21	260	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)	0.61	449.35						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	30,042,079	30,042,079	931,213.00	32.26	1
2	Non-physician anesthetist Part A						2
3	Non-physician anesthetest Part B						3
4	Physician-Part A - Administrative						4
4.01	Physician-Part A - Teaching						4.01
5	Physician-Part B						5
6	Non-physician-Part B						6
7	Interns & residents (in an approved program)	21					7
7.01	Contracted interns & residents (in an approved program)						7.01
8	Home office and/or related organization personnel		2,144,020	2,144,020	58,387.00	36.72	8
9	SNF	44					9
10	Excluded area salaries (see instructions)		2,588,068	114,998	2,703,066	80,756.00	33.47
OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		124,486		124,486	2,271.00	54.82
12	Contract management and administrative services						
13	Contract labor: Physician-Part A - Administrative		197,311		197,311	1,376.00	143.39
14	Home office salaries & wage-related costs						
14.01	Home office salaries		4,288,039		4,288,039	116,774.00	36.72
14.02	Related organization salaries						
15	Home office: Physician Part A - Administrative						
16	Home office & Contract Physicians Part A - Teaching						
WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		5,253,396		5,253,396		
18	Wage-related costs (other)(see instructions)						
19	Excluded areas		523,262		523,262		
20	Non-physician anesthetist Part A						
21	Non-physician anesthetist Part B						
22	Physician Part A - Administrative						
22.01	Physician Part A - Teaching						
23	Physician Part B						
24	Wage-related costs (RHC/FQHC)						
25	Interns & residents (in an approved program)						
25.50	Home office wage-related		406,723		406,723		
25.51	Related organization wage-related						
25.52	Home office: Physician Part A - Administrative - wage-related						
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						
OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		180,665	19,629	200,294	6,339.00	31.60
27	Administrative & General		4,235,059	-517,241	3,717,818	101,426.00	36.66
28	Administrative & General under contract (see instructions)						
29	Maintenance & Repairs						
30	Operation of Plant		1,147,923		1,147,923	44,431.00	25.84
31	Laundry & Linen Service						
32	Housekeeping		824,584		824,584	58,266.00	14.15
33	Housekeeping under contract (see instructions)						
34	Dietary		882,596		882,596	53,144.00	16.61
35	Dietary under contract (see instructions)						
36	Cafeteria						
37	Maintenance of Personnel						
38	Nursing Administration		589,682		589,682	13,118.00	44.95
39	Central Services and Supply		199,946		199,946	10,545.00	18.96
40	Pharmacy		1,052,533	91,663	1,144,196	25,421.00	45.01
41	Medical Records & Medical Records Library		198,944	290,951	489,895	24,495.00	20.00
42	Social Service						
43	Other General Service						

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		27,898,059		27,898,059	872,826.00	31.96	1
2	Excluded area salaries (see instructions)		2,588,068	114,998	2,703,066	80,756.00	33.47	2
3	Subtotal salaries (line 1 minus line 2)		25,309,991	-114,998	25,194,993	792,070.00	31.81	3
4	Subtotal other wages & related costs (see instructions)		4,609,836		4,609,836	120,421.00	38.28	4

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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III**

5	Subtotal wage-related costs (see instructions)		5,660,119		5,660,119		22.47%	5
6	Total (sum of lines 3 through 5)		35,579,946	-114,998	35,464,948	912,491.00	38.87	6
7	Total overhead cost (see instructions)		9,311,932	-114,998	9,196,934	337,185.00	27.28	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	365,974	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)	2,287,035	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	-50,530	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	300,513	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	1,838,389	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	453,264	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	58,752	23
24	Total Wage Related cost (Sum of lines 1-23)	5,253,397	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTS (SPECIFY)		25
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KPMG LLP Compu-Max 2552-10

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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	124,486	5,253,397	1
2	Hospital	124,486	5,253,397	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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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)	0.187118	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,223,349	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	10,428,392	5
6	Medicaid charges	130,684,976	6
7	Medicaid cost (line 1 times line 6)	24,453,511	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.	10,801,770	8

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

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

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

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

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

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	10,801,770	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	10,985,098	17,611	11,002,709	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,055,510	17,611	2,073,121	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	2,055,510	17,611	2,073,121	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	5,079,093	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	619,080	27
27.0	Medicare allowable bad debts for the entire hospital complex (see instructions)	952,430	27.0
1			1
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	4,126,663	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,105,523	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,178,644	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,980,414	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				3,296,443	3,296,443	1,143,907	4,440,350	1
2	00200	Cap Rel Costs-Mvble Equip				892,398	892,398	1,317,112	2,209,510	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	180,665	5,871,064	6,051,729	20,925	6,072,654	103,451	6,176,105	4
5	00500	Administrative & General	4,235,059	10,384,882	14,619,941	-4,420,697	10,199,244	1,412,833	11,612,077	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,147,923	3,418,319	4,566,242	-67,083	4,499,159	-473	4,498,686	7
8	00800	Laundry & Linen Service		415,729	415,729	35,886	451,615		451,615	8
9	00900	Housekeeping	824,584	384,709	1,209,293	-1,511	1,207,782		1,207,782	9
10	01000	Dietary	882,596	342,636	1,225,232	-820	1,224,412	-165,067	1,059,345	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	589,682	12,056	601,738	-11	601,727	-1,410	600,317	13
14	01400	Central Services & Supply	199,946	187,638	387,584	95,531	483,115		483,115	14
15	01500	Pharmacy	1,052,533	2,046,952	3,099,485	-1,371,269	1,728,216	-4,801	1,723,415	15
16	01600	Medical Records & Library	198,944	148,622	347,566	355,042	702,608	-20,273	682,335	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		239	239	-5	234		234	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	6,307,308	528,130	6,835,438	-924,251	5,911,187	-40,130	5,871,057	30
31	03100	Intensive Care Unit	1,352,758	94,172	1,446,930	-50,600	1,396,330		1,396,330	31
40	04000	Subprovider - IPF	1,182,788	51,724	1,234,512	-3,095	1,231,417	-13,426	1,217,991	40
41	04100	Subprovider - IRF	1,111,400	140,837	1,252,237	-22,851	1,229,386	-31,094	1,198,292	41
43	04300	Nursery	518,279	450,847	969,126	662,695	1,631,821	-401,960	1,229,861	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,774,761	3,503,158	5,277,919	-2,214,834	3,063,085	-99,218	2,963,867	50
50.01	03340	GASTRO INTESTINAL SERVICES	197,020	123,891	320,911	-21,087	299,824		299,824	50.01
51	05100	Recovery Room	320,347	7,475	327,822	-3,798	324,024		324,024	51
52	05200	Delivery Room & Labor Room	1,283,936	639,369	1,923,305	106	1,923,411	-431,438	1,491,973	52
53	05300	Anesthesiology	113,579	552,840	666,419	-108,805	557,614	-420,241	137,373	53
54	05400	Radiology-Diagnostic	896,980	122,343	1,019,323	-29,163	990,160	-2,469	987,691	54
56	05600	Radioisotope	110,508	216,111	326,619	-920	325,699		325,699	56
56.01	03630	ULTRA SOUND	451,453	15,971	467,424	-1,720	465,704		465,704	56.01
57	05700	CT Scan	193,006	49,208	242,214	-25,080	217,134	-921	216,213	57
58	05800	MRI	133,000	6,279	139,279	-1,306	137,973		137,973	58
59	05900	Cardiac Catheterization	386,981	688,484	1,075,465	-499,818	575,647	-68,728	506,919	59
60	06000	Laboratory	149,510	1,484,146	1,633,656		1,633,656		1,633,656	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	Blood Storing, Processing & Trans.		104,942	104,942		104,942		104,942	63
65	06500	Respiratory Therapy	611,959	134,262	746,221	-67,134	679,087	-16,107	662,980	65
66	06600	Physical Therapy	750,126	62,979	813,105	-6,231	806,874	-88,303	718,571	66
67	06700	Occupational Therapy	425,217	66,166	491,383		491,383	-50	491,333	67
68	06800	Speech Pathology	114,602	1,635	116,237		116,237	-37	116,200	68
69	06900	Electrocardiology	198,203	42,456	240,659	-2,879	237,780	-32,733	205,047	69
70	07000	Electroencephalography	8,299	214	8,513	-15	8,498		8,498	70
71	07100	Medical Supplies Charged to Patients				1,430,887	1,430,887		1,430,887	71
72	07200	Impl. Dev. Charged to Patients				1,535,291	1,535,291		1,535,291	72
73	07300	Drugs Charged to Patients				1,556,670	1,556,670		1,556,670	73
74	07400	Renal Dialysis		356,954	356,954		356,954		356,954	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	1,844,247	1,420,179	3,264,426	-136,709	3,127,717	-1,127,762	1,999,955	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	29,748,199	34,077,618	63,825,817	-99,818	63,725,999	1,010,662	64,736,661	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		4,916	4,916		4,916		4,916	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	88,304	316,562	404,866	44,572	449,438		449,438	194
194.0	07952	COMMUNITY RELATIONS	138,801	30,453	169,254		169,254		169,254	194.0
2										2
194.0	07953	SENIOR CENTER		37,432	37,432	629	38,061		38,061	194.0
3										3
194.0	07954	PHYSICIAN CLINICS				65,961	65,961		65,961	194.0
4										4
194.0	07955	POB		277,470	277,470	-11,344	266,126		266,126	194.0
5										5
194.0	07956	TRITON HLTH CAREER SCHOLARSHIP PROG	66,775		66,775		66,775		66,775	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)	30,042,079	34,744,451	64,786,530		64,786,530	1,010,662	65,797,192	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		1,896,545	1
2	DEPRECIATION EXPENSE	A	Cap Rel Costs-Mvble Equip	2		592,140	2
500	Total reclassifications					2,488,685	500
	Code Letter - A						
1	RENTS	B	Cap Rel Costs-Bldg & Fixt	1		157,938	1
2	RENTS	B	Cap Rel Costs-Mvble Equip	2		300,258	2
3	RENTS	B					3
4	RENTS	B					4
5	RENTS	B					5
6	RENTS	B					6
7	RENTS	B					7
8	RENTS	B					8
9	RENTS	B					9
10	RENTS	B					10
11	RENTS	B					11
500	Total reclassifications					458,196	500
	Code Letter - B						
1	PROPERTY TAXES	C	Cap Rel Costs-Bldg & Fixt	1		1,224,971	1
500	Total reclassifications					1,224,971	500
	Code Letter - C						
1	INSURANCE	D	Cap Rel Costs-Bldg & Fixt	1		16,989	1
500	Total reclassifications					16,989	500
	Code Letter - D						
1	BILLABLE DRUGS	E	Drugs Charged to Patients	73		1,556,670	1
2	BILLABLE DRUGS	E	Subprovider - IPF	40		31	2
3	BILLABLE DRUGS	E	Recovery Room	51		64	3
4	BILLABLE DRUGS	E	Delivery Room & Labor Room	52		21	4
5	BILLABLE DRUGS	E	SENIOR CENTER	194.03		629	5
6	BILLABLE DRUGS	E					6
7	BILLABLE DRUGS	E					7
8	BILLABLE DRUGS	E					8
9	BILLABLE DRUGS	E					9
10	BILLABLE DRUGS	E					10
11	BILLABLE DRUGS	E					11
12	BILLABLE DRUGS	E					12
13	BILLABLE DRUGS	E					13
14	BILLABLE DRUGS	E					14
15	BILLABLE DRUGS	E					15
16	BILLABLE DRUGS	E					16
17	BILLABLE DRUGS	E					17
18	BILLABLE DRUGS	E					18
19	BILLABLE DRUGS	E					19
20	BILLABLE DRUGS	E					20
21	BILLABLE DRUGS	E					21
500	Total reclassifications					1,557,415	500
	Code Letter - E						
1	LAUNDRY	F	Laundry & Linen Service	8		35,886	1
2	LAUNDRY	F					2
3	LAUNDRY	F					3
4	LAUNDRY	F					4
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
14	LAUNDRY	F					14
15	LAUNDRY	F					15
500	Total reclassifications					35,886	500
	Code Letter - F						
1	BILLABLE SUPPLIES	G	Medical Supplies Charged to P	71		1,430,887	1

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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	
2	BILLABLE SUPPLIES	G	Central Services & Supply	14		194,064	2
3	BILLABLE SUPPLIES	G	Delivery Room & Labor Room	52		85	3
4	BILLABLE SUPPLIES	G	Radiology-Diagnostic	54		4,182	4
5	BILLABLE SUPPLIES	G					5
6	BILLABLE SUPPLIES	G					6
7	BILLABLE SUPPLIES	G					7
8	BILLABLE SUPPLIES	G					8
9	BILLABLE SUPPLIES	G					9
10	BILLABLE SUPPLIES	G					10
11	BILLABLE SUPPLIES	G					11
12	BILLABLE SUPPLIES	G					12
13	BILLABLE SUPPLIES	G					13
14	BILLABLE SUPPLIES	G					14
15	BILLABLE SUPPLIES	G					15
16	BILLABLE SUPPLIES	G					16
17	BILLABLE SUPPLIES	G					17
18	BILLABLE SUPPLIES	G					18
19	BILLABLE SUPPLIES	G					19
20	BILLABLE SUPPLIES	G					20
21	BILLABLE SUPPLIES	G					21
22	BILLABLE SUPPLIES	G					22
23	BILLABLE SUPPLIES	G					23
24	BILLABLE SUPPLIES	G					24
25	BILLABLE SUPPLIES	G					25
26	BILLABLE SUPPLIES	G					26
500	Total reclassifications					1,629,218	500
	Code Letter - G						
1	IMPLANTABLE DEVICE	H	Impl. Dev. Charged to Patient	72		1,535,291	1
2	IMPLANTABLE DEVICE	H					2
3	IMPLANTABLE DEVICE	H					3
4	IMPLANTABLE DEVICE	H					4
5	IMPLANTABLE DEVICE	H					5
6	IMPLANTABLE DEVICE	H					6
7	IMPLANTABLE DEVICE	H					7
500	Total reclassifications					1,535,291	500
	Code Letter - H						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9	NURSERY	I	Nursery	43	646,279	58,637	9
500	Total reclassifications				646,279	58,637	500
	Code Letter - I						
1	HOSPITAL SPACE IN POB	J	Employee Benefits Department	4		2,007	1
2	HOSPITAL SPACE IN POB	J	Administrative & General	5		9,337	2
500	Total reclassifications					11,344	500
	Code Letter - J						
1	REGIONAL ALLOCATION	K	Employee Benefits Department	4	19,629	1,819	1
2	REGIONAL ALLOCATION	K	Pharmacy	15	91,663	14,004	2
3	REGIONAL ALLOCATION	K	Medical Records & Library	16	290,951	64,091	3
4	REGIONAL ALLOCATION	K	MARKETING	194	48,957		4
5	REGIONAL ALLOCATION	K	PHYSICIAN CLINICS	194.04	66,041		5
500	Total reclassifications				517,241	79,914	500
	Code Letter - K						
	GRAND TOTAL (Increases)				1,163,520	9,096,546	

(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		2,488,685	9	
2	DEPRECIATION EXPENSE	A					9	
500	Total reclassifications					2,488,685	500	
	Code letter - A							
1	RENTS	B	Administrative & General	5		94,839	10	
2	RENTS	B	Operation of Plant	7		65,651	10	
3	RENTS	B	Dietary	10		80	3	
4	RENTS	B	Central Services & Supply	14		97,977	4	
5	RENTS	B	Pharmacy	15		58,696	5	
6	RENTS	B	Nursery	43		5,882	6	
7	RENTS	B	Operating Room	50		17,695	7	
8	RENTS	B	Anesthesiology	53		66,367	8	
9	RENTS	B	Radiology-Diagnostic	54		32,271	9	
10	RENTS	B	Respiratory Therapy	65		18,710	10	
11	RENTS	B	Emergency	91		28	11	
500	Total reclassifications					458,196	500	
	Code letter - B							
1	PROPERTY TAXES	C	Administrative & General	5		1,224,971	13	
500	Total reclassifications					1,224,971	500	
	Code letter - C							
1	INSURANCE	D	Administrative & General	5		16,989	12	
500	Total reclassifications					16,989	500	
	Code letter - D							
1	BILLABLE DRUGS	E	Employee Benefits Department	4		2,317	1	
2	BILLABLE DRUGS	E	Administrative & General	5		6,223	2	
3	BILLABLE DRUGS	E	Central Services & Supply	14		556	3	
4	BILLABLE DRUGS	E	Pharmacy	15		1,392,202	4	
5	BILLABLE DRUGS	E	Adults & Pediatrics	30		34,763	5	
6	BILLABLE DRUGS	E	Intensive Care Unit	31		10,716	6	
7	BILLABLE DRUGS	E	Subprovider - IRF	41		2,376	7	
8	BILLABLE DRUGS	E	Nursery	43		2,766	8	
9	BILLABLE DRUGS	E	Operating Room	50		30,378	9	
10	BILLABLE DRUGS	E	GASTRO INTESTINAL SERVICES	50.01		3,361	10	
11	BILLABLE DRUGS	E	Anesthesiology	53		3,314	11	
12	BILLABLE DRUGS	E	Radiology-Diagnostic	54		890	12	
13	BILLABLE DRUGS	E	Radioisotope	56		520	13	
14	BILLABLE DRUGS	E	ULTRA SOUND	56.01		129	14	
15	BILLABLE DRUGS	E	CT Scan	57		2,315	15	
16	BILLABLE DRUGS	E	MRI	58		1,016	16	
17	BILLABLE DRUGS	E	Cardiac Catheterization	59		2,956	17	
18	BILLABLE DRUGS	E	Respiratory Therapy	65		450	18	
19	BILLABLE DRUGS	E	Electrocardiology	69		111	19	
20	BILLABLE DRUGS	E	Electroencephalography	70		15	20	
21	BILLABLE DRUGS	E	Emergency	91		60,041	21	
500	Total reclassifications					1,557,415	500	
	Code letter - E							
1	LAUNDRY	F	Administrative & General	5		17	1	
2	LAUNDRY	F	Housekeeping	9		292	2	
3	LAUNDRY	F	Adults & Pediatrics	30		3,802	3	
4	LAUNDRY	F	Intensive Care Unit	31		898	4	
5	LAUNDRY	F	Subprovider - IPF	40		482	5	
6	LAUNDRY	F	Subprovider - IRF	41		508	6	
7	LAUNDRY	F	Operating Room	50		26,400	7	
8	LAUNDRY	F	Anesthesiology	53		295	8	
9	LAUNDRY	F	Radiology-Diagnostic	54		184	9	
10	LAUNDRY	F	ULTRA SOUND	56.01		12	10	
11	LAUNDRY	F	CT Scan	57		4	11	
12	LAUNDRY	F	Cardiac Catheterization	59		1,188	12	
13	LAUNDRY	F	Physical Therapy	66		159	13	
14	LAUNDRY	F	Electrocardiology	69		2	14	
15	LAUNDRY	F	Emergency	91		1,643	15	
500	Total reclassifications					35,886	500	
	Code letter - F							

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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
1	BILLABLE SUPPLIES	G	Employee Benefits Department	4		213	1
2	BILLABLE SUPPLIES	G	Administrative & General	5		5,620	2
3	BILLABLE SUPPLIES	G	Operation of Plant	7		1,034	3
4	BILLABLE SUPPLIES	G	Housekeeping	9		1,219	4
5	BILLABLE SUPPLIES	G	Dietary	10		3	5
6	BILLABLE SUPPLIES	G	Nursing Administration	13		11	6
7	BILLABLE SUPPLIES	G	Pharmacy	15		24,332	7
8	BILLABLE SUPPLIES	G	I&R Services-Other Prgm Costs	22		5	8
9	BILLABLE SUPPLIES	G	Adults & Pediatrics	30		180,770	9
10	BILLABLE SUPPLIES	G	Intensive Care Unit	31		38,986	10
11	BILLABLE SUPPLIES	G	Subprovider - IPF	40		2,644	11
12	BILLABLE SUPPLIES	G	Subprovider - IRF	41		19,967	12
13	BILLABLE SUPPLIES	G	Nursery	43		33,573	13
14	BILLABLE SUPPLIES	G	Operating Room	50		927,788	14
15	BILLABLE SUPPLIES	G	GASTRO INTESTINAL SERVICES	50.01		16,790	15
16	BILLABLE SUPPLIES	G	Recovery Room	51		3,862	16
17	BILLABLE SUPPLIES	G	Anesthesiology	53		38,617	17
18	BILLABLE SUPPLIES	G	Radioisotope	56		400	18
19	BILLABLE SUPPLIES	G	ULTRA SOUND	56.01		1,579	19
20	BILLABLE SUPPLIES	G	CT Scan	57		22,761	20
21	BILLABLE SUPPLIES	G	MRI	58		290	21
22	BILLABLE SUPPLIES	G	Cardiac Catheterization	59		176,945	22
23	BILLABLE SUPPLIES	G	Respiratory Therapy	65		47,974	23
24	BILLABLE SUPPLIES	G	Physical Therapy	66		6,072	24
25	BILLABLE SUPPLIES	G	Electrocardiology	69		2,766	25
26	BILLABLE SUPPLIES	G	Emergency	91		74,997	26
500	Total reclassifications					1,629,218	500
	Code letter - G						
1	IMPLANTABLE DEVICE	H	Operation of Plant	7		398	1
2	IMPLANTABLE DEVICE	H	Dietary	10		737	2
3	IMPLANTABLE DEVICE	H	Pharmacy	15		1,706	3
4	IMPLANTABLE DEVICE	H	Operating Room	50		1,212,573	4
5	IMPLANTABLE DEVICE	H	GASTRO INTESTINAL SERVICES	50.01		936	5
6	IMPLANTABLE DEVICE	H	Anesthesiology	53		212	6
7	IMPLANTABLE DEVICE	H	Cardiac Catheterization	59		318,729	7
500	Total reclassifications					1,535,291	500
	Code letter - H						
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9	NURSERY	I	Adults & Pediatrics	30	646,279	58,637	9
500	Total reclassifications				646,279	58,637	500
	Code letter -						
1	HOSPITAL SPACE IN POB	J	POB	194.05		11,344	1
2	HOSPITAL SPACE IN POB	J					2
500	Total reclassifications					11,344	500
	Code letter - J						
1	REGIONAL ALLOCATION	K	Administrative & General	5	517,241	75,449	1
2	REGIONAL ALLOCATION	K	MARKETING	194		4,385	2
3	REGIONAL ALLOCATION	K	PHYSICIAN CLINICS	194.04		80	3
4	REGIONAL ALLOCATION	K					4
5	REGIONAL ALLOCATION	K					5
500	Total reclassifications				517,241	79,914	500
	Code letter - K						
	GRAND TOTAL (Decreases)				1,163,520	9,096,546	

(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	

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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	66,849,889					66,849,889		3
4	Building Improvements	6,164,886	73,715		73,715		6,238,601		4
5	Fixed Equipment	4,124,706					4,124,706		5
6	Movable Equipment	74,885,172	962,266		962,266		75,847,438		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	161,106,145	1,035,981		1,035,981		162,142,126		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	161,106,145	1,035,981		1,035,981		162,142,126		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	77,982,114		77,982,114	0.493701					1
2	Cap Rel Costs-Mvble Equ	79,972,144		79,972,144	0.506299					2
3	Total (sum of lines 1-2)	157,954,258		157,954,258	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	2,403,728	157,938		16,989	1,861,695		4,440,350	1	
2	Cap Rel Costs-Mvble Equip	1,909,252	300,258					2,209,510	2	
3	Total (sum of lines 1-2)	4,312,980	458,196		16,989	1,861,695		6,649,860	3	

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

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-4,125,625			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1	27,263			12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-156,571	Dietary	10	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts	B	-8,913	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines	B	-8,476	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	-200,167	Cap Rel Costs-Bldg & Fixt	1	9 26
27	Depreciation--movable equipment	A	1,377,120	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	-42,624	Administrative & General	5	33
33.01	PBX SALARY	A	-20,860	Administrative & General	5	33.01
33.02	PBX BENEFITS	A	-19,399	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	-175	Employee Benefits Department	4	33.04
33.05	RENTAL INCOME	B	-41,693	Administrative & General	5	33.05
33.06	ADMIN SVCS	B	-22,934	Administrative & General	5	33.06
33.07	OTHER OPERATING REVENUE	B	-590	Administrative & General	5	33.07
33.08	CHAPEL FUNDS	B	-229	Administrative & General	5	33.08
33.09	HEALTHWAYS	B	-1,236	Administrative & General	5	33.09
33.10	DRUG SCREENS	B	-246,945	Administrative & General	5	33.10
33.11	GRANT REVENUE	B	-71,675	Administrative & General	5	33.11
33.12	OTHER OPERATING REVENUE	B	-140	Operation of Plant	7	33.12
33.13	SEASON HOSPICE	B	-49	Pharmacy	15	33.13
33.14	OTHER OPERATING REVENUE	B	-2,250	Nursery	43	33.14
33.15	BARIATRIC PHONE LINE	B	-829	Operating Room	50	33.15
33.16	OTHER OPERATING REVENUE	B	-115	Delivery Room & Labor Room	52	33.16
33.17	SEASON HOSPICE	B	-100	Radiology-Diagnostic	54	33.17
33.18	FITNESS CENTER REVENUE	B	-88,221	Physical Therapy	66	33.18
33.19	INTEREST INCOME	A	-808	Administrative & General	5	33.19
33.20	ADVERTISING	A	-8,867	Administrative & General	5	33.20
33.21	ADVERTISING	A	-227	Operating Room	50	33.21
33.22	ADVERTISING	A	-1,565	Radiology-Diagnostic	54	33.22
33.23	PURCHASED SVCS	A	-6,697	Administrative & General	5	33.23
33.24	PURCHASED SVCS	A	-115	Operation of Plant	7	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	-4,343	Pharmacy	15	33.25
33.26	PURCHASED SVCS	A	-11,360	Medical Records & Library	16	33.26
33.27	PURCHASED SVCS	A	-30,612	Operating Room	50	33.27
33.28	PHYSICIAN RECRUITMENT	A	-696	Administrative & General	5	33.28
33.29	PHYSICIAN RELOCATION	A	-8,000	Administrative & General	5	33.29
33.30	PHYSICIAN DUES/SUBSCRIPTIONS	A	-727	Administrative & General	5	33.30
33.31	TRAVEL	A	-2,914	Administrative & General	5	33.31
33.32	TRAVEL	A	-358	Subprovider - IRF	41	33.32
33.33	TRAVEL	A	-133	Cardiac Catheterization	59	33.33
33.34	ALCOHOL	A	-487	Administrative & General	5	33.34
33.35	MEALS	A	-2,270	Administrative & General	5	33.35
33.36	MEALS	A	-20	Dietary	10	33.36
33.37	MEALS	A	-49	Subprovider - IRF	41	33.37
33.38	MEALS	A	-7	Cardiac Catheterization	59	33.38
33.39	MEALS	A	-82	Physical Therapy	66	33.39
33.40	MEALS	A	-50	Occupational Therapy	67	33.40
33.41	MEALS	A	-37	Speech Pathology	68	33.41
33.42	PROPERTY TAXES	A	636,724	Cap Rel Costs-Bldg & Fixt	1	13 33.42
33.43	DONATIONS/CONTRIBUTIONS	A	-27,651	Administrative & General	5	33.43
33.44	DUES & SUBSCRIPTION	A	-4,984	Administrative & General	5	33.44
33.45	LOBBYING	A	-37,312	Administrative & General	5	33.45
33.46	PATIENT TRANSPORTATION	A	-2,870	Administrative & General	5	33.46
33.47	PATIENT TRANSPORTATION	A	-1,410	Nursing Administration	13	33.47
33.48	PATIENT TRANSPORTATION	A	-54	Radiology-Diagnostic	54	33.48
33.49	PATIENT TRANSPORTATION	A	-594	Emergency	91	33.49
33.50	LEGAL	A	-19,758	Administrative & General	5	33.50
33.51	PENALTIES AND FINES	A	-409	Pharmacy	15	33.51
33.52	H.O. WORKER COMPENSATION	A	262,390	Employee Benefits Department	4	33.52
33.53	PERIOD 13 ADJUSTMENTS	A	-139,365	Employee Benefits Department	4	33.53
33.54	PERIOD 13 ADJUSTMENTS	A	4,141,820	Administrative & General	5	33.54
34						34
35						35
36						36
37						37
38						38
39						39
40						40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		1,010,662			50

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

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

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

WORKSHEET A-8-1

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
1	2	3	4	5	6	7		
1	1	Cap Rel Costs-Bldg & Fixt	TENET DIRECT ALLOC.- CAPITAL	365,762		365,762	9	1
2	1	Cap Rel Costs-Bldg & Fixt	TENET POOL ALLOC.- CAPITAL	341,588		341,588	9	2
3	5	Administrative & General	TENET POOL/DIRECT ALLOC.-NON CAPITAL	1,845,479		1,845,479		3
4	5	Administrative & General	PERIOD 13 ADJ - IC OVERHEAD ALLOC		2,525,566	-2,525,566		4
4.01	1	Cap Rel Costs-Bldg & Fixt	REGIONAL ALLOCATION	91,773		91,773	10	4.01
4.02	2	Cap Rel Costs-Mvble Equip	REGIONAL ALLOCATION	3,065		3,065	10	4.02
4.03	4	Employee Benefits Department	REGIONAL ALLOCATION	21,449		21,449		4.03
4.04	5	Administrative & General	REGIONAL ALLOCATION	3,411,913		3,411,913		4.04
4.05	15	Pharmacy	REGIONAL ALLOCATION	105,666		105,666		4.05
4.06	16	Medical Records & Library	REGIONAL ALLOCATION	355,041		355,041		4.06
4.07	194	MARKETING	REGIONAL ALLOCATION	44,572		44,572		4.07
4.08	194.0	PHYSICIAN CLINICS	REGIONAL ALLOCATION					4.08
	4			65,961		65,961		
4.09	60	Laboratory	GENESIS LAB	1,485,322		1,485,322		4.09
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			8,137,591		8,110,328	27,263	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	1,493,367	1,464,505	28,862	177,200	203	17,294	865	1
2	7	Operation of Plant OPERATION OF PL	218	218						2
3	30	Adults & Pediatrics ADULTS & PEDIAT	52,354	27,604	24,750	154,100	165	12,224	611	3
4	40	Subprovider - IPF SUBPROVIDER - I	25,650	900	24,750	154,100	165	12,224	611	4
5	41	Subprovider - IRF SUBPROVIDER - I	79,758	18,485	61,273	177,200	576	49,071	2,454	5
6	43	Nursery NURSERY	399,710	399,710						6
7	50	Operating Room OPERATING ROOM	85,550	51,074	34,476	208,000	180	18,000	900	7
8	52	Delivery Room & Labo LABOR ROOM & DE	431,323	431,323						8
9	53	Anesthesiology ANESTHESIOLOGY	420,241	420,241						9
10	54	Radiology-Diagnostic RADIOLOGY - DIA	750	750						10
11	57	CT Scan CT SCAN	921	921						11
12	59	Cardiac Catheterizat CARDIAC CATHETE	76,000	52,800	23,200	177,200	87	7,412	371	12
13	65	Respiratory Therapy RESPIRATORY THE	16,107	16,107						13
14	69	Electrocardiology ELECTRO CARDIOL	32,733	32,733						14
15	91	Emergency EMERGENCY	1,127,168	1,127,168						15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	4,241,850	4,044,539	197,311		1,376	116,225	5,812	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					17,294	11,568	1,476,073	1
2	7	Operation of Plant OPERATION OF PL							218	2
3	30	Adults & Pediatrics ADULTS & PEDIAT					12,224	12,526	40,130	3
4	40	Subprovider - IPF SUBPROVIDER - I					12,224	12,526	13,426	4
5	41	Subprovider - IRF SUBPROVIDER - I					49,071	12,202	30,687	5
6	43	Nursery NURSERY							399,710	6
7	50	Operating Room OPERATING ROOM					18,000	16,476	67,550	7
8	52	Delivery Room & Labo LABOR ROOM & DE							431,323	8
9	53	Anesthesiology ANESTHESIOLOGY							420,241	9
10	54	Radiology-Diagnostic RADIOLOGY - DIA							750	10
11	57	CT Scan CT SCAN							921	11
12	59	Cardiac Catheterizat CARDIAC CATHETE					7,412	15,788	68,588	12
13	65	Respiratory Therapy RESPIRATORY THE							16,107	13
14	69	Electrocardiology ELECTRO CARDIOL							32,733	14
15	91	Emergency EMERGENCY							1,127,168	15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					116,225	81,086	4,125,625	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	4,440,350	4,440,350					1
2	Cap Rel Costs-Mvble Equip	2,209,510		2,209,510				2
4	Employee Benefits Department	6,176,105			6,176,105			4
5	Administrative & General	11,612,077	291,465	145,032	769,447	12,818,021	12,818,021	5
6	Maintenance & Repairs							6
7	Operation of Plant	4,498,686	603,949	300,524	237,576	5,640,735	1,364,748	7
8	Laundry & Linen Service	451,615	23,886	11,886		487,387	117,921	8
9	Housekeeping	1,207,782	38,725	19,269	170,658	1,436,434	347,538	9
10	Dietary	1,059,345	152,463	75,865	182,664	1,470,337	355,741	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	600,317	21,548	10,722	122,042	754,629	182,579	13
14	Central Services & Supply	483,115	29,482	14,670	41,381	568,648	137,582	14
15	Pharmacy	1,723,415	28,716	14,289	236,805	2,003,225	484,670	15
16	Medical Records & Library	682,335	45,601	22,691	101,390	852,017	206,141	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	234				234	57	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,871,057	332,013	165,209	1,171,604	7,539,883	1,824,207	30
31	Intensive Care Unit	1,396,330	96,561	48,049	279,970	1,820,910	440,560	31
40	Subprovider - IPF	1,217,991	82,892	41,247	244,792	1,586,922	383,948	40
41	Subprovider - IRF	1,198,292	178,214	88,679	230,018	1,695,203	410,146	41
43	Nursery	1,229,861	70,239	34,951	241,019	1,576,070	381,322	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,963,867	178,312	88,728	367,308	3,598,215	870,570	50
50.01	GASTRO INTESTINAL SERVICES	299,824	26,169	13,022	40,776	379,791	91,889	50.01
51	Recovery Room	324,024	19,209	9,558	66,300	419,091	101,397	51
52	Delivery Room & Labor Room	1,491,973	274,427	136,555	265,726	2,168,681	524,702	52
53	Anesthesiology	137,373	5,540	2,757	23,507	169,177	40,932	53
54	Radiology-Diagnostic	987,691	145,169	72,236	185,641	1,390,737	336,482	54
56	Radioisotope	325,699	10,788	5,368	22,871	364,726	88,244	56
56.01	ULTRA SOUND	465,704	8,213	4,087	93,434	571,438	138,257	56.01
57	CT Scan	216,213	11,553	5,749	39,945	273,460	66,162	57
58	MRI	137,973	10,537	5,243	27,526	181,279	43,860	58
59	Cardiac Catheterization	506,919	48,566	24,166	80,090	659,741	159,621	59
60	Laboratory	1,633,656	92,650	46,102	30,943	1,803,351	436,312	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	104,942	3,856	1,919		110,717	26,787	63
65	Respiratory Therapy	662,980	8,268	4,114	126,652	802,014	194,043	65
66	Physical Therapy	718,571	81,375	40,492	155,248	995,686	240,901	66
67	Occupational Therapy	491,333			88,004	579,337	140,168	67
68	Speech Pathology	116,200	6,514	3,242	23,718	149,674	36,213	68
69	Electrocardiology	205,047	28,689	14,275	41,020	289,031	69,930	69
70	Electroencephalography	8,498			1,718	10,216	2,472	70
71	Medical Supplies Charged to Patients	1,430,887				1,430,887	346,196	71
72	Impl. Dev. Charged to Patients	1,535,291				1,535,291	371,456	72
73	Drugs Charged to Patients	1,556,670				1,556,670	376,629	73
74	Renal Dialysis	356,954				356,954	86,363	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	1,999,955	153,771	76,516	381,689	2,611,931	631,944	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	64,736,661	3,109,360	1,547,212	6,091,482	62,658,750	12,058,690	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	4,916	2,575	1,281		8,772	2,122	190
192	Physicians' Private Offices							192
194	MARKETING	449,438	8,171	4,066	28,408	490,083	118,573	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)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
194.0 2	COMMUNITY RELATIONS	169,254	7,002	3,484	28,727	208,467	50,438	194.0 2
194.0 3	SENIOR CENTER	38,061				38,061	9,209	194.0 3
194.0 4	PHYSICIAN CLINICS	65,961	17,483	8,700	13,668	105,812	25,601	194.0 4
194.0 5	POB	266,126	1,295,759	644,767		2,206,652	533,888	194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG	66,775			13,820	80,595	19,500	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)	65,797,192	4,440,350	2,209,510	6,176,105	65,797,192	12,818,021	202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	7,005,483						7
8	Laundry & Linen Service	47,204	652,512					8
9	Housekeeping	76,527	7,394	1,867,893				9
10	Dietary	301,296		81,780	2,209,154			10
11	Cafeteria				808,825	808,825		11
12	Maintenance of Personnel							12
13	Nursing Administration	42,583		11,558		15,900	1,007,249	13
14	Central Services & Supply	58,262		15,814		12,776		14
15	Pharmacy	56,749		15,403		30,793		15
16	Medical Records & Library	90,116		24,460		29,684		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		138					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	656,123	315,617	178,089	634,504	212,498	371,524	30
31	Intensive Care Unit	190,824	37,584	51,795	74,905	40,645	71,062	31
40	Subprovider - IPF	163,811	43,703	44,463	163,506	49,969	87,363	40
41	Subprovider - IRF	352,186	32,165	95,593	144,723	40,167	70,357	41
43	Nursery	138,806		37,676		34,396	60,136	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	352,379	53,581	95,645		60,653	106,042	50
50.01	GASTRO INTESTINAL SERVICES	51,715		14,037		5,141	8,987	50.01
51	Recovery Room	37,961	20,110	10,304		8,139	14,230	51
52	Delivery Room & Labor Room	542,322		147,201		42,787	74,807	52
53	Anesthesiology	10,948		2,972		6,476	11,322	53
54	Radiology-Diagnostic	286,882	43,930	77,867		32,582		54
56	Radioisotope	21,319		5,786		2,646		56
56.01	ULTRA SOUND	16,230		4,405		12,373		56.01
57	CT Scan	22,832		6,197		6,048		57
58	MRI	20,824		5,652		3,377		58
59	Cardiac Catheterization	95,976		26,050		8,668	15,155	59
60	Laboratory	183,094	112	49,697		10,130		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	7,620		2,068				63
65	Respiratory Therapy	16,340	5,784	4,435		24,014		65
66	Physical Therapy	160,812	30,411	43,649		27,996		66
67	Occupational Therapy		762			13,179		67
68	Speech Pathology	12,874		3,494		3,578		68
69	Electrocardiology	56,694		15,388		7,610	13,305	69
70	Electroencephalography					403	705	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	303,882	59,139	82,482		58,486	102,254	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,375,191	650,430	1,153,960	1,826,463	801,114	1,007,249	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,089		1,381				190
192	Physicians' Private Offices				374,092			192
194	MARKETING	16,147		4,383		3,906		194
194.0	COMMUNITY RELATIONS	13,837		3,756		2,091		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	34,550		9,378		1,714		194.0 4
194.0 5	POB	2,560,669	2,082	695,035				194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG							194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS				8,599			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)	7,005,483	652,512	1,867,893	2,209,154	808,825	1,007,249	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	793,082						14
15	Pharmacy		2,590,840					15
16	Medical Records & Library			1,202,418				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				429			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			199,393	429	11,932,267	-429	30
31	Intensive Care Unit			34,515		2,762,800		31
40	Subprovider - IPF			41,516		2,565,201		40
41	Subprovider - IRF			14,599		2,855,139		41
43	Nursery			19,086		2,247,492		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			74,266		5,211,351		50
50.01	GASTRO INTESTINAL SERVICES			12,343		563,903		50.01
51	Recovery Room			17,063		628,295		51
52	Delivery Room & Labor Room			34,647		3,535,147		52
53	Anesthesiology			17,822		259,649		53
54	Radiology-Diagnostic			31,760		2,200,240		54
56	Radioisotope			8,145		490,866		56
56.01	ULTRA SOUND			31,284		773,987		56.01
57	CT Scan			90,198		464,897		57
58	MRI			12,310		267,302		58
59	Cardiac Catheterization			27,540		992,751		59
60	Laboratory			110,131		2,592,827		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.			7,854		155,046		63
65	Respiratory Therapy			16,305		1,062,935		65
66	Physical Therapy			26,669		1,526,124		66
67	Occupational Therapy			16,383		749,829		67
68	Speech Pathology			4,179		210,012		68
69	Electrocardiology			18,096		470,054		69
70	Electroencephalography			749		14,545		70
71	Medical Supplies Charged to Patients	382,583		28,325		2,187,991		71
72	Impl. Dev. Charged to Patients	410,499		32,042		2,349,288		72
73	Drugs Charged to Patients		2,590,840	135,866		4,660,005		73
74	Renal Dialysis			2,048		445,365		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			137,284		3,987,402		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	793,082	2,590,840	1,202,418	429	58,162,710	-429	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					17,364		190
192	Physicians' Private Offices					374,092		192
194	MARKETING					633,092		194
194.0	COMMUNITY RELATIONS					278,589		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					47,270		194.0 3
194.0 4	PHYSICIAN CLINICS					177,055		194.0 4
194.0 5	POB					5,998,326		194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG					100,095		194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS					8,599		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)	793,082	2,590,840	1,202,418	429	65,797,192	-429	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	11,931,838					30
31	Intensive Care Unit	2,762,800					31
40	Subprovider - IPF	2,565,201					40
41	Subprovider - IRF	2,855,139					41
43	Nursery	2,247,492					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	5,211,351					50
50.01	GASTRO INTESTINAL SERVICES	563,903					50.01
51	Recovery Room	628,295					51
52	Delivery Room & Labor Room	3,535,147					52
53	Anesthesiology	259,649					53
54	Radiology-Diagnostic	2,200,240					54
56	Radioisotope	490,866					56
56.01	ULTRA SOUND	773,987					56.01
57	CT Scan	464,897					57
58	MRI	267,302					58
59	Cardiac Catheterization	992,751					59
60	Laboratory	2,592,827					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	155,046					63
65	Respiratory Therapy	1,062,935					65
66	Physical Therapy	1,526,124					66
67	Occupational Therapy	749,829					67
68	Speech Pathology	210,012					68
69	Electrocardiology	470,054					69
70	Electroencephalography	14,545					70
71	Medical Supplies Charged to Patients	2,187,991					71
72	Impl. Dev. Charged to Patients	2,349,288					72
73	Drugs Charged to Patients	4,660,005					73
74	Renal Dialysis	445,365					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	3,987,402					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	58,162,281					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	17,364					190
192	Physicians' Private Offices	374,092					192
194	MARKETING	633,092					194
194.0	COMMUNITY RELATIONS	278,589					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	47,270						194.0 3
194.0 4	PHYSICIAN CLINICS	177,055						194.0 4
194.0 5	POB	5,998,326						194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG	100,095						194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS	8,599						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)	65,796,763						202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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		291,465	145,032	436,497	436,497		5
6	Maintenance & Repairs							6
7	Operation of Plant		603,949	300,524	904,473	46,474	950,947	7
8	Laundry & Linen Service		23,886	11,886	35,772	4,016	6,408	8
9	Housekeeping		38,725	19,269	57,994	11,835	10,388	9
10	Dietary		152,463	75,865	228,328	12,114	40,899	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration		21,548	10,722	32,270	6,217	5,780	13
14	Central Services & Supply		29,482	14,670	44,152	4,685	7,909	14
15	Pharmacy		28,716	14,289	43,005	16,505	7,703	15
16	Medical Records & Library		45,601	22,691	68,292	7,020	12,233	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		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		332,013	165,209	497,222	62,121	89,064	30
31	Intensive Care Unit		96,561	48,049	144,610	15,002	25,903	31
40	Subprovider - IPF		82,892	41,247	124,139	13,075	22,236	40
41	Subprovider - IRF		178,214	88,679	266,893	13,967	47,807	41
43	Nursery		70,239	34,951	105,190	12,985	18,842	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		178,312	88,728	267,040	29,646	47,833	50
50.01	GASTRO INTESTINAL SERVICES		26,169	13,022	39,191	3,129	7,020	50.01
51	Recovery Room		19,209	9,558	28,767	3,453	5,153	51
52	Delivery Room & Labor Room		274,427	136,555	410,982	17,868	73,617	52
53	Anesthesiology		5,540	2,757	8,297	1,394	1,486	53
54	Radiology-Diagnostic		145,169	72,236	217,405	11,458	38,942	54
56	Radioisotope		10,788	5,368	16,156	3,005	2,894	56
56.01	ULTRA SOUND		8,213	4,087	12,300	4,708	2,203	56.01
57	CT Scan		11,553	5,749	17,302	2,253	3,099	57
58	MRI		10,537	5,243	15,780	1,494	2,827	58
59	Cardiac Catheterization		48,566	24,166	72,732	5,436	13,028	59
60	Laboratory		92,650	46,102	138,752	14,858	24,854	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		3,856	1,919	5,775	912	1,034	63
65	Respiratory Therapy		8,268	4,114	12,382	6,608	2,218	65
66	Physical Therapy		81,375	40,492	121,867	8,203	21,829	66
67	Occupational Therapy					4,773		67
68	Speech Pathology		6,514	3,242	9,756	1,233	1,748	68
69	Electrocardiology		28,689	14,275	42,964	2,381	7,696	69
70	Electroencephalography					84		70
71	Medical Supplies Charged to Patients					11,789		71
72	Impl. Dev. Charged to Patients					12,649		72
73	Drugs Charged to Patients					12,825		73
74	Renal Dialysis					2,941		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		153,771	76,516	230,287	21,520	41,250	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		3,109,360	1,547,212	4,656,572	410,638	593,903	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,575	1,281	3,856	72	691	190
192	Physicians' Private Offices							192
194	MARKETING		8,171	4,066	12,237	4,038	2,192	194
194.0	COMMUNITY RELATIONS		7,002	3,484	10,486	1,718	1,878	194.0
2								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					314		194.0 3
194.0 4	PHYSICIAN CLINICS		17,483	8,700	26,183	872	4,690	194.0 4
194.0 5	POB		1,295,759	644,767	1,940,526	18,181	347,593	194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG					664		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)		4,440,350	2,209,510	6,649,860	436,497	950,947	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 ADMINISTRATION	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	46,196						8
9	Housekeeping	523	80,740					9
10	Dietary		3,535	284,876				10
11	Cafeteria			104,300	104,300			11
12	Maintenance of Personnel							12
13	Nursing Administration		500			2,050	46,817	13
14	Central Services & Supply		684			1,647	59,077	14
15	Pharmacy		666			3,971		15
16	Medical Records & Library		1,057			3,828		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	10						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	22,345	7,698	81,821	27,403	17,269		30
31	Intensive Care Unit	2,661	2,239	9,659	5,241	3,303		31
40	Subprovider - IPF	3,094	1,922	21,085	6,444	4,061		40
41	Subprovider - IRF	2,277	4,132	18,662	5,180	3,270		41
43	Nursery		1,629		4,435	2,795		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,793	4,134		7,821	4,929		50
50.01	GASTRO INTESTINAL SERVICES		607		663	418		50.01
51	Recovery Room	1,424	445		1,050	661		51
52	Delivery Room & Labor Room		6,363		5,518	3,477		52
53	Anesthesiology		128		835	526		53
54	Radiology-Diagnostic	3,110	3,366		4,202			54
56	Radioisotope		250		341			56
56.01	ULTRA SOUND		190		1,595			56.01
57	CT Scan		268		780			57
58	MRI		244		435			58
59	Cardiac Catheterization		1,126		1,118	704		59
60	Laboratory	8	2,148		1,306			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		89					63
65	Respiratory Therapy	410	192		3,097			65
66	Physical Therapy	2,153	1,887		3,610			66
67	Occupational Therapy	54			1,699			67
68	Speech Pathology		151		461			68
69	Electrocardiology		665		981	618		69
70	Electroencephalography				52	33		70
71	Medical Supplies Charged to Patients						28,499	71
72	Impl. Dev. Charged to Patients						30,578	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	4,187	3,565		7,542	4,753		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	46,049	49,880	235,527	103,305	46,817	59,077	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		60					190
192	Physicians' Private Offices			48,240				192
194	MARKETING		189		504			194
194.0	COMMUNITY RELATIONS		162		270			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		405		221			194.0 4
194.0 5	POB	147	30,044					194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG							194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS			1,109				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)	46,196	80,740	284,876	104,300	46,817	59,077	202

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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	71,850						15
16	Medical Records & Library		92,430					16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd			12				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		15,416		820,359		820,359	30
31	Intensive Care Unit		2,650		211,268		211,268	31
40	Subprovider - IPF		3,188		199,244		199,244	40
41	Subprovider - IRF		1,121		363,309		363,309	41
43	Nursery		1,465		147,341		147,341	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,702		370,898		370,898	50
50.01	GASTRO INTESTINAL SERVICES		948		51,976		51,976	50.01
51	Recovery Room		1,310		42,263		42,263	51
52	Delivery Room & Labor Room		2,660		520,485		520,485	52
53	Anesthesiology		1,368		14,034		14,034	53
54	Radiology-Diagnostic		2,439		280,922		280,922	54
56	Radioisotope		625		23,271		23,271	56
56.01	ULTRA SOUND		2,402		23,398		23,398	56.01
57	CT Scan		6,926		30,628		30,628	57
58	MRI		945		21,725		21,725	58
59	Cardiac Catheterization		2,115		96,259		96,259	59
60	Laboratory		8,456		190,382		190,382	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		603		8,413		8,413	63
65	Respiratory Therapy		1,252		26,159		26,159	65
66	Physical Therapy		2,048		161,597		161,597	66
67	Occupational Therapy		1,258		7,784		7,784	67
68	Speech Pathology		321		13,670		13,670	68
69	Electrocardiology		1,390		56,695		56,695	69
70	Electroencephalography		57		226		226	70
71	Medical Supplies Charged to Patients		2,175		42,463		42,463	71
72	Impl. Dev. Charged to Patients		2,460		45,687		45,687	72
73	Drugs Charged to Patients	71,850	10,432		95,107		95,107	73
74	Renal Dialysis		157		3,098		3,098	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		10,541		323,645		323,645	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	71,850	92,430		4,192,306		4,192,306	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				4,679		4,679	190
192	Physicians' Private Offices				48,240		48,240	192
194	MARKETING				19,160		19,160	194
194.0	COMMUNITY RELATIONS				14,514		14,514	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				314		314	194.0 3
194.0 4	PHYSICIAN CLINICS				32,371		32,371	194.0 4
194.0 5	POB				2,336,491		2,336,491	194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG				664		664	194.0 6
194.0 7	GUEST TRAYS & CATERING MEALS				1,109		1,109	194.0 7
194.0 8	HOSPICE							194.0 8
200	Cross Foot Adjustments			12	12		12	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	71,850	92,430	12	6,649,860		6,649,860	202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	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			29,841,785				4
5	Administrative & General	20,939	20,939	3,717,818	-12,818,021	52,979,171		5
6	Maintenance & Repairs							6
7	Operation of Plant	43,388	43,388	1,147,923		5,640,735	254,670	7
8	Laundry & Linen Service	1,716	1,716			487,387	1,716	8
9	Housekeeping	2,782	2,782	824,584		1,436,434	2,782	9
10	Dietary	10,953	10,953	882,596		1,470,337	10,953	10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	1,548	1,548	589,682		754,629	1,548	13
14	Central Services & Supply	2,118	2,118	199,946		568,648	2,118	14
15	Pharmacy	2,063	2,063	1,144,196		2,003,225	2,063	15
16	Medical Records & Library	3,276	3,276	489,895		852,017	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					234		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	23,852	23,852	5,661,029		7,539,883	23,852	30
31	Intensive Care Unit	6,937	6,937	1,352,758		1,820,910	6,937	31
40	Subprovider - IPF	5,955	5,955	1,182,788		1,586,922	5,955	40
41	Subprovider - IRF	12,803	12,803	1,111,400		1,695,203	12,803	41
43	Nursery	5,046	5,046	1,164,558		1,576,070	5,046	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,810	12,810	1,774,761		3,598,215	12,810	50
50.01	GASTRO INTESTINAL SERVICES	1,880	1,880	197,020		379,791	1,880	50.01
51	Recovery Room	1,380	1,380	320,347		419,091	1,380	51
52	Delivery Room & Labor Room	19,715	19,715	1,283,936		2,168,681	19,715	52
53	Anesthesiology	398	398	113,579		169,177	398	53
54	Radiology-Diagnostic	10,429	10,429	896,980		1,390,737	10,429	54
56	Radioisotope	775	775	110,508		364,726	775	56
56.01	ULTRA SOUND	590	590	451,453		571,438	590	56.01
57	CT Scan	830	830	193,006		273,460	830	57
58	MRI	757	757	133,000		181,279	757	58
59	Cardiac Catheterization	3,489	3,489	386,981		659,741	3,489	59
60	Laboratory	6,656	6,656	149,510		1,803,351	6,656	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	277	277			110,717	277	63
65	Respiratory Therapy	594	594	611,959		802,014	594	65
66	Physical Therapy	5,846	5,846	750,126		995,686	5,846	66
67	Occupational Therapy			425,217		579,337		67
68	Speech Pathology	468	468	114,602		149,674	468	68
69	Electrocardiology	2,061	2,061	198,203		289,031	2,061	69
70	Electroencephalography			8,299		10,216		70
71	Medical Supplies Charged to Patients					1,430,887		71
72	Impl. Dev. Charged to Patients					1,535,291		72
73	Drugs Charged to Patients					1,556,670		73
74	Renal Dialysis					356,954		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	1,844,247		2,611,931	11,047	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	223,378	223,378	29,432,907	-12,818,021	49,840,729	159,051	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	185	185			8,772	185	190
192	Physicians' Private Offices							192
194	MARKETING	587	587	137,261		490,083	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 DEPARTMEN T GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
194.0 2	COMMUNITY RELATIONS	503	503	138,801		208,467	503	194.0 2
194.0 3	SENIOR CENTER					38,061		194.0 3
194.0 4	PHYSICIAN CLINICS	1,256	1,256	66,041		105,812	1,256	194.0 4
194.0 5	POB	93,088	93,088			2,206,652	93,088	194.0 5
194.0 6	TRITON HLTH CAREER SCHOLARSHIP PROG			66,775		80,595		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)	4,440,350	2,209,510	6,176,105		12,818,021	7,005,483	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.919723	6.926429	0.206962		0.241945	27.508081	203
204	Cost to be allocated (Per Wkst. B, Part II)					436,497	950,947	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.008239	3.734036	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	675,384						8
9	Housekeeping	7,653	250,172					9
10	Dietary		10,953	224,528				10
11	Cafeteria			82,205	32,098			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,548		631	22,863		13
14	Central Services & Supply		2,118		507		10,000	14
15	Pharmacy		2,063		1,222			15
16	Medical Records & Library		3,276		1,178			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	143						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	326,680	23,852	64,488	8,433	8,433		30
31	Intensive Care Unit	38,901	6,937	7,613	1,613	1,613		31
40	Subprovider - IPF	45,235	5,955	16,618	1,983	1,983		40
41	Subprovider - IRF	33,292	12,803	14,709	1,594	1,597		41
43	Nursery		5,046		1,365	1,365		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	55,459	12,810		2,407	2,407		50
50.01	GASTRO INTESTINAL SERVICES		1,880		204	204		50.01
51	Recovery Room	20,815	1,380		323	323		51
52	Delivery Room & Labor Room		19,715		1,698	1,698		52
53	Anesthesiology		398		257	257		53
54	Radiology-Diagnostic	45,470	10,429		1,293			54
56	Radioisotope		775		105			56
56.01	ULTRA SOUND		590		491			56.01
57	CT Scan		830		240			57
58	MRI		757		134			58
59	Cardiac Catheterization		3,489		344	344		59
60	Laboratory	116	6,656		402			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.		277					63
65	Respiratory Therapy	5,987	594		953			65
66	Physical Therapy	31,477	5,846		1,111			66
67	Occupational Therapy	789			523			67
68	Speech Pathology		468		142			68
69	Electrocardiology		2,061		302	302		69
70	Electroencephalography				16	16		70
71	Medical Supplies Charged to Patients						4,824	71
72	Impl. Dev. Charged to Patients						5,176	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	61,212	11,047		2,321	2,321		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	673,229	154,553	185,633	31,792	22,863	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		185					190
192	Physicians' Private Offices			38,021				192
194	MARKETING		587		155			194
194.0	COMMUNITY RELATIONS		503		83			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		68			194.04
194.05	POB	2,155	93,088					194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS			874				194.07
194.08	HOSPICE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	652,512	1,867,893	2,209,154	808,825	1,007,249	793,082	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.966135	7.466435	9.839102	25.198611	44.055854	79.308200	203
204	Cost to be allocated (Per Wkst. B, Part II)	46,196	80,740	284,876	104,300	46,817	59,077	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.068400	0.322738	1.268777	3.249424	2.047719	5.907700	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		310,831,991				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			61			22
23	Paramed Ed Prgm-(specify)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		51,518,608	61			30
31	Intensive Care Unit		8,923,202				31
40	Subprovider - IPF		10,733,079				40
41	Subprovider - IRF		3,774,282				41
43	Nursery		4,934,271				43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room		19,199,989				50
50.01	GASTRO INTESTINAL SERVICES		3,190,947				50.01
51	Recovery Room		4,411,301				51
52	Delivery Room & Labor Room		8,957,367				52
53	Anesthesiology		4,607,641				53
54	Radiology-Diagnostic		8,210,898				54
56	Radioisotope		2,105,766				56
56.01	ULTRA SOUND		8,087,996				56.01
57	CT Scan		23,319,016				57
58	MRI		3,182,590				58
59	Cardiac Catheterization		7,119,980				59
60	Laboratory		28,472,213				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.		2,030,597				63
65	Respiratory Therapy		4,215,278				65
66	Physical Therapy		6,894,746				66
67	Occupational Therapy		4,235,449				67
68	Speech Pathology		1,080,441				68
69	Electrocardiology		4,678,514				69
70	Electroencephalography		193,555				70
71	Medical Supplies Charged to Patients		7,322,811				71
72	Impl. Dev. Charged to Patients		8,283,903				72
73	Drugs Charged to Patients	100	35,125,723				73
74	Renal Dialysis		529,557				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		35,492,271				91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	310,831,991	61			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)	2,590,840	1,202,418	429				202
203	Unit Cost Multiplier (Wkst. B, Part I)	25,908.400000	0.003868	7.032787				203
204	Cost to be allocated (Per Wkst. B, Part II)	71,850	92,430	12				204
205	Unit Cost Multiplier (Wkst. B, Part II)	718.500000	0.000297	0.196721				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	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
				1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	11,931,838		11,931,838	12,526	11,944,364	30
31	Intensive Care Unit	2,762,800		2,762,800		2,762,800	31
40	Subprovider - IPF	2,565,201		2,565,201	12,526	2,577,727	40
41	Subprovider - IRF	2,855,139		2,855,139	12,202	2,867,341	41
43	Nursery	2,247,492		2,247,492		2,247,492	43
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,211,351		5,211,351	16,476	5,227,827	50
50.01	GASTRO INTESTINAL SERVICES	563,903		563,903		563,903	50.01
51	Recovery Room	628,295		628,295		628,295	51
52	Delivery Room & Labor Room	3,535,147		3,535,147		3,535,147	52
53	Anesthesiology	259,649		259,649		259,649	53
54	Radiology-Diagnostic	2,200,240		2,200,240		2,200,240	54
56	Radioisotope	490,866		490,866		490,866	56
56.01	ULTRA SOUND	773,987		773,987		773,987	56.01
57	CT Scan	464,897		464,897		464,897	57
58	MRI	267,302		267,302		267,302	58
59	Cardiac Catheterization	992,751		992,751	15,788	1,008,539	59
60	Laboratory	2,592,827		2,592,827		2,592,827	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Trans.	155,046		155,046		155,046	63
65	Respiratory Therapy	1,062,935		1,062,935		1,062,935	65
66	Physical Therapy	1,526,124		1,526,124		1,526,124	66
67	Occupational Therapy	749,829		749,829		749,829	67
68	Speech Pathology	210,012		210,012		210,012	68
69	Electrocardiology	470,054		470,054		470,054	69
70	Electroencephalography	14,545		14,545		14,545	70
71	Medical Supplies Charged to Patients	2,187,991		2,187,991		2,187,991	71
72	Impl. Dev. Charged to Patients	2,349,288		2,349,288		2,349,288	72
73	Drugs Charged to Patients	4,660,005		4,660,005		4,660,005	73
74	Renal Dialysis	445,365		445,365		445,365	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	3,987,402		3,987,402		3,987,402	91
92	Observation Beds (Non-Distinct Part)	1,091,354		1,091,354		1,091,354	92
OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	59,253,635		59,253,635	69,518	59,323,153	200
201	Less Observation Beds	1,091,354		1,091,354		1,091,354	201
202	Total (line 200 minus line 201)	58,162,281		58,162,281		58,231,799	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	46,743,391		46,743,391				30
31	Intensive Care Unit	8,923,202		8,923,202				31
40	Subprovider - IPF	10,733,079		10,733,079				40
41	Subprovider - IRF	3,774,282		3,774,282				41
43	Nursery	4,934,271		4,934,271				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,346,640	10,853,349	19,199,989	0.271425	0.271425	0.272283	50
50.01	GASTRO INTESTINAL SERVICES	780,567	2,410,380	3,190,947	0.176720	0.176720	0.176720	50.01
51	Recovery Room	2,030,532	2,380,769	4,411,301	0.142429	0.142429	0.142429	51
52	Delivery Room & Labor Room	8,167,390	789,977	8,957,367	0.394664	0.394664	0.394664	52
53	Anesthesiology	1,635,902	2,971,739	4,607,641	0.056352	0.056352	0.056352	53
54	Radiology-Diagnostic	1,919,046	6,291,852	8,210,898	0.267966	0.267966	0.267966	54
56	Radioisotope	767,107	1,338,659	2,105,766	0.233106	0.233106	0.233106	56
56.01	ULTRA SOUND	1,374,989	6,713,007	8,087,996	0.095696	0.095696	0.095696	56.01
57	CT Scan	6,887,727	16,431,289	23,319,016	0.019936	0.019936	0.019936	57
58	MRI	1,048,360	2,134,230	3,182,590	0.083989	0.083989	0.083989	58
59	Cardiac Catheterization	4,751,290	2,368,690	7,119,980	0.139432	0.139432	0.141649	59
60	Laboratory	16,875,695	11,596,518	28,472,213	0.091065	0.091065	0.091065	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	Blood Storing, Processing & Trans.	1,663,232	367,365	2,030,597	0.076355	0.076355	0.076355	63
65	Respiratory Therapy	3,868,325	346,953	4,215,278	0.252162	0.252162	0.252162	65
66	Physical Therapy	3,704,630	3,190,116	6,894,746	0.221346	0.221346	0.221346	66
67	Occupational Therapy	3,637,200	598,249	4,235,449	0.177036	0.177036	0.177036	67
68	Speech Pathology	1,051,599	28,842	1,080,441	0.194376	0.194376	0.194376	68
69	Electrocardiology	2,031,507	2,647,007	4,678,514	0.100471	0.100471	0.100471	69
70	Electroencephalography	166,767	26,788	193,555	0.075147	0.075147	0.075147	70
71	Medical Supplies Charged to Patients	3,564,355	3,758,456	7,322,811	0.298791	0.298791	0.298791	71
72	Impl. Dev. Charged to Patients	5,914,909	2,368,994	8,283,903	0.283597	0.283597	0.283597	72
73	Drugs Charged to Patients	24,212,823	10,912,900	35,125,723	0.132666	0.132666	0.132666	73
74	Renal Dialysis	502,929	26,628	529,557	0.841014	0.841014	0.841014	74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	5,139,662	30,352,609	35,492,271	0.112346	0.112346	0.112346	91
92	Observation Beds (Non-Distinct Part)	780,284	3,994,933	4,775,217	0.228545	0.228545	0.228545	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	185,931,692	124,900,299	310,831,991				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	185,931,692	124,900,299	310,831,991				202

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	820,359		820,359	17,544	46.76	4,598	215,002	30
31	Intensive Care Unit	211,268		211,268	1,882	112.26	551	61,855	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	199,244		199,244	4,108	48.50	1,826	88,561	40
41	Subprovider - IRF	363,309		363,309	3,636	99.92	1,684	168,265	41
42	Subprovider I								42
43	Nursery	147,341		147,341	2,378	61.96			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,741,521		1,741,521	29,548		8,659	533,683	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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) PPS
 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	6	7	8
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	370,898	19,199,989	0.019318	1,809,452	34,955	50
50.01	GASTRO INTESTINAL SERVICES	51,976	3,190,947	0.016289	338,704	5,517	50.01
51	Recovery Room	42,263	4,411,301	0.009581	415,489	3,981	51
52	Delivery Room & Labor Room	520,485	8,957,367	0.058107	8,760	509	52
53	Anesthesiology	14,034	4,607,641	0.003046	360,117	1,097	53
54	Radiology-Diagnostic	280,922	8,210,898	0.034213	821,625	28,110	54
56	Radioisotope	23,271	2,105,766	0.011051	259,899	2,872	56
56.01	ULTRA SOUND	23,398	8,087,996	0.002893	537,495	1,555	56.01
57	CT Scan	30,628	23,319,016	0.001313	2,516,886	3,305	57
58	MRI	21,725	3,182,590	0.006826	418,579	2,857	58
59	Cardiac Catheterization	96,259	7,119,980	0.013520	1,627,788	22,008	59
60	Laboratory	190,382	28,472,213	0.006687	5,839,474	39,049	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	8,413	2,030,597	0.004143	528,666	2,190	63
65	Respiratory Therapy	26,159	4,215,278	0.006206	919,134	5,704	65
66	Physical Therapy	161,597	6,894,746	0.023438	586,312	13,742	66
67	Occupational Therapy	7,784	4,235,449	0.001838	548,819	1,009	67
68	Speech Pathology	13,670	1,080,441	0.012652	82,533	1,044	68
69	Electrocardiology	56,695	4,678,514	0.012118	898,975	10,894	69
70	Electroencephalography	226	193,555	0.001168	76,246	89	70
71	Medical Supplies Charged to Pat	42,463	7,322,811	0.005799	689,555	3,999	71
72	Impl. Dev. Charged to Patients	45,687	8,283,903	0.005515	1,024,765	5,652	72
73	Drugs Charged to Patients	95,107	35,125,723	0.002708	6,464,840	17,507	73
74	Renal Dialysis	3,098	529,557	0.005850	247,749	1,449	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	323,645	35,492,271	0.009119	1,942,022	17,709	91
92	Observation Beds (Non-Distinct	74,956	4,775,217	0.015697	336,055	5,275	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,525,741	235,723,766		29,299,939	232,078	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	17,544		4,598		30
31	Intensive Care Unit	1,882		551		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	4,108		1,826		40
41	Subprovider - IRF	3,636		1,684		41
42	Subprovider I					42
43	Nursery	2,378				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	29,548		8,659		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	19,199,989			1,809,452		2,098,397		50
50.01	GASTRO INTESTINAL SERVICES	3,190,947			338,704		556,639		50.01
51	Recovery Room	4,411,301			415,489		656,546		51
52	Delivery Room & Labor Room	8,957,367			8,760				52
53	Anesthesiology	4,607,641			360,117		456,655		53
54	Radiology-Diagnostic	8,210,898			821,625		849,983		54
56	Radioisotope	2,105,766			259,899		423,823		56
56.01	ULTRA SOUND	8,087,996			537,495		179,849		56.01
57	CT Scan	23,319,016			2,516,886		2,804,019		57
58	MRI	3,182,590			418,579		450,068		58
59	Cardiac Catheterization	7,119,980			1,627,788		916,055		59
60	Laboratory	28,472,213			5,839,474		1,718,016		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,030,597			528,666		19,538		63
65	Respiratory Therapy	4,215,278			919,134		34,079		65
66	Physical Therapy	6,894,746			586,312		36,525		66
67	Occupational Therapy	4,235,449			548,819		34,349		67
68	Speech Pathology	1,080,441			82,533		1,480		68
69	Electrocardiology	4,678,514			898,975		878,906		69
70	Electroencephalography	193,555			76,246		13,140		70
71	Medical Supplies Charged to Pat	7,322,811			689,555		561,753		71
72	Impl. Dev. Charged to Patients	8,283,903			1,024,765		909,007		72
73	Drugs Charged to Patients	35,125,723			6,464,840		1,436,373		73
74	Renal Dialysis	529,557			247,749		18,423		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	35,492,271			1,942,022		3,061,612		91
92	Observation Beds (Non-Distinct	4,775,217			336,055		823,653		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	235,723,766			29,299,939		18,938,888		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	0.271425	2,098,397			569,557		50	
50.01	GASTRO INTESTINAL SERVICES	0.176720	556,639			98,369		50.01	
51	Recovery Room	0.142429	656,546			93,511		51	
52	Delivery Room & Labor Room	0.394664						52	
53	Anesthesiology	0.056352	456,655			25,733		53	
54	Radiology-Diagnostic	0.267966	849,983			227,767		54	
56	Radioisotope	0.233106	423,823			98,796		56	
56.01	ULTRA SOUND	0.095696	179,849			17,211		56.01	
57	CT Scan	0.019936	2,804,019			55,901		57	
58	MRI	0.083989	450,068			37,801		58	
59	Cardiac Catheterization	0.139432	916,055			127,727		59	
60	Laboratory	0.091065	1,718,016			156,451		60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
63	Blood Storing, Processing & Tra	0.076355	19,538			1,492		63	
65	Respiratory Therapy	0.252162	34,079			8,593		65	
66	Physical Therapy	0.221346	36,525			8,085		66	
67	Occupational Therapy	0.177036	34,349			6,081		67	
68	Speech Pathology	0.194376	1,480			288		68	
69	Electrocardiology	0.100471	878,906			88,305		69	
70	Electroencephalography	0.075147	13,140			987		70	
71	Medical Supplies Charged to Pat	0.298791	561,753			167,847		71	
72	Impl. Dev. Charged to Patients	0.283597	909,007			257,792		72	
73	Drugs Charged to Patients	0.132666	1,436,373		23,406	190,558	3,105	73	
74	Renal Dialysis	0.841014	18,423			15,494		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	0.112346	3,061,612			343,960		91	
92	Observation Beds (Non-Distinct	0.228545	823,653			188,242		92	
OTHER REIMBURSABLE COST CENTERS									
200	Subtotal (see instructions)		18,938,888		23,406	2,786,548	3,105	200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)		18,938,888		23,406	2,786,548	3,105	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	6	7	8
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	370,898	19,199,989	0.019318	536	10	50
50.01	GASTRO INTESTINAL SERVICES	51,976	3,190,947	0.016289			50.01
51	Recovery Room	42,263	4,411,301	0.009581			51
52	Delivery Room & Labor Room	520,485	8,957,367	0.058107			52
53	Anesthesiology	14,034	4,607,641	0.003046	45,584	139	53
54	Radiology-Diagnostic	280,922	8,210,898	0.034213	18,912	647	54
56	Radioisotope	23,271	2,105,766	0.011051			56
56.01	ULTRA SOUND	23,398	8,087,996	0.002893	521	2	56.01
57	CT Scan	30,628	23,319,016	0.001313	27,118	36	57
58	MRI	21,725	3,182,590	0.006826	11,308	77	58
59	Cardiac Catheterization	96,259	7,119,980	0.013520			59
60	Laboratory	190,382	28,472,213	0.006687	220,933	1,477	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	8,413	2,030,597	0.004143			63
65	Respiratory Therapy	26,159	4,215,278	0.006206	6,405	40	65
66	Physical Therapy	161,597	6,894,746	0.023438	12,942	303	66
67	Occupational Therapy	7,784	4,235,449	0.001838	8,898	16	67
68	Speech Pathology	13,670	1,080,441	0.012652	493	6	68
69	Electrocardiology	56,695	4,678,514	0.012118	63,679	772	69
70	Electroencephalography	226	193,555	0.001168	6,489	8	70
71	Medical Supplies Charged to Pat	42,463	7,322,811	0.005799	56		71
72	Impl. Dev. Charged to Patients	45,687	8,283,903	0.005515	555	3	72
73	Drugs Charged to Patients	95,107	35,125,723	0.002708	736,126	1,993	73
74	Renal Dialysis	3,098	529,557	0.005850			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	323,645	35,492,271	0.009119	5,090	46	91
92	Observation Beds (Non-Distinct		4,775,217				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,450,785	235,723,766		1,165,645	5,575	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	19,199,989			536				50
50.01	GASTRO INTESTINAL SERVICES	3,190,947							50.01
51	Recovery Room	4,411,301							51
52	Delivery Room & Labor Room	8,957,367							52
53	Anesthesiology	4,607,641			45,584				53
54	Radiology-Diagnostic	8,210,898			18,912		6,320		54
56	Radioisotope	2,105,766					4,445		56
56.01	ULTRA SOUND	8,087,996			521		2,665		56.01
57	CT Scan	23,319,016			27,118		5,231		57
58	MRI	3,182,590			11,308		11,745		58
59	Cardiac Catheterization	7,119,980							59
60	Laboratory	28,472,213			220,933				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,030,597							63
65	Respiratory Therapy	4,215,278			6,405				65
66	Physical Therapy	6,894,746			12,942				66
67	Occupational Therapy	4,235,449			8,898				67
68	Speech Pathology	1,080,441			493				68
69	Electrocardiology	4,678,514			63,679		10,997		69
70	Electroencephalography	193,555			6,489				70
71	Medical Supplies Charged to Pat	7,322,811			56		359		71
72	Impl. Dev. Charged to Patients	8,283,903			555				72
73	Drugs Charged to Patients	35,125,723			736,126		5,293		73
74	Renal Dialysis	529,557							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	35,492,271			5,090				91
92	Observation Beds (Non-Distinct	4,775,217							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	235,723,766			1,165,645		47,055		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	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	0.271425							50
50.01	GASTRO INTESTINAL SERVICES	0.176720							50.01
51	Recovery Room	0.142429							51
52	Delivery Room & Labor Room	0.394664							52
53	Anesthesiology	0.056352							53
54	Radiology-Diagnostic	0.267966	6,320			1,694			54
56	Radioisotope	0.233106	4,445			1,036			56
56.01	ULTRA SOUND	0.095696	2,665			255			56.01
57	CT Scan	0.019936	5,231			104			57
58	MRI	0.083989	11,745			986			58
59	Cardiac Catheterization	0.139432							59
60	Laboratory	0.091065							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	0.076355							63
65	Respiratory Therapy	0.252162							65
66	Physical Therapy	0.221346							66
67	Occupational Therapy	0.177036							67
68	Speech Pathology	0.194376							68
69	Electrocardiology	0.100471	10,997			1,105			69
70	Electroencephalography	0.075147							70
71	Medical Supplies Charged to Pat	0.298791	359			107			71
72	Impl. Dev. Charged to Patients	0.283597							72
73	Drugs Charged to Patients	0.132666	5,293			702			73
74	Renal Dialysis	0.841014							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	0.112346							91
92	Observation Beds (Non-Distinct)	0.228545							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		47,055			5,989			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		47,055			5,989			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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	370,898	19,199,989	0.019318	16,973	328	50
50.01	GASTRO INTESTINAL SERVICES	51,976	3,190,947	0.016289			50.01
51	Recovery Room	42,263	4,411,301	0.009581	13,554	130	51
52	Delivery Room & Labor Room	520,485	8,957,367	0.058107			52
53	Anesthesiology	14,034	4,607,641	0.003046	2,212	7	53
54	Radiology-Diagnostic	280,922	8,210,898	0.034213	64,495	2,207	54
56	Radioisotope	23,271	2,105,766	0.011051	1,729	19	56
56.01	ULTRA SOUND	23,398	8,087,996	0.002893	5,225	15	56.01
57	CT Scan	30,628	23,319,016	0.001313	94,428	124	57
58	MRI	21,725	3,182,590	0.006826			58
59	Cardiac Catheterization	96,259	7,119,980	0.013520			59
60	Laboratory	190,382	28,472,213	0.006687	571,120	3,819	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	8,413	2,030,597	0.004143	24,063	100	63
65	Respiratory Therapy	26,159	4,215,278	0.006206	131,519	816	65
66	Physical Therapy	161,597	6,894,746	0.023438	1,230,174	28,833	66
67	Occupational Therapy	7,784	4,235,449	0.001838	1,243,260	2,285	67
68	Speech Pathology	13,670	1,080,441	0.012652	453,517	5,738	68
69	Electrocardiology	56,695	4,678,514	0.012118	14,949	181	69
70	Electroencephalography	226	193,555	0.001168			70
71	Medical Supplies Charged to Pat	42,463	7,322,811	0.005799	1,357	8	71
72	Impl. Dev. Charged to Patients	45,687	8,283,903	0.005515	1,506	8	72
73	Drugs Charged to Patients	95,107	35,125,723	0.002708	913,829	2,475	73
74	Renal Dialysis	3,098	529,557	0.005850	33,618	197	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	323,645	35,492,271	0.009119			91
92	Observation Beds (Non-Distinct		4,775,217				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,450,785	235,723,766		4,817,528	47,290	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	19,199,989			16,973				50
50.01	GASTRO INTESTINAL SERVICES	3,190,947							50.01
51	Recovery Room	4,411,301			13,554				51
52	Delivery Room & Labor Room	8,957,367							52
53	Anesthesiology	4,607,641			2,212				53
54	Radiology-Diagnostic	8,210,898			64,495		1,694		54
56	Radioisotope	2,105,766			1,729				56
56.01	ULTRA SOUND	8,087,996			5,225				56.01
57	CT Scan	23,319,016			94,428		10,992		57
58	MRI	3,182,590							58
59	Cardiac Catheterization	7,119,980							59
60	Laboratory	28,472,213			571,120				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,030,597			24,063				63
65	Respiratory Therapy	4,215,278			131,519				65
66	Physical Therapy	6,894,746			1,230,174				66
67	Occupational Therapy	4,235,449			1,243,260				67
68	Speech Pathology	1,080,441			453,517				68
69	Electrocardiology	4,678,514			14,949		1,920		69
70	Electroencephalography	193,555							70
71	Medical Supplies Charged to Pat	7,322,811			1,357				71
72	Impl. Dev. Charged to Patients	8,283,903			1,506				72
73	Drugs Charged to Patients	35,125,723			913,829		1,929		73
74	Renal Dialysis	529,557			33,618				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	35,492,271							91
92	Observation Beds (Non-Distinct	4,775,217							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	235,723,766			4,817,528		16,535		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	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	0.271425						50	
50.01	GASTRO INTESTINAL SERVICES	0.176720						50.01	
51	Recovery Room	0.142429						51	
52	Delivery Room & Labor Room	0.394664						52	
53	Anesthesiology	0.056352						53	
54	Radiology-Diagnostic	0.267966	1,694			454		54	
56	Radioisotope	0.233106						56	
56.01	ULTRA SOUND	0.095696						56.01	
57	CT Scan	0.019936	10,992			219		57	
58	MRI	0.083989						58	
59	Cardiac Catheterization	0.139432						59	
60	Laboratory	0.091065						60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
63	Blood Storing, Processing & Tra	0.076355						63	
65	Respiratory Therapy	0.252162						65	
66	Physical Therapy	0.221346						66	
67	Occupational Therapy	0.177036						67	
68	Speech Pathology	0.194376						68	
69	Electrocardiology	0.100471	1,920			193		69	
70	Electroencephalography	0.075147						70	
71	Medical Supplies Charged to Pat	0.298791						71	
72	Impl. Dev. Charged to Patients	0.283597						72	
73	Drugs Charged to Patients	0.132666	1,929			256		73	
74	Renal Dialysis	0.841014						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	0.112346						91	
92	Observation Beds (Non-Distinct)	0.228545						92	
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		16,535			1,122		200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)		16,535			1,122		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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 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)	820,359		820,359	17,544	46.76	2,272	106,239	30
31	Intensive Care Unit	211,268		211,268	1,882	112.26	119	13,359	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	199,244		199,244	4,108	48.50	2,057	99,765	40
41	Subprovider - IRF	363,309		363,309	3,636	99.92	949	94,824	41
42	Subprovider I								42
43	Nursery	147,341		147,341	2,378	61.96	453	28,068	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,741,521		1,741,521	29,548		5,850	342,255	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	370,898	19,199,989	0.019318			50
50.01	GASTRO INTESTINAL SERVICES	51,976	3,190,947	0.016289			50.01
51	Recovery Room	42,263	4,411,301	0.009581			51
52	Delivery Room & Labor Room	520,485	8,957,367	0.058107			52
53	Anesthesiology	14,034	4,607,641	0.003046			53
54	Radiology-Diagnostic	280,922	8,210,898	0.034213			54
56	Radioisotope	23,271	2,105,766	0.011051			56
56.01	ULTRA SOUND	23,398	8,087,996	0.002893			56.01
57	CT Scan	30,628	23,319,016	0.001313			57
58	MRI	21,725	3,182,590	0.006826			58
59	Cardiac Catheterization	96,259	7,119,980	0.013520			59
60	Laboratory	190,382	28,472,213	0.006687			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	8,413	2,030,597	0.004143			63
65	Respiratory Therapy	26,159	4,215,278	0.006206			65
66	Physical Therapy	161,597	6,894,746	0.023438			66
67	Occupational Therapy	7,784	4,235,449	0.001838			67
68	Speech Pathology	13,670	1,080,441	0.012652			68
69	Electrocardiology	56,695	4,678,514	0.012118			69
70	Electroencephalography	226	193,555	0.001168			70
71	Medical Supplies Charged to Pat	42,463	7,322,811	0.005799			71
72	Impl. Dev. Charged to Patients	45,687	8,283,903	0.005515			72
73	Drugs Charged to Patients	95,107	35,125,723	0.002708			73
74	Renal Dialysis	3,098	529,557	0.005850			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	323,645	35,492,271	0.009119			91
92	Observation Beds (Non-Distinct	74,956	4,775,217	0.015697			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,525,741	235,723,766				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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	17,544		2,272		30
31	Intensive Care Unit	1,882		119		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	4,108		2,057		40
41	Subprovider - IRF	3,636		949		41
42	Subprovider I					42
43	Nursery	2,378		453		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	29,548		5,850		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	19,199,989							50
50.01	GASTRO INTESTINAL SERVICES	3,190,947							50.01
51	Recovery Room	4,411,301							51
52	Delivery Room & Labor Room	8,957,367							52
53	Anesthesiology	4,607,641							53
54	Radiology-Diagnostic	8,210,898							54
56	Radioisotope	2,105,766							56
56.01	ULTRA SOUND	8,087,996							56.01
57	CT Scan	23,319,016							57
58	MRI	3,182,590							58
59	Cardiac Catheterization	7,119,980							59
60	Laboratory	28,472,213							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,030,597							63
65	Respiratory Therapy	4,215,278							65
66	Physical Therapy	6,894,746							66
67	Occupational Therapy	4,235,449							67
68	Speech Pathology	1,080,441							68
69	Electrocardiology	4,678,514							69
70	Electroencephalography	193,555							70
71	Medical Supplies Charged to Pat	7,322,811							71
72	Impl. Dev. Charged to Patients	8,283,903							72
73	Drugs Charged to Patients	35,125,723							73
74	Renal Dialysis	529,557							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	35,492,271							91
92	Observation Beds (Non-Distinct	4,775,217							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	235,723,766							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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	0.271425						50	
50.01	GASTRO INTESTINAL SERVICES	0.176720						50.01	
51	Recovery Room	0.142429						51	
52	Delivery Room & Labor Room	0.394664						52	
53	Anesthesiology	0.056352						53	
54	Radiology-Diagnostic	0.267966						54	
56	Radioisotope	0.233106						56	
56.01	ULTRA SOUND	0.095696						56.01	
57	CT Scan	0.019936						57	
58	MRI	0.083989						58	
59	Cardiac Catheterization	0.139432						59	
60	Laboratory	0.091065						60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
63	Blood Storing, Processing & Tra	0.076355						63	
65	Respiratory Therapy	0.252162						65	
66	Physical Therapy	0.221346						66	
67	Occupational Therapy	0.177036						67	
68	Speech Pathology	0.194376						68	
69	Electrocardiology	0.100471						69	
70	Electroencephalography	0.075147						70	
71	Medical Supplies Charged to Pat	0.298791						71	
72	Impl. Dev. Charged to Patients	0.283597						72	
73	Drugs Charged to Patients	0.132666						73	
74	Renal Dialysis	0.841014						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	0.112346						91	
92	Observation Beds (Non-Distinct	0.228545						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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	370,898	19,199,989	0.019318			50
50.01	GASTRO INTESTINAL SERVICES	51,976	3,190,947	0.016289			50.01
51	Recovery Room	42,263	4,411,301	0.009581			51
52	Delivery Room & Labor Room	520,485	8,957,367	0.058107			52
53	Anesthesiology	14,034	4,607,641	0.003046			53
54	Radiology-Diagnostic	280,922	8,210,898	0.034213			54
56	Radioisotope	23,271	2,105,766	0.011051			56
56.01	ULTRA SOUND	23,398	8,087,996	0.002893			56.01
57	CT Scan	30,628	23,319,016	0.001313			57
58	MRI	21,725	3,182,590	0.006826			58
59	Cardiac Catheterization	96,259	7,119,980	0.013520			59
60	Laboratory	190,382	28,472,213	0.006687			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	8,413	2,030,597	0.004143			63
65	Respiratory Therapy	26,159	4,215,278	0.006206			65
66	Physical Therapy	161,597	6,894,746	0.023438			66
67	Occupational Therapy	7,784	4,235,449	0.001838			67
68	Speech Pathology	13,670	1,080,441	0.012652			68
69	Electrocardiology	56,695	4,678,514	0.012118			69
70	Electroencephalography	226	193,555	0.001168			70
71	Medical Supplies Charged to Pat	42,463	7,322,811	0.005799			71
72	Impl. Dev. Charged to Patients	45,687	8,283,903	0.005515			72
73	Drugs Charged to Patients	95,107	35,125,723	0.002708			73
74	Renal Dialysis	3,098	529,557	0.005850			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	323,645	35,492,271	0.009119			91
92	Observation Beds (Non-Distinct		4,775,217				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,450,785	235,723,766				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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	19,199,989							50
50.01	GASTRO INTESTINAL SERVICES	3,190,947							50.01
51	Recovery Room	4,411,301							51
52	Delivery Room & Labor Room	8,957,367							52
53	Anesthesiology	4,607,641							53
54	Radiology-Diagnostic	8,210,898							54
56	Radioisotope	2,105,766							56
56.01	ULTRA SOUND	8,087,996							56.01
57	CT Scan	23,319,016							57
58	MRI	3,182,590							58
59	Cardiac Catheterization	7,119,980							59
60	Laboratory	28,472,213							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,030,597							63
65	Respiratory Therapy	4,215,278							65
66	Physical Therapy	6,894,746							66
67	Occupational Therapy	4,235,449							67
68	Speech Pathology	1,080,441							68
69	Electrocardiology	4,678,514							69
70	Electroencephalography	193,555							70
71	Medical Supplies Charged to Pat	7,322,811							71
72	Impl. Dev. Charged to Patients	8,283,903							72
73	Drugs Charged to Patients	35,125,723							73
74	Renal Dialysis	529,557							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	35,492,271							91
92	Observation Beds (Non-Distinct	4,775,217							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	235,723,766							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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	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	0.271425						50	
50.01	GASTRO INTESTINAL SERVICES	0.176720						50.01	
51	Recovery Room	0.142429						51	
52	Delivery Room & Labor Room	0.394664						52	
53	Anesthesiology	0.056352						53	
54	Radiology-Diagnostic	0.267966						54	
56	Radioisotope	0.233106						56	
56.01	ULTRA SOUND	0.095696						56.01	
57	CT Scan	0.019936						57	
58	MRI	0.083989						58	
59	Cardiac Catheterization	0.139432						59	
60	Laboratory	0.091065						60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
63	Blood Storing, Processing & Tra	0.076355						63	
65	Respiratory Therapy	0.252162						65	
66	Physical Therapy	0.221346						66	
67	Occupational Therapy	0.177036						67	
68	Speech Pathology	0.194376						68	
69	Electrocardiology	0.100471						69	
70	Electroencephalography	0.075147						70	
71	Medical Supplies Charged to Pat	0.298791						71	
72	Impl. Dev. Charged to Patients	0.283597						72	
73	Drugs Charged to Patients	0.132666						73	
74	Renal Dialysis	0.841014						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	0.112346						91	
92	Observation Beds (Non-Distinct)	0.228545						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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	370,898	19,199,989	0.019318			50
50.01	GASTRO INTESTINAL SERVICES	51,976	3,190,947	0.016289			50.01
51	Recovery Room	42,263	4,411,301	0.009581			51
52	Delivery Room & Labor Room	520,485	8,957,367	0.058107			52
53	Anesthesiology	14,034	4,607,641	0.003046			53
54	Radiology-Diagnostic	280,922	8,210,898	0.034213			54
56	Radioisotope	23,271	2,105,766	0.011051			56
56.01	ULTRA SOUND	23,398	8,087,996	0.002893			56.01
57	CT Scan	30,628	23,319,016	0.001313			57
58	MRI	21,725	3,182,590	0.006826			58
59	Cardiac Catheterization	96,259	7,119,980	0.013520			59
60	Laboratory	190,382	28,472,213	0.006687			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	Blood Storing, Processing & Tra	8,413	2,030,597	0.004143			63
65	Respiratory Therapy	26,159	4,215,278	0.006206			65
66	Physical Therapy	161,597	6,894,746	0.023438			66
67	Occupational Therapy	7,784	4,235,449	0.001838			67
68	Speech Pathology	13,670	1,080,441	0.012652			68
69	Electrocardiology	56,695	4,678,514	0.012118			69
70	Electroencephalography	226	193,555	0.001168			70
71	Medical Supplies Charged to Pat	42,463	7,322,811	0.005799			71
72	Impl. Dev. Charged to Patients	45,687	8,283,903	0.005515			72
73	Drugs Charged to Patients	95,107	35,125,723	0.002708			73
74	Renal Dialysis	3,098	529,557	0.005850			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	323,645	35,492,271	0.009119			91
92	Observation Beds (Non-Distinct		4,775,217				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,450,785	235,723,766				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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	19,199,989							50
50.01	GASTRO INTESTINAL SERVICES	3,190,947							50.01
51	Recovery Room	4,411,301							51
52	Delivery Room & Labor Room	8,957,367							52
53	Anesthesiology	4,607,641							53
54	Radiology-Diagnostic	8,210,898							54
56	Radioisotope	2,105,766							56
56.01	ULTRA SOUND	8,087,996							56.01
57	CT Scan	23,319,016							57
58	MRI	3,182,590							58
59	Cardiac Catheterization	7,119,980							59
60	Laboratory	28,472,213							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	Blood Storing, Processing & Tra	2,030,597							63
65	Respiratory Therapy	4,215,278							65
66	Physical Therapy	6,894,746							66
67	Occupational Therapy	4,235,449							67
68	Speech Pathology	1,080,441							68
69	Electrocardiology	4,678,514							69
70	Electroencephalography	193,555							70
71	Medical Supplies Charged to Pat	7,322,811							71
72	Impl. Dev. Charged to Patients	8,283,903							72
73	Drugs Charged to Patients	35,125,723							73
74	Renal Dialysis	529,557							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	35,492,271							91
92	Observation Beds (Non-Distinct	4,775,217							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	235,723,766							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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	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	0.271425						50	
50.01	GASTRO INTESTINAL SERVICES	0.176720						50.01	
51	Recovery Room	0.142429						51	
52	Delivery Room & Labor Room	0.394664						52	
53	Anesthesiology	0.056352						53	
54	Radiology-Diagnostic	0.267966						54	
56	Radioisotope	0.233106						56	
56.01	ULTRA SOUND	0.095696						56.01	
57	CT Scan	0.019936						57	
58	MRI	0.083989						58	
59	Cardiac Catheterization	0.139432						59	
60	Laboratory	0.091065						60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30	
63	Blood Storing, Processing & Tra	0.076355						63	
65	Respiratory Therapy	0.252162						65	
66	Physical Therapy	0.221346						66	
67	Occupational Therapy	0.177036						67	
68	Speech Pathology	0.194376						68	
69	Electrocardiology	0.100471						69	
70	Electroencephalography	0.075147						70	
71	Medical Supplies Charged to Pat	0.298791						71	
72	Impl. Dev. Charged to Patients	0.283597						72	
73	Drugs Charged to Patients	0.132666						73	
74	Renal Dialysis	0.841014						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	0.112346						91	
92	Observation Beds (Non-Distinct)	0.228545						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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	17,544	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,544	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)	15,941	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	4,598	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)	11,944,364	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)	11,944,364	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)	11,944,364	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)					680.82	38
39	Program general inpatient routine service cost (line 9 x line 38)					3,130,410	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)					3,130,410	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	2,762,800	1,882	1,468.01	551	808,874	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)					4,284,163	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					8,223,447	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					276,857	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					232,078	51
52	Total Program excludable cost (sum of lines 50 and 51)					508,935	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					7,714,512	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)					1,603	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					680.82	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,091,354	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	820,359	11,944,364	0.068682	1,091,354	74,956	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	4,108	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,108	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)	4,108	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)	1,826	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)	2,577,727	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)	2,577,727	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)	2,577,727	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	627.49	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,145,797	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)	1,145,797	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	140,885	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,286,682	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	88,561	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,575	51
52	Total Program excludable cost (sum of lines 50 and 51)	94,136	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,192,546	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	3,636	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,636	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,636	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)	1,684	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)	2,867,341	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)	2,867,341	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)	2,867,341	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	788.60	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,328,002	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)	1,328,002	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	846,144	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,174,146	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	168,265	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	47,290	51
52	Total Program excludable cost (sum of lines 50 and 51)	215,555	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,958,591	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0240

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,544	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,544	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)	15,941	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)	2,272	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)	2,378	15
16	Nursery days (title V or XIX only)	453	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)	11,931,838	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)	11,931,838	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)	11,931,838	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)						680.11	38
39	Program general inpatient routine service cost (line 9 x line 38)						1,545,210	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)						1,545,210	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)	2,247,492	2,378	945.12	453	428,139		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	2,762,800	1,882	1,468.01	119	174,693		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)						2,148,042	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						147,666	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)						147,666	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)					1,603	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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 [XX] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX - I/P [] IRF [] NF [XX] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,108	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,108	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)	4,108	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)	2,057	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)	2,565,201	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)	2,565,201	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)	2,565,201	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	624.44	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,284,473	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)	1,284,473	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)	1,284,473	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	99,765	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)	99,765	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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: [XX] Title XIX - I/P [XX] IRF [] NF [XX] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,636	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,636	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,636	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)	949	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)	2,855,139	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)	2,855,139	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)	2,855,139	37

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	785.24	38
39	Program general inpatient routine service cost (line 9 x line 38)	745,193	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)	745,193	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)	745,193	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	94,824	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)	94,824	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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		14,992,667		30
31	Intensive Care Unit		2,748,449		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.272283	1,809,452	492,683	50
50.01	GASTRO INTESTINAL SERVICES	0.176720	338,704	59,856	50.01
51	Recovery Room	0.142429	415,489	59,178	51
52	Delivery Room & Labor Room	0.394664	8,760	3,457	52
53	Anesthesiology	0.056352	360,117	20,293	53
54	Radiology-Diagnostic	0.267966	821,625	220,168	54
56	Radioisotope	0.233106	259,899	60,584	56
56.01	ULTRA SOUND	0.095696	537,495	51,436	56.01
57	CT Scan	0.019936	2,516,886	50,177	57
58	MRI	0.083989	418,579	35,156	58
59	Cardiac Catheterization	0.141649	1,627,788	230,575	59
60	Laboratory	0.091065	5,839,474	531,772	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.076355	528,666	40,366	63
65	Respiratory Therapy	0.252162	919,134	231,771	65
66	Physical Therapy	0.221346	586,312	129,778	66
67	Occupational Therapy	0.177036	548,819	97,161	67
68	Speech Pathology	0.194376	82,533	16,042	68
69	Electrocardiology	0.100471	898,975	90,321	69
70	Electroencephalography	0.075147	76,246	5,730	70
71	Medical Supplies Charged to Patients	0.298791	689,555	206,033	71
72	Impl. Dev. Charged to Patients	0.283597	1,024,765	290,620	72
73	Drugs Charged to Patients	0.132666	6,464,840	857,664	73
74	Renal Dialysis	0.841014	247,749	208,360	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	0.112346	1,942,022	218,178	91
92	Observation Beds (Non-Distinct Part)	0.228545	336,055	76,804	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		29,299,939	4,284,163	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		29,299,939		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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

(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		4,659,855		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.272283	536	146	50
50.01	GASTRO INTESTINAL SERVICES	0.176720			50.01
51	Recovery Room	0.142429			51
52	Delivery Room & Labor Room	0.394664			52
53	Anesthesiology	0.056352	45,584	2,569	53
54	Radiology-Diagnostic	0.267966	18,912	5,068	54
56	Radioisotope	0.233106			56
56.01	ULTRA SOUND	0.095696	521	50	56.01
57	CT Scan	0.019936	27,118	541	57
58	MRI	0.083989	11,308	950	58
59	Cardiac Catheterization	0.141649			59
60	Laboratory	0.091065	220,933	20,119	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.076355			63
65	Respiratory Therapy	0.252162	6,405	1,615	65
66	Physical Therapy	0.221346	12,942	2,865	66
67	Occupational Therapy	0.177036	8,898	1,575	67
68	Speech Pathology	0.194376	493	96	68
69	Electrocardiology	0.100471	63,679	6,398	69
70	Electroencephalography	0.075147	6,489	488	70
71	Medical Supplies Charged to Patients	0.298791	56	17	71
72	Impl. Dev. Charged to Patients	0.283597	555	157	72
73	Drugs Charged to Patients	0.132666	736,126	97,659	73
74	Renal Dialysis	0.841014			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	0.112346	5,090	572	91
92	Observation Beds (Non-Distinct Part)	0.228545			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,165,645	140,885	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,165,645		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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		1,863,171		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.272283	16,973	4,621	50
50.01	GASTRO INTESTINAL SERVICES	0.176720			50.01
51	Recovery Room	0.142429	13,554	1,930	51
52	Delivery Room & Labor Room	0.394664			52
53	Anesthesiology	0.056352	2,212	125	53
54	Radiology-Diagnostic	0.267966	64,495	17,282	54
56	Radioisotope	0.233106	1,729	403	56
56.01	ULTRA SOUND	0.095696	5,225	500	56.01
57	CT Scan	0.019936	94,428	1,883	57
58	MRI	0.083989			58
59	Cardiac Catheterization	0.141649			59
60	Laboratory	0.091065	571,120	52,009	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.076355	24,063	1,837	63
65	Respiratory Therapy	0.252162	131,519	33,164	65
66	Physical Therapy	0.221346	1,230,174	272,294	66
67	Occupational Therapy	0.177036	1,243,260	220,102	67
68	Speech Pathology	0.194376	453,517	88,153	68
69	Electrocardiology	0.100471	14,949	1,502	69
70	Electroencephalography	0.075147			70
71	Medical Supplies Charged to Patients	0.298791	1,357	405	71
72	Impl. Dev. Charged to Patients	0.283597	1,506	427	72
73	Drugs Charged to Patients	0.132666	913,829	121,234	73
74	Renal Dialysis	0.841014	33,618	28,273	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	0.112346			91
92	Observation Beds (Non-Distinct Part)	0.228545			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,817,528	846,144	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,817,528		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	0.271425			50
50.01	GASTRO INTESTINAL SERVICES	0.176720			50.01
51	Recovery Room	0.142429			51
52	Delivery Room & Labor Room	0.394664			52
53	Anesthesiology	0.056352			53
54	Radiology-Diagnostic	0.267966			54
56	Radioisotope	0.233106			56
56.01	ULTRA SOUND	0.095696			56.01
57	CT Scan	0.019936			57
58	MRI	0.083989			58
59	Cardiac Catheterization	0.139432			59
60	Laboratory	0.091065			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.076355			63
65	Respiratory Therapy	0.252162			65
66	Physical Therapy	0.221346			66
67	Occupational Therapy	0.177036			67
68	Speech Pathology	0.194376			68
69	Electrocardiology	0.100471			69
70	Electroencephalography	0.075147			70
71	Medical Supplies Charged to Patients	0.298791			71
72	Impl. Dev. Charged to Patients	0.283597			72
73	Drugs Charged to Patients	0.132666			73
74	Renal Dialysis	0.841014			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	0.112346			91
92	Observation Beds (Non-Distinct Part)	0.228545			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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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

(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	0.271425			50
50.01	GASTRO INTESTINAL SERVICES	0.176720			50.01
51	Recovery Room	0.142429			51
52	Delivery Room & Labor Room	0.394664			52
53	Anesthesiology	0.056352			53
54	Radiology-Diagnostic	0.267966			54
56	Radioisotope	0.233106			56
56.01	ULTRA SOUND	0.095696			56.01
57	CT Scan	0.019936			57
58	MRI	0.083989			58
59	Cardiac Catheterization	0.139432			59
60	Laboratory	0.091065			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.076355			63
65	Respiratory Therapy	0.252162			65
66	Physical Therapy	0.221346			66
67	Occupational Therapy	0.177036			67
68	Speech Pathology	0.194376			68
69	Electrocardiology	0.100471			69
70	Electroencephalography	0.075147			70
71	Medical Supplies Charged to Patients	0.298791			71
72	Impl. Dev. Charged to Patients	0.283597			72
73	Drugs Charged to Patients	0.132666			73
74	Renal Dialysis	0.841014			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	0.112346			91
92	Observation Beds (Non-Distinct Part)	0.228545			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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-T240

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.271425			50
50.01	GASTRO INTESTINAL SERVICES	0.176720			50.01
51	Recovery Room	0.142429			51
52	Delivery Room & Labor Room	0.394664			52
53	Anesthesiology	0.056352			53
54	Radiology-Diagnostic	0.267966			54
56	Radioisotope	0.233106			56
56.01	ULTRA SOUND	0.095696			56.01
57	CT Scan	0.019936			57
58	MRI	0.083989			58
59	Cardiac Catheterization	0.139432			59
60	Laboratory	0.091065			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	Blood Storing, Processing & Trans.	0.076355			63
65	Respiratory Therapy	0.252162			65
66	Physical Therapy	0.221346			66
67	Occupational Therapy	0.177036			67
68	Speech Pathology	0.194376			68
69	Electrocardiology	0.100471			69
70	Electroencephalography	0.075147			70
71	Medical Supplies Charged to Patients	0.298791			71
72	Impl. Dev. Charged to Patients	0.283597			72
73	Drugs Charged to Patients	0.132666			73
74	Renal Dialysis	0.841014			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	0.112346			91
92	Observation Beds (Non-Distinct Part)	0.228545			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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,835,990			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,076,498			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)	1,812			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	2,044,391			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	116.61			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	0.61			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	0.61			12
13	Total allowable FTE count for the prior year	0.60			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	0.34			14
15	Sum of lines 12 through 14 divided by 3	0.52			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	0.52			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.004459			19
20	Prior year resident to bed ratio (see instructions)	0.005165			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.004459			21
22	IME payment adjustment (see instructions)	16,832			22
22.01	IME payment adjustment - Managed Care (see instructions)	4,978			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)	-1.39			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)	16,832			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	4,978			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0783			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4955			31
32	Sum of lines 30 and 31	0.5738			32
33	Allowable disproportionate share percentage (see instructions)	0.3655			33
34	Disproportionate share adjustment (see instructions)	631,629			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)	1,705,944		1,688,955	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	428,816		1,263,245	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,692,061			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

KPMG LLP Compu-Max 2552-10

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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)	9,254,822			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)	9,259,800			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	628,660			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)	20,466			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)	9,908,926			59
60	Primary payer payments	15,612			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	9,893,314			61
62	Deductibles billed to program beneficiaries	720,188			62
63	Coinsurance billed to program beneficiaries	134,260			63
64	Allowable bad debts (see instructions)	664,601			64
65	Adjusted reimbursable bad debts (see instructions)	431,991			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	465,446			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	9,470,857			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)	-11,783			70.93
70.94	HRR adjustment amount (see instructions)	-15,185			70.94
71	Amount due provider (see instructions)	9,443,889			71
71.01	Sequestration adjustment (see instructions)	188,878			71.01
72	Interim payments	8,704,011			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	551,000			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	165,598			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

HSP Bonus Payment Amount

		Prior to 10/1	On or After 10/1	
100	HSP bonus amount (see instructions)			100

HVBP Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101
102	HVBP adjustment amount for HSP bonus payment (see instructions)			102

HRR Adjustment for HSP Bonus Payment

		Prior to 10/1	On or After 10/1	
103	HRR adjustment factor (see instructions)	0.0000	0.0000	103
104	HRR adjustment amount for HSP bonus payment (see instructions)			104

KPMG LLP Compu-Max 2552-10

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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)	3,105			1
2	Medical and other services reimbursed under OPPS (see instructions)	2,786,548			2
3	PPS payments	2,513,107			3
4	Outlier payment (see instructions)	10,296			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)	3,105			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	23,406			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)	23,406			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)	23,406			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions))	20,301			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)	3,105			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)	2,523,403			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	504,372			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)	2,022,136			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	4,893			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,027,029			30
31	Primary payer payments	7,128			31
32	Subtotal (line 30 minus line 31)	2,019,901			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)	287,829			34
35	Adjusted reimbursable bad debts (see instructions)	187,089			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	183,879			36
37	Subtotal (see instructions)	2,206,990			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)	2,206,990			40
40.01	Sequestration adjustment (see instructions)	44,140			40.01
41	Interim payments	2,148,726			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	14,124			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)				1
2	Medical and other services reimbursed under OPPS (see instructions)	5,989			2
3	PPS payments	5,147			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)	5,147			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,238			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)	3,909			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)	3,909			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	3,909			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)	3,909			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)	3,909			40
40.01	Sequestration adjustment (see instructions)	78			40.01
41	Interim payments	3,831			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	1,122			2
3	PPS payments	1,143			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)	1,143			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	293			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)	850			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)	850			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	850			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)	850			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)	850			40
40.01	Sequestration adjustment (see instructions)	17			40.01
41	Interim payments	833			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0240

**WORKSHEET E-1
PART I**

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

	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		8,686,437		2,140,533	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	01/19/2017	17,574	01/19/2017	8,193	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		17,574		8,193	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)			8,704,011		2,148,726	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		551,000		14,124	6.01
		.02					6.02
7	Total Medicare program liability (see instructions)			9,255,011		2,162,850	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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		1,369,951		3,831	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)		1,369,951		3,831	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		3		6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		1,369,954		3,831	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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		2,601,780		833
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)		2,601,780		833
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	13,923		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		2,615,703		833
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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	3,930	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	5,149	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,243	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	17,823	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	310,831,991	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	11,002,709	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)	237,599	8
9	Sequestration adjustment amount (see instructions)	4,752	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	232,847	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	236,142	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	-3,295	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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)	1,541,669	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment	22,570	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)	11.254795	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)	1,564,239	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)	1,564,239	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,564,239	18
19	Deductibles	89,880	19
20	Subtotal (line 18 minus line 19)	1,474,359	20
21	Coinsurance	76,447	21
22	Subtotal (line 20 minus line 21)	1,397,912	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)	1,397,912	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)	1,397,912	31
31.01	Sequestration adjustment (see instructions)	27,958	31.01
32	Interim payments	1,369,951	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	3	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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-T240

**WORKSHEET E-3
PART III**

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	2,437,499		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.032600		2
3	Inpatient Rehabilitation LIP payments (see instructions)	207,675		3
4	Outlier payments	78,154		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)	9.961644		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	2,723,328		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)	2,723,328		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	2,723,328		19
20	Deductibles	15,568		20
21	Subtotal (line 19 minus line 20)	2,707,760		21
22	Coinsurance	38,675		22
23	Subtotal (line 21 minus line 22)	2,669,085		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)	2,669,085		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)	2,669,085		32
32.01	Sequestration adjustment (see instructions)	53,382		32.01
33	Interim payments	2,601,780		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 33 and 34)	13,923		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	33,637		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)	78,154		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	2,148,042		1
2			2
3			3
4	2,148,042		4
5			5
6			6
7	2,148,042		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18	2,148,042		18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	2,148,042		30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	1,284,473		1
2			2
3			3
4	1,284,473		4
5			5
6			6
7	1,284,473		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15	1.000000	1.000000	15
16			16
17			17
18	1,284,473		18
19			19
20			20
21			21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	1,284,473		30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	745,193		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	745,193		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	745,193		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)	745,193		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)	745,193		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: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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					
		Primary Care	Other	Total	
		1	2	3	
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)			0.61	6
7	Enter the lesser of line 5 or line 6			0.61	7
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.61	0.00	0.61	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	0.61	0.00	0.61	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
11	Total weighted FTE count	0.61	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.60	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.32	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.51	0.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.51	0.00		17
18	Per resident amount	117,945.72	114,777.85		18
19	Approved amount for resident costs	60,152		60,152	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)			60,152	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	8,659	2,616		26
27	Total inpatient days (see instructions)	25,867	25,867		27
28	Ratio of inpatient days to total inpatient days	0.334751	0.101133		28
29	Program direct GME amount	20,136	6,083		29
30	Reduction for direct GME payments for Medicare Advantage		860		30
31	Net Program direct GME amount			25,359	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)			529,557	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)			11,684,275	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)			15,612	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			11,668,663	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			2,796,764	42
43	Primary payer payments (see instructions)			7,128	43
44	Total Part B reasonable cost (line 42 minus line 43)			2,789,636	44
45	Total reasonable cost (sum of lines 41 and 44)			14,458,299	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.807056	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.192944	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			25,359	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			20,466	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			4,893	50

KPMG LLP Compu-Max 2552-10

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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					
		Primary Care 1	Other 2	Total 3	
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
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
10.01	Unweighted dental and podiatric resident FTE count for the current year				10.01
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
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.00	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	5,590	11,055		26
27	Total inpatient days (see instructions)	25,867	25,867		27
28	Ratio of inpatient days to total inpatient days	0.216105	0.427379		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)

Assets (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	41,550				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	13,282,064				4
5	Other receivables	423,677				5
6	Allowances for uncollectible notes and accounts receivable	-1,602,820				6
7	Inventory	1,565,262				7
8	Prepaid expenses	352,196				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	14,061,929				11
FIXED ASSETS						
12	Land	9,300,000				12
13	Land improvements	260,000				13
14	Accumulated depreciation					14
15	Buildings	19,075,045				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	4,330,101				23
24	Accumulated depreciation	-8,664,352				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	49,943				29
30	Total fixed assets (sum of lines 12-29)	24,350,737				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	456,397				34
35	Total other assets (sum of lines 31-34)	456,397				35
36	Total assets (sum of lines 11, 30 and 35)	38,869,063				36

Liabilities and Fund Balances (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	2,664,790				37
38	Salaries, wages and fees payable	4,531,782				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	-174,325				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	104,475				44
45	Total current liabilities (sum of lines 37 thru 44)	7,126,722				45
LONG TERM LIABILITIES						
46	Mortgage payable	78,124,818				46
47	Notes payable	127,528				47
48	Unsecured loans					48
49	Other long term liabilities	2,410,310				49
50	Total long term liabilities (sum of lines 46 thru 49)	80,662,656				50
51	Total liabilities (sum of lines 45 and 50)	87,789,378				51
CAPITAL ACCOUNTS						
52	General fund balance	-48,920,315				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)	-48,920,315				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	38,869,063				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		-39,445,759		1
2	Net income (loss) (from Worksheet G-3, line 29)		-5,472,091		2
3	Total (sum of line 1 and line 2)		-44,917,850		3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		-44,917,850		11
12	Deductions (debit adjustments) (specify)				12
13	PERIOD 13 ADJ	4,002,455			13
14	RECONCILING	10			14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		4,002,465		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-48,920,315		19

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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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	51,677,662		51,677,662	1
2	Subprovider IPF	10,733,079		10,733,079	2
3	Subprovider IRF	3,774,282		3,774,282	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)	66,185,023		66,185,023	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	8,923,202		8,923,202	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)	8,923,202		8,923,202	16
17	Total inpatient routine care services (sum of lines 10 and 16)	75,108,225		75,108,225	17
18	Ancillary services	104,903,520	90,552,759	195,456,279	18
19	Outpatient services	5,919,946	34,347,542	40,267,488	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)	185,931,691	124,900,301	310,831,992	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		64,786,530	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)		64,786,530	43

KPMG LLP Compu-Max 2552-10

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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)	310,831,992	1
2	Less contractual allowances and discounts on patients' accounts	253,202,621	2
3	Net patient revenues (line 1 minus line 2)	57,629,371	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	64,786,530	4
5	Net income from service to patients (line 3 minus line 4)	-7,157,159	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 other 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	8,476	21
22	Rental of hospital space	908,406	22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	768,186	24
25	Total other income (sum of lines 6-24)	1,685,068	25
26	Total (line 5 plus line 25)	-5,472,091	26
29	Net income (or loss) for the period (line 26 minus line 28)	-5,472,091	29

KPMG LLP Compu-Max 2552-10

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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	558,157	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	64	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)	49.65	3
4	Number of interns & residents (see instructions)	0.52	4
5	Indirect medical education percentage (see instructions)	0.30	5
6	Indirect medical education adjustment (see instructions)	1,674	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.0783	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4955	8
9	Sum of lines 7 and 8	0.5738	9
10	Allowable disproportionate share percentage (see instructions)	0.1232	10
11	Disproportionate share adjustment (see instructions)	68,765	11
12	Total prospective capital payments (see instructions)	628,660	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

KPMG LLP Compu-Max 2552-10

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/16/2017 Run Time: 12:08 Version: 2017.10 (10/12/2017)
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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