WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically filed cost report Date: 11/20/2018 Time: 12:06 2. [X] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WESTLAKE COMMUNITY HOSPITAL (14-0240) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, 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.

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

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

VP OF OPERATIONS/REIMBURSEMENT
Title

11/20/2018 12:06
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		312,753	86,977			1
2	SUBPROVIDER - IPF		1	-1			2
3	SUBPROVIDER - IRF		1,507	687			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		314,261	87,663			200

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

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,

search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence
not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2017	To: 06 / 30 / 2018	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.	1,912	761	39		5,821	175	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.	104	100			527		25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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. Enter in column 4, the direct GME FTE unweighted count.

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67					1.27		67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N		71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	Y			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N		76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06

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

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.					109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.			111

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-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:	1,523,082			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126

127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

141	Name: TENET HEALTHCARE CORPORATION	Contractor's Name: NOVITAS SOLUTIONS		Contractor's Number: 04011	141
142	Street: 1445 ROSS AVE., STE 1400	P.O. Box:			142
143	City: DALLAS, TX	State: TX	ZIP Code: 75202-2703		143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	9.99			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		01 / 01 / 2017	03 / 31 / 2017	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	02/26/2018	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/01/2018	Y	10/01/2018	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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

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

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

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

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

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

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

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render 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 EMPLOYMENT INC.			42
43	Phone number: 606-451-1228	E-mail Address: BETH1.SLOAN@TENETHEALTH.COM		43

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	109	39,785			4,665	2,167	15,835	1
2	HMO and other (see instructions)						1,351	5,821		2
3	HMO IPF Subprovider						899	3,908		3
4	HMO IRF Subprovider						201	527		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			4,665	2,167	15,835	7
8	Intensive Care Unit	31	12	4,380			494	113	1,831	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						432	1,965	13
14	Total (see instructions)		121	44,165			5,159	2,712	19,631	14
15	CAH Visits									15
16	Subprovider - IPF	40	17	6,205			1,330	1,489	3,583	16
17	Subprovider - IRF	41	20	7,300			1,563	204	3,180	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								1,563	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							175	258	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					822	381	3,826	1
2	HMO and other (see instructions)					271	1,222		2
3	HMO IPF Subprovider						359		3
4	HMO IRF Subprovider						45		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)	0.15	420.42			822	381	3,826	14
15	CAH Visits								15
16	Subprovider - IPF		18.20			96	13	372	16
17	Subprovider - IRF		16.30			105	17	222	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)	0.15	454.92						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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	30,597,867		30,597,867	946,225.00	32.34	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		1,927,949		1,927,949	54,623.00	35.30	8
9	SNF	44						9
10	Excluded area salaries (see instructions)		2,632,049	85,280	2,717,329	83,280.00	32.63	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		166,193		166,193	2,255.00	73.70	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative		222,839		222,839	1,478.00	150.77	13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries		1,927,949		1,927,949	54,623.00	35.30	14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		5,215,415		5,215,415			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		515,404		515,404			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)							25
25.50	Home office wage-related		407,835		407,835			25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		522,600	21,175	543,775	31,852.00	17.07	26
27	Administrative & General		3,186,001	-444,734	2,741,267	95,637.00	28.66	27
28	Administrative & General under contract (see instructions)							28
29	Maintenance & Repairs							29
30	Operation of Plant		1,184,443		1,184,443	44,101.00	26.86	30
31	Laundry & Linen Service							31
32	Housekeeping		761,220		761,220	52,730.00	14.44	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		860,383		860,383	50,122.00	17.17	34
35	Dietary under contract (see instructions)							35
36	Cafeteria							36
37	Maintenance of Personnel							37
38	Nursing Administration		605,716		605,716	13,645.00	44.39	38
39	Central Services and Supply		149,819		149,819	9,499.00	15.77	39
40	Pharmacy		1,031,670	55,047	1,086,717	25,095.00	43.30	40
41	Medical Records & Medical Records Library		812,884	283,232	1,096,116	20,255.00	54.12	41
42	Social Service							42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		28,669,918		28,669,918	891,602.00	32.16	1
2	Excluded area salaries (see instructions)		2,632,049	85,280	2,717,329	83,280.00	32.63	2
3	Subtotal salarles (line 1 minus line 2)		26,037,869	-85,280	25,952,589	808,322.00	32.11	3
4	Subtotal other wages & related costs (see instructions)		2,316,981		2,316,981	58,356.00	39.70	4

5	Subtotal wage-related costs (see instructions)		5,623,250		5,623,250		21.67%	5
6	Total (sum of lines 3 through 5)		33,978,100	-85,280	33,892,820	866,678.00	39.11	6
7	Total overhead cost (see instructions)		9,114,736	-85,280	9,029,456	342,936.00	26.33	7

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

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	388,223	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)	2,273,434	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)	-56,798	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	455,863	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	1,999,419	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	151,493	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	3,781	23
24	Total Wage Related cost (Sum of lines 1-23)	5,215,415	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25

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	166,193	5,215,415	1
2	Hospital	166,193	5,215,415	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

HOSPITAL 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)	0.163318	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	13,374,280	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	10,114,585	5
6	Medicaid charges	149,625,705	6
7	Medicaid cost (line 1 times line 6)	24,436,571	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.	947,706	8

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

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

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

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

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

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	947,706	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)	16,136,683	240,022	16,376,705	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,635,411	240,022	2,875,433	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)	2,635,411	240,022	2,875,433	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)	4,523,874	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	450,102	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	692,464	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,831,410	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	868,100	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,743,533	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,691,239	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				3,448,804	3,448,804	1,057,335	4,506,139	1
2	00200	Cap Rel Costs-Mvble Equip				1,028,171	1,028,171	1,091,636	2,119,807	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	522,600	5,873,959	6,396,559	20,095	6,416,654	-164,086	6,252,568	4
5	00500	Administrative & General	3,186,001	10,875,992	14,061,993	-4,530,294	9,531,699	317,623	9,849,322	5
7	00700	Operation of Plant	1,184,443	3,833,146	5,017,589	-16,647	5,000,942	-2,040	4,998,902	7
8	00800	Laundry & Linen Service		370,754	370,754	7,517	378,271		378,271	8
9	00900	Housekeeping	761,220	345,978	1,107,198	69	1,107,267		1,107,267	9
10	01000	Dietary	860,383	400,858	1,261,241	-2,808	1,258,433	-156,486	1,101,947	10
11	01100	Cafeteria								11
13	01300	Nursing Administration	605,716	4,280	609,996	-13	609,983	-705	609,278	13
14	01400	Central Services & Supply	149,819	250,110	399,929	-16,855	383,074		383,074	14
15	01500	Pharmacy	1,031,670	1,812,625	2,844,295	-1,432,437	1,411,858	-16,070	1,395,788	15
16	01600	Medical Records & Library	812,884	196,568	1,009,452	293,502	1,302,954	-15,567	1,287,387	16
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	6,347,160	492,939	6,840,099	-913,662	5,926,437	-15,644	5,910,793	30
31	03100	Intensive Care Unit	1,338,150	87,863	1,426,013	-18,338	1,407,675		1,407,675	31
40	04000	Subprovider - IPF	1,140,233	86,077	1,226,310	-758	1,225,552	-14,770	1,210,782	40
41	04100	Subprovider - IRF	1,207,753	143,917	1,351,670	-10,706	1,340,964	-20,334	1,320,630	41
43	04300	Nursery	466,487	433,238	899,725	748,462	1,648,187	-409,512	1,238,675	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,885,274	3,555,616	5,440,890	-1,633,021	3,807,869	-126,897	3,680,972	50
50.01	03340	GASTRO INTESTINAL SERVICES	204,826	123,140	327,966	-12,008	315,958		315,958	50.01
51	05100	Recovery Room	337,113	15,477	352,590	-1,506	351,084		351,084	51
52	05200	Delivery Room & Labor Room	1,368,823	652,622	2,021,445		2,021,445	-533,204	1,488,241	52
53	05300	Anesthesiology	139,759	1,093,465	1,233,224	-101,433	1,131,791	-906,673	225,118	53
54	05400	Radiology-Diagnostic	874,314	137,845	1,012,159	-35,848	976,311	-128,372	847,939	54
56	05600	Radioisotope	116,387	223,832	340,219	-13,298	326,921		326,921	56
56.01	03630	ULTRA SOUND	454,482	15,778	470,260	-408	469,852		469,852	56.01
57	05700	CT Scan	220,492	43,022	263,514	-6,247	257,267	-1,049	256,218	57
58	05800	MRI	137,114	20,563	157,677	-287	157,390		157,390	58
59	05900	Cardiac Catheterization	428,076	691,048	1,119,124	-444,504	674,620	-20,212	654,408	59
60	06000	Laboratory	531,518	1,732,026	2,263,544	-566	2,262,978	-411,238	1,851,740	60
63	06300	Blood Storing, Processing & Trans.		148,716	148,716		148,716		148,716	63
65	06500	Respiratory Therapy	642,347	141,554	783,901	-67,955	715,946	-20,349	695,597	65
66	06600	Physical Therapy	797,928	45,160	843,088	174	843,262	-62,738	780,524	66
67	06700	Occupational Therapy	406,810	111,597	518,407		518,407	-32	518,375	67
68	06800	Speech Pathology	107,322	53,553	160,875		160,875	-10	160,865	68
69	06900	Electrocardiology	187,828	24,460	212,288	-2,857	209,431	-14,662	194,769	69
70	07000	Electroencephalography	6,240	630	6,870		6,870	-560	6,310	70
71	07100	Medical Supplies Charged to Patients				893,543	893,543		893,543	71
72	07200	Impl. Dev. Charged to Patients				1,300,446	1,300,446		1,300,446	72
73	07300	Drugs Charged to Patients				1,520,352	1,520,352		1,520,352	73
74	07400	Renal Dialysis		363,852	363,852	-196	363,656		363,656	74
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	1,852,632	1,492,619	3,345,251	-61,761	3,283,490	-1,241,281	2,042,209	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	30,313,804	35,894,879	66,208,683	-63,278	66,145,405	-1,815,897	64,329,508	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen		2,735	2,735		2,735		2,735	190
191	19100	Research	63,523	-13,869	49,654		49,654		49,654	191
192	19200	Physicians' Private Offices								192
194	07950	MARKETING	98,794	394,714	493,508	10,195	503,703		503,703	194
194.02	07952	COMMUNITY RELATIONS	110,659	33,088	143,747		143,747		143,747	194.02
194.03	07953	SENIOR CENTER		27,461	27,461	-22	27,439		27,439	194.03
194.04	07954	PHYSICIAN CLINICS				57,871	57,871		57,871	194.04

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194.05	07955	POB		115,605	115,605	-4,766	110,839		110,839	194.05
194.06	07956	TRITON HLTH CAREER SCHOLARSHIP PROG	11,087		11,087		11,087		11,087	194.06
194.07	07957	GUEST TRAYS & CATERING MEALS								194.07
194.08	07958	HOSPICE								194.08
200		TOTAL (sum of lines 118-199)	30,597,867	36,454,613	67,052,480		67,052,480	-1,815,897	65,236,583	200

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRECIATION	A	Cap Rel Costs-Bldg & Fixt	1		1,894,572	1
2	DEPRECIATION	A	Cap Rel Costs-Mvble Equip	2		691,299	2
500	Total reclassifications					2,585,871	500
	Code Letter - A						
1	RENTS	B	Cap Rel Costs-Bldg & Fixt	1		226,995	1
2	RENTS	B	Cap Rel Costs-Mvble Equip	2		331,640	2
3	RENTS	B	Operating Room	50		3,551	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					562,186	500
	Code Letter - B						
1	INTEREST EXPENSE	C	Cap Rel Costs-Mvble Equip	2		5,232	1
500	Total reclassifications					5,232	500
	Code Letter - C						
1	PROPERTY TAXES	D	Cap Rel Costs-Bldg & Fixt	1		1,308,739	1
500	Total reclassifications					1,308,739	500
	Code Letter - D						
1	INSURANCE	E	Cap Rel Costs-Bldg & Fixt	1		18,498	1
500	Total reclassifications					18,498	500
	Code Letter - E						
1	BILLABLE DRUGS	F	Drugs Charged to Patients	73		1,520,352	1
2	BILLABLE DRUGS	F	Dietary	10		34	2
3	BILLABLE DRUGS	F	Central Services & Supply	14		34	3
4	BILLABLE DRUGS	F	Subprovider - IPF	40		168	4
5	BILLABLE DRUGS	F					5
6	BILLABLE DRUGS	F					6
7	BILLABLE DRUGS	F					7
8	BILLABLE DRUGS	F					8
9	BILLABLE DRUGS	F					9
10	BILLABLE DRUGS	F					10
11	BILLABLE DRUGS	F					11
12	BILLABLE DRUGS	F					12
13	BILLABLE DRUGS	F					13
14	BILLABLE DRUGS	F					14
15	BILLABLE DRUGS	F					15
16	BILLABLE DRUGS	F					16
17	BILLABLE DRUGS	F					17
18	BILLABLE DRUGS	F					18
19	BILLABLE DRUGS	F					19
20	BILLABLE DRUGS	F					20
21	BILLABLE DRUGS	F					21
22	BILLABLE DRUGS	F					22
23	BILLABLE DRUGS	F					23
24	BILLABLE DRUGS	F					24
500	Total reclassifications					1,520,588	500
	Code Letter - F						
1	LAUNDRY	G	Laundry & Linen Service	8		7,517	1
2	LAUNDRY	G					2
3	LAUNDRY	G					3
4	LAUNDRY	G					4
5	LAUNDRY	G					5
6	LAUNDRY	G					6
7	LAUNDRY	G					7
8	LAUNDRY	G					8
9	LAUNDRY	G					9
10	LAUNDRY	G					10
11	LAUNDRY	G					11
12	LAUNDRY	G					12

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
13	LAUNDRY	G					13
14	LAUNDRY	G					14
500	Total reclassifications					7,517	500
	Code Letter - G						
1	BILLABLE SUPPLIES	H	Medical Supplies Charged to P	71		893,543	1
2	BILLABLE SUPPLIES	H	Employee Benefits Department	4		113	2
3	BILLABLE SUPPLIES	H	Housekeeping	9		69	3
4	BILLABLE SUPPLIES	H	Central Services & Supply	14		101,095	4
5	BILLABLE SUPPLIES	H	Pharmacy	15		991	5
6	BILLABLE SUPPLIES	H	Physical Therapy	66		769	6
7	BILLABLE SUPPLIES	H					7
8	BILLABLE SUPPLIES	H					8
9	BILLABLE SUPPLIES	H					9
10	BILLABLE SUPPLIES	H					10
11	BILLABLE SUPPLIES	H					11
12	BILLABLE SUPPLIES	H					12
13	BILLABLE SUPPLIES	H					13
14	BILLABLE SUPPLIES	H					14
15	BILLABLE SUPPLIES	H					15
16	BILLABLE SUPPLIES	H					16
17	BILLABLE SUPPLIES	H					17
18	BILLABLE SUPPLIES	H					18
19	BILLABLE SUPPLIES	H					19
500	Total reclassifications					996,580	500
	Code Letter - H						
1	IMPLANTABLE DEVICE	I	Impl. Dev. Charged to Patient	72		1,300,446	1
2	IMPLANTABLE DEVICE	I					2
3	IMPLANTABLE DEVICE	I					3
4	IMPLANTABLE DEVICE	I					4
5	IMPLANTABLE DEVICE	I					5
6	IMPLANTABLE DEVICE	I					6
500	Total reclassifications					1,300,446	500
	Code Letter - I						
1	NURSERY	J	Nursery	43	697,612	70,030	1
500	Total reclassifications				697,612	70,030	500
	Code Letter - J						
1	HOSPITAL SPACE IN POB	K	Employee Benefits Department	4		843	1
2	HOSPITAL SPACE IN POB	K	Radiology-Diagnostic	54		3,923	2
500	Total reclassifications					4,766	500
	Code Letter - K						
1	REGIONAL CORP ALLOCATION	L	Employee Benefits Department	4	21,175	4,700	1
2	REGIONAL CORP ALLOCATION	L	Pharmacy	15	55,047	2,278	2
3	REGIONAL CORP ALLOCATION	L	Medical Records & Library	16	283,232	10,270	3
4	REGIONAL CORP ALLOCATION	L	MARKETING	194	10,021	174	4
5	REGIONAL CORP ALLOCATION	L	PHYSICIAN CLINICS	194.04	75,259		5
500	Total reclassifications				444,734	17,422	500
	Code Letter - L						
	GRAND TOTAL (Increases)				1,142,346	8,397,875	

(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.

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION	A	Administrative & General	5		2,585,871	9	1
2	DEPRECIATION	A					9	2
500	Total reclassifications					2,585,871		500
	Code letter - A							
1	RENTS	B	Employee Benefits Department	4		120	10	1
2	RENTS	B	Administrative & General	5		161,799	10	2
3	RENTS	B	Operation of Plant	7		16,634		3
4	RENTS	B	Dietary	10		76		4
5	RENTS	B	Central Services & Supply	14		117,635		5
6	RENTS	B	Pharmacy	15		132,245		6
7	RENTS	B	Nursery	43		2,326		7
8	RENTS	B	Anesthesiology	53		75,295		8
9	RENTS	B	Radiology-Diagnostic	54		33,466		9
10	RENTS	B	CT Scan	57		974		10
11	RENTS	B	Respiratory Therapy	65		21,616		11
500	Total reclassifications					562,186		500
	Code letter - B							
1	INTEREST EXPENSE	C	Administrative & General	5		5,232	11	1
500	Total reclassifications					5,232		500
	Code letter - C							
1	PROPERTY TAXES	D	Administrative & General	5		1,308,739	13	1
500	Total reclassifications					1,308,739		500
	Code letter - D							
1	INSURANCE	E	Administrative & General	5		18,498	12	1
500	Total reclassifications					18,498		500
	Code letter - E							
1	BILLABLE DRUGS	F	Employee Benefits Department	4		6,616		1
2	BILLABLE DRUGS	F	Administrative & General	5		3,076		2
3	BILLABLE DRUGS	F	Operation of Plant	7		13		3
4	BILLABLE DRUGS	F	Nursing Administration	13		13		4
5	BILLABLE DRUGS	F	Pharmacy	15		1,355,582		5
6	BILLABLE DRUGS	F	Adults & Pediatrics	30		35,863		6
7	BILLABLE DRUGS	F	Intensive Care Unit	31		6,119		7
8	BILLABLE DRUGS	F	Subprovider - IRF	41		1,493		8
9	BILLABLE DRUGS	F	Nursery	43		12,490		9
10	BILLABLE DRUGS	F	Operating Room	50		25,682		10
11	BILLABLE DRUGS	F	GASTRO INTESTINAL SERVICES	50.01		8,673		11
12	BILLABLE DRUGS	F	Recovery Room	51		640		12
13	BILLABLE DRUGS	F	Anesthesiology	53		5,483		13
14	BILLABLE DRUGS	F	Radiology-Diagnostic	54		292		14
15	BILLABLE DRUGS	F	Radioisotope	56		11,916		15
16	BILLABLE DRUGS	F	ULTRA SOUND	56.01		22		16
17	BILLABLE DRUGS	F	CT Scan	57		2,453		17
18	BILLABLE DRUGS	F	MRI	58		287		18
19	BILLABLE DRUGS	F	Cardiac Catheterization	59		4,028		19
20	BILLABLE DRUGS	F	Respiratory Therapy	65		128		20
21	BILLABLE DRUGS	F	Electrocardiology	69		80		21
22	BILLABLE DRUGS	F	Renal Dialysis	74		196		22
23	BILLABLE DRUGS	F	Emergency	91		39,421		23
24	BILLABLE DRUGS	F	SENIOR CENTER	194.03		22		24
500	Total reclassifications					1,520,588		500
	Code letter - F							
1	LAUNDRY	G	Administrative & General	5		181		1
2	LAUNDRY	G	Dietary	10		61		2
3	LAUNDRY	G	Central Services & Supply	14		303		3
4	LAUNDRY	G	Adults & Pediatrics	30		2,031		4
5	LAUNDRY	G	Intensive Care Unit	31		599		5
6	LAUNDRY	G	Subprovider - IPF	40		646		6
7	LAUNDRY	G	Subprovider - IRF	41		19		7
8	LAUNDRY	G	Nursery	43		188		8
9	LAUNDRY	G	Operating Room	50		966		9
10	LAUNDRY	G	Radiology-Diagnostic	54		64		10
11	LAUNDRY	G	Cardiac Catheterization	59		87		11

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
12	LAUNDRY	G	Physical Therapy	66		595		12
13	LAUNDRY	G	Electrocardiology	69		7		13
14	LAUNDRY	G	Emergency	91		1,770		14
500	Total reclassifications					7,517		500
	Code letter - G							
1	BILLABLE SUPPLIES	H	Administrative & General	5		2,130		1
2	BILLABLE SUPPLIES	H	Adults & Pediatrics	30		108,126		2
3	BILLABLE SUPPLIES	H	Intensive Care Unit	31		11,620		3
4	BILLABLE SUPPLIES	H	Subprovider - IPF	40		280		4
5	BILLABLE SUPPLIES	H	Subprovider - IRF	41		9,194		5
6	BILLABLE SUPPLIES	H	Nursery	43		4,176		6
7	BILLABLE SUPPLIES	H	Operating Room	50		691,074		7
8	BILLABLE SUPPLIES	H	GASTRO INTESTINAL SERVICES	50.01		2,709		8
9	BILLABLE SUPPLIES	H	Recovery Room	51		866		9
10	BILLABLE SUPPLIES	H	Anesthesiology	53		20,655		10
11	BILLABLE SUPPLIES	H	Radiology-Diagnostic	54		5,949		11
12	BILLABLE SUPPLIES	H	Radioisotope	56		1,382		12
13	BILLABLE SUPPLIES	H	ULTRA SOUND	56.01		386		13
14	BILLABLE SUPPLIES	H	CT Scan	57		2,820		14
15	BILLABLE SUPPLIES	H	Cardiac Catheterization	59		65,096		15
16	BILLABLE SUPPLIES	H	Laboratory	60		566		16
17	BILLABLE SUPPLIES	H	Respiratory Therapy	65		46,211		17
18	BILLABLE SUPPLIES	H	Electrocardiology	69		2,770		18
19	BILLABLE SUPPLIES	H	Emergency	91		20,570		19
500	Total reclassifications					996,580		500
	Code letter - H							
1	IMPLANTABLE DEVICE	I	Dietary	10		2,705		1
2	IMPLANTABLE DEVICE	I	Central Services & Supply	14		46		2
3	IMPLANTABLE DEVICE	I	Pharmacy	15		2,926		3
4	IMPLANTABLE DEVICE	I	Operating Room	50		918,850		4
5	IMPLANTABLE DEVICE	I	GASTRO INTESTINAL SERVICES	50.01		626		5
6	IMPLANTABLE DEVICE	I	Cardiac Catheterization	59		375,293		6
500	Total reclassifications					1,300,446		500
	Code letter - I							
1	NURSERY	J	Adults & Pediatrics	30	697,612	70,030		1
500	Total reclassifications				697,612	70,030		500
	Code letter - J							
1	HOSPITAL SPACE IN POB	K	POB	194.05		4,766		1
2	HOSPITAL SPACE IN POB	K						2
500	Total reclassifications					4,766		500
	Code letter - K							
1	REGIONAL CORP ALLOCATION	L	Administrative & General	5	444,734	34		1
2	REGIONAL CORP ALLOCATION	L	PHYSICIAN CLINICS	194.04		17,388		2
3	REGIONAL CORP ALLOCATION	L						3
4	REGIONAL CORP ALLOCATION	L						4
5	REGIONAL CORP ALLOCATION	L						5
500	Total reclassifications				444,734	17,422		500
	Code letter - L							
	GRAND TOTAL (Decreases)				1,142,346	8,397,875		

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

RECONCILIATION OF CAPITAL COST CENTERS **WORKSHEET A-7**
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	4,187,868					4,187,868		1
2	Land Improvements	4,893,624					4,893,624		2
3	Buildings and Fixtures	66,849,889					66,849,889		3
4	Building Improvements	6,238,601	283,556		283,556		6,522,157		4
5	Fixed Equipment	4,124,706					4,124,706		5
6	Movable Equipment	75,847,438	366,245		366,245		76,213,683		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	162,142,126	649,801		649,801		162,791,927		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	162,142,126	649,801		649,801		162,791,927		10

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

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

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	78,265,670		78,265,670	0.493466					1
2	Cap Rel Costs-Mvble Equ	80,338,389		80,338,389	0.506534					2
3	Total (sum of lines 1-2)	158,604,059		158,604,059	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	2,385,700	226,995		18,498	1,874,946		4,506,139	1
2	Cap Rel Costs-Mvble Equip	1,842,943	271,632	5,232				2,119,807	2
3	Total (sum of lines 1-2)	4,228,643	498,627	5,232	18,498	1,874,946		6,625,946	3

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

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-4,617,967				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1	-571,854				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-148,718	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	-8,170	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-7,749	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	-179,290	Cap Rel Costs-Bldg & Fixt	1	9	26
27	Depreciation--movable equipment	A	1,151,644	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	DIRECT PHONE COSTS	A	-40,564	Administrative & General	5		33
33.01	PBX SALARY	A	-19,174	Administrative & General	5		33.01
33.02	PBX BENEFITS	A	-18,670	Employee Benefits Department	4		33.02
33.03	TELEVISION CABLE/SATELITE & DEPREC	A	-60,008	Cap Rel Costs-Mvble Equip	2	10	33.03
33.04	RENTAL INCOME	B	-7,000	Administrative & General	5		33.04
33.05	ADMIN SVCS	B	-215,065	Administrative & General	5		33.05
33.06	OTHER OPERATING REVENUE	B	-7,200	Administrative & General	5		33.06
33.07	CHAPEL FUNDS	B	123	Administrative & General	5		33.07
33.08	DRUG SCREENS	B	-364,505	Administrative & General	5		33.08
33.09	OTHER OPERATING REVENUE	B	-130	Operation of Plant	7		33.09
33.10	SEASON HOSPICE	B	-7,000	Pharmacy	15		33.10
33.11	BARIATRIC PHONE LINE	B	-540	Operating Room	50		33.11
33.12	OTHER OPERATING REVENUE	B	-623	Delivery Room & Labor Room	52		33.12
33.13	SEASON HOSPICE	B	-270	Radiology-Diagnostic	54		33.13
33.14	OTHER OPERATING REVENUE	B	-128,852	Radiology-Diagnostic	54		33.14
33.15	FITNESS CENTER REVENUE	B	-62,697	Physical Therapy	66		33.15
33.16	ADVERTISING	A	-1,691	Employee Benefits Department	4		33.16
33.17	ADVERTISING	A	-18,060	Administrative & General	5		33.17
33.18	ADVERTISING	A	-1,910	Operation of Plant	7		33.18
33.19	PURCHASED SVCS	A	-4,348	Administrative & General	5		33.19
33.20	PURCHASED SVCS	A	-7,321	Pharmacy	15		33.20
33.21	PURCHASED SVCS	A	-7,397	Medical Records & Library	16		33.21
33.22	PURCHASED SVCS	A	-43,574	Operating Room	50		33.22
33.23	TRAVEL	A	-539	Administrative & General	5		33.23
33.24	TRAVEL	A	-2	Subprovider - IRF	41		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	MEALS	A	-2,681	Administrative & General	5		33.25
33.26	MEALS	A	-19	Dietary	10		33.26
33.27	MEALS	A	-41	Physical Therapy	66		33.27
33.28	MEALS	A	-32	Occupational Therapy	67		33.28
33.29	MEALS	A	-10	Speech Pathology	68		33.29
33.30	PROPERTY TAXES	A	566,207	Cap Rel Costs-Bldg & Fixt	1	13	33.30
33.31	DONATIONS/CONTRIBUTIONS	A	-10,513	Administrative & General	5		33.31
33.32	DUES & SUBSCRIPTION	A	-3,675	Administrative & General	5		33.32
33.33	LOBBYING	A	-27,512	Administrative & General	5		33.33
33.34	PATIENT TRANSPORTATION	A	-654	Administrative & General	5		33.34
33.35	PATIENT TRANSPORTATION	A	-705	Nursing Administration	13		33.35
33.36	PATIENT TRANSPORTATION	A	-512	Nursery	43		33.36
33.37	PATIENT TRANSPORTATION	A	594	Emergency	91		33.37
33.38	LEGAL	A	-21,159	Administrative & General	5		33.38
33.39	PENALTIES AND FINES	A	-6,337	Employee Benefits Department	4		33.39
33.40	PENALTIES AND FINES	A	-5,268	Administrative & General	5		33.40
33.41	PENALTIES AND FINES	A	-1,749	Pharmacy	15		33.41
33.42	H.O. WORKER COMPENSATION	A	141,294	Employee Benefits Department	4		33.42
33.43	PERIOD 13 ADJUSTMENTS	A	-278,682	Employee Benefits Department	4		33.43
33.44	PERIOD 13 ADJUSTMENTS	A	3,322,775	Administrative & General	5		33.44
33.45	CHIEF STRATEGY OFFICER	A	-88,097	Administrative & General	5		33.45
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)		-1,815,897				50

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

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE DIRECT CAPITAL	363,582		363,582	9	1
2	1	Cap Rel Costs-Bldg & Fixt	HOME OFFICE POOLED CAPITAL	306,836		306,836	9	2
3	5	Administrative & General	HOME OFFICE SHARED SERVICES	1,135,794		1,135,794		3
4	5	Administrative & General	PERIOD 13 ADJ - IC OVERHEAD ALLOC		1,966,828	-1,966,828		4
4.01	1	Cap Rel Costs-Bldg & Fixt	REGIONAL ALLOCATION	160,832	160,832		10	4.01
4.02	2	Cap Rel Costs-Mvble Equip	REGIONAL ALLOCATION	967	967		10	4.02
4.03	4	Employee Benefits Department	REGIONAL ALLOCATION	25,875	25,875			4.03
4.04	5	Administrative & General	REGIONAL ALLOCATION	3,158,979	3,158,979			4.04
4.05	15	Pharmacy	REGIONAL ALLOCATION	57,326	57,326			4.05
4.06	16	Medical Records & Library	REGIONAL ALLOCATION	293,502	293,502			4.06
4.07	194	MARKETING	REGIONAL ALLOCATION	10,195	10,195			4.07
4.08	194.04	PHYSICIAN CLINICS	REGIONAL ALLOCATION	57,871	57,871			4.08
4.09	60	Laboratory	GENESIS LAB	1,107,573	1,518,811	-411,238		4.09
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12			6,679,332	7,251,186	-571,854		5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			TENET HLTHCARE	100.00	HEALTHCARE	6
7	G			GENESIS	1.00	LAB	7
8	G			REGIONAL	1.00	HEALTHCARE	8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify: SHARED SVCS

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	1,368,732	1,331,613	37,119	211,500	300	30,505	1,525	1
2	30	Adults & Pediatrics ADULTS & PEDIAT	28,718	6,218	22,500	181,300	150	13,074	654	2
3	40	Subprovider - IPF SUBPROVIDER - I	27,844	5,344	22,500	181,300	150	13,074	654	3
4	41	Subprovider - IRF SUBPROVIDER - I	72,800		72,800	211,500	516	52,468	2,623	4
5	43	Nursery NURSERY	409,000	409,000						5
6	50	Operating Room OPERATING ROOM	111,569	61,129	50,440	246,400	243	28,786	1,439	6
7	52	Delivery Room & Labo LABOR ROOM & DE	532,581	532,581						7
8	53	Anesthesiology ANESTHESIOLOGY	906,673	906,673						8
9	54	Radiology-Diagnostic RADIOLOGY - DIA	-750	-750						9
10	57	CT Scan CT SCAN	1,049	1,049						10
11	59	Cardiac Catheterizat CARDIAC CATHETE	27,635	13,635	14,000	211,500	73	7,423	371	11
12	60	Laboratory LABORATORY	3,480		3,480	260,300	46	5,757	288	12
13	65	Respiratory Therapy RESPIRATORY THE	20,349	20,349						13
14	69	Electrocardiology ELECTRO CARDIOL	14,662	14,662						14
15	70	Electroencephalograp ELECTROENCEPHAL	560	560						15
16	91	Emergency EMERGENCY	1,241,875	1,241,875						16
17										17
18										18
19										19
20										20
200		TOTAL	4,766,777	4,543,938	222,839		1,478	151,087	7,554	200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen ADMINISTRATIVE					30,505	6,614	1,338,227	1
2	30	Adults & Pediatrics ADULTS & PEDIAT					13,074	9,426	15,644	2
3	40	Subprovider - IPF SUBPROVIDER - I					13,074	9,426	14,770	3
4	41	Subprovider - IRF SUBPROVIDER - I					52,468	20,332	20,332	4
5	43	Nursery NURSERY							409,000	5
6	50	Operating Room OPERATING ROOM					28,786	21,654	82,783	6
7	52	Delivery Room & Labo LABOR ROOM & DE							532,581	7
8	53	Anesthesiology ANESTHESIOLOGY							906,673	8
9	54	Radiology-Diagnostic RADIOLOGY - DIA							-750	9
10	57	CT Scan CT SCAN							1,049	10
11	59	Cardiac Catheterizat CARDIAC CATHETE					7,423	6,577	20,212	11
12	60	Laboratory LABORATORY					5,757			12
13	65	Respiratory Therapy RESPIRATORY THE							20,349	13
14	69	Electrocardiology ELECTRO CARDIOL							14,662	14
15	70	Electroencephalograp ELECTROENCEPHAL							560	15
16	91	Emergency EMERGENCY							1,241,875	16
17										17
18										18
19										19
20										20
200		TOTAL					151,087	74,029	4,617,967	200

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	4,506,139	4,506,139					1
2	Cap Rel Costs-Mvble Equip	2,119,807		2,119,807				2
4	Employee Benefits Department	6,252,568			6,252,568			4
5	Administrative & General	9,849,322	295,783	139,144	570,304	10,854,553	10,854,553	5
7	Operation of Plant	4,998,902	612,897	288,323	246,416	6,146,538	1,226,837	7
8	Laundry & Linen Service	378,271	24,240	11,403		413,914	82,616	8
9	Housekeeping	1,107,267	39,298	18,487	158,367	1,323,419	264,152	9
10	Dietary	1,101,947	154,722	72,785	178,998	1,508,452	301,084	10
11	Cafeteria							11
13	Nursing Administration	609,278	21,867	10,287	126,016	767,448	153,181	13
14	Central Services & Supply	383,074	29,919	14,075	31,169	458,237	91,463	14
15	Pharmacy	1,395,788	29,142	13,709	226,085	1,664,724	332,276	15
16	Medical Records & Library	1,287,387	46,277	21,770	228,040	1,583,474	316,058	16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,910,793	336,932	158,502	1,175,349	7,581,576	1,513,275	30
31	Intensive Care Unit	1,407,675	97,992	46,098	278,394	1,830,159	365,296	31
40	Subprovider - IPF	1,210,782	84,120	39,572	237,219	1,571,693	313,707	40
41	Subprovider - IRF	1,320,630	180,855	85,079	251,266	1,837,830	366,827	41
43	Nursery	1,238,675	71,280	33,532	242,184	1,585,671	316,497	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,680,972	180,954	85,125	392,220	4,339,271	866,110	50
50.01	GASTRO INTESTINAL SERVICES	315,958	26,557	12,493	42,613	397,621	79,364	50.01
51	Recovery Room	351,084	19,494	9,170	70,134	449,882	89,796	51
52	Delivery Room & Labor Room	1,488,241	278,493	131,011	284,775	2,182,520	435,627	52
53	Anesthesiology	225,118	5,622	2,645	29,076	262,461	52,387	53
54	Radiology-Diagnostic	847,939	147,320	69,303	181,896	1,246,458	248,791	54
56	Radioisotope	326,921	10,948	5,150	24,214	367,233	73,299	56
56.01	ULTRA SOUND	469,852	8,334	3,921	94,552	576,659	115,100	56.01
57	CT Scan	256,218	11,725	5,516	45,872	319,331	63,738	57
58	MRI	157,390	10,693	5,030	28,526	201,639	40,247	58
59	Cardiac Catheterization	654,408	49,285	23,185	89,059	815,937	162,859	59
60	Laboratory	1,851,740	94,022	44,231	110,579	2,100,572	419,270	60
63	Blood Storing, Processing & Trans.	148,716	3,913	1,841		154,470	30,832	63
65	Respiratory Therapy	695,597	8,391	3,947	133,636	841,571	167,976	65
66	Physical Therapy	780,524	82,580	38,848	166,004	1,067,956	213,162	66
67	Occupational Therapy	518,375			84,634	603,009	120,359	67
68	Speech Pathology	160,865	6,611	3,110	22,328	192,914	38,505	68
69	Electrocardiology	194,769	29,114	13,696	39,076	276,655	55,220	69
70	Electroencephalography	6,310			1,298	7,608	1,519	70
71	Medical Supplies Charged to Patients	893,543				893,543	178,349	71
72	Impl. Dev. Charged to Patients	1,300,446				1,300,446	259,566	72
73	Drugs Charged to Patients	1,520,352				1,520,352	303,459	73
74	Renal Dialysis	363,656				363,656	72,585	74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	2,042,209	156,049	73,410	385,429	2,657,097	530,351	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	64,329,508	3,155,429	1,484,398	6,175,728	62,266,549	10,261,740	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,735	2,613	1,229		6,577	1,313	190
191	Research	49,654			13,216	62,870	12,549	191
192	Physicians' Private Offices							192
194	MARKETING	503,703	8,292	3,901	22,638	538,534	107,490	194
194.02	COMMUNITY RELATIONS	143,747	7,105	3,343	23,022	177,217	35,372	194.02
194.03	SENIOR CENTER	27,439				27,439	5,477	194.03
194.04	PHYSICIAN CLINICS	57,871	17,742	8,346	15,657	99,616	19,883	194.04
194.05	POB	110,839	1,314,958	618,590		2,044,387	408,056	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG	11,087			2,307	13,394	2,673	194.06

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	
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	65,236,583	4,506,139	2,119,807	6,252,568	65,236,583	10,854,553	202

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant	7,373,375						7
8	Laundry & Linen Service	49,683	546,213					8
9	Housekeeping	80,546	6,190	1,674,307				9
10	Dietary	317,119		73,304	2,199,959			10
11	Cafeteria				800,362	800,362		11
13	Nursing Administration	44,819		10,360		16,257	992,065	13
14	Central Services & Supply	61,322		14,175		11,325		14
15	Pharmacy	59,729		13,807		29,887		15
16	Medical Records & Library	94,849		21,925		24,138		16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd		116					22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	690,579	264,201	159,632	661,757	200,464	356,106	30
31	Intensive Care Unit	200,845	31,461	46,427	76,514	38,610	68,588	31
40	Subprovider - IPF	172,413	36,584	39,855	149,741	45,103	80,122	40
41	Subprovider - IRF	370,681	26,925	85,686	132,891	40,395	71,758	41
43	Nursery	146,095		33,771		33,704	59,872	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	370,884	44,852	85,733		62,079	110,278	50
50.01	GASTRO INTESTINAL SERVICES	54,431		12,582		5,328	9,465	50.01
51	Recovery Room	39,955	16,833	9,236		7,955	14,131	51
52	Delivery Room & Labor Room	570,802		131,945		44,360	78,802	52
53	Anesthesiology	11,523		2,664		7,013	12,459	53
54	Radiology-Diagnostic	301,947	36,773	69,797		29,540		54
56	Radioisotope	22,438		5,187		2,676		56
56.01	ULTRA SOUND	17,082		3,949		12,143		56.01
57	CT Scan	24,031		5,555		6,270		57
58	MRI	21,917		5,066		3,370		58
59	Cardiac Catheterization	101,016		23,351		8,996	15,980	59
60	Laboratory	192,709	94	44,546		25,402		60
63	Blood Storing, Processing & Trans.	8,020		1,854				63
65	Respiratory Therapy	17,198	4,842	3,975		23,964		65
66	Physical Therapy	169,257	25,456	39,125		28,152		66
67	Occupational Therapy		638			11,846		67
68	Speech Pathology	13,550		3,132		3,222		68
69	Electrocardiology	59,671		13,793		6,666	11,842	69
70	Electroencephalography					273	484	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	319,840	49,505	73,933		57,519	102,178	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,604,951	544,470	1,034,365	1,821,265	786,657	992,065	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,356		1,238				190
191	Research							191
192	Physicians' Private Offices				370,179			192
194	MARKETING	16,995		3,929		3,544		194
194.02	COMMUNITY RELATIONS	14,563		3,366		1,239		194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS	36,365		8,406		8,922		194.04
194.05	POB	2,695,145	1,743	623,003				194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS				8,515			194.07

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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	
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	7,373,375	546,213	1,674,307	2,199,959	800,362	992,065	202

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	22	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply	636,522						14
15	Pharmacy		2,100,423					15
16	Medical Records & Library			2,040,444				16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd				116			22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics			350,285	116	11,777,991	-116	30
31	Intensive Care Unit			59,265		2,717,165		31
40	Subprovider - IPF			60,956		2,470,174		40
41	Subprovider - IRF			22,190		2,955,183		41
43	Nursery			27,734		2,203,344		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			128,618		6,007,825		50
50.01	GASTRO INTESTINAL SERVICES			21,836		580,627		50.01
51	Recovery Room			31,046		658,834		51
52	Delivery Room & Labor Room			53,231		3,497,287		52
53	Anesthesiology			35,103		383,610		53
54	Radiology-Diagnostic			48,051		1,981,357		54
56	Radioisotope			13,320		484,153		56
56.01	ULTRA SOUND			49,454		774,387		56.01
57	CT Scan			166,417		585,342		57
58	MRI			17,132		289,371		58
59	Cardiac Catheterization			43,726		1,171,865		59
60	Laboratory			198,334		2,980,927		60
63	Blood Storing, Processing & Trans.			13,717		208,893		63
65	Respiratory Therapy			22,882		1,082,408		65
66	Physical Therapy			45,735		1,588,843		66
67	Occupational Therapy			26,259		762,111		67
68	Speech Pathology			5,622		256,945		68
69	Electrocardiology			30,650		454,497		69
70	Electroencephalography			981		10,865		70
71	Medical Supplies Charged to Patients	259,255		53,320		1,384,467		71
72	Impl. Dev. Charged to Patients	377,267		51,951		1,989,230		72
73	Drugs Charged to Patients		2,100,423	202,414		4,126,648		73
74	Renal Dialysis			4,342		440,583		74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency			255,873		4,046,296		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	636,522	2,100,423	2,040,444	116	57,871,228	-116	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					14,484		190
191	Research					75,419		191
192	Physicians' Private Offices					370,179		192
194	MARKETING					670,492		194
194.02	COMMUNITY RELATIONS					231,757		194.02
194.03	SENIOR CENTER					32,916		194.03
194.04	PHYSICIAN CLINICS					173,192		194.04
194.05	POB					5,772,334		194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG					16,067		194.06
194.07	GUEST TRAYS & CATERING MEALS					8,515		194.07

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	
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	636,522	2,100,423	2,040,444	116	65,236,583	-116	202

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

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,777,875						30
31	Intensive Care Unit	2,717,165						31
40	Subprovider - IPF	2,470,174						40
41	Subprovider - IRF	2,955,183						41
43	Nursery	2,203,344						43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,007,825						50
50.01	GASTRO INTESTINAL SERVICES	580,627						50.01
51	Recovery Room	658,834						51
52	Delivery Room & Labor Room	3,497,287						52
53	Anesthesiology	383,610						53
54	Radiology-Diagnostic	1,981,357						54
56	Radioisotope	484,153						56
56.01	ULTRA SOUND	774,387						56.01
57	CT Scan	585,342						57
58	MRI	289,371						58
59	Cardiac Catheterization	1,171,865						59
60	Laboratory	2,980,927						60
63	Blood Storing, Processing & Trans.	208,893						63
65	Respiratory Therapy	1,082,408						65
66	Physical Therapy	1,588,843						66
67	Occupational Therapy	762,111						67
68	Speech Pathology	256,945						68
69	Electrocardiology	454,497						69
70	Electroencephalography	10,865						70
71	Medical Supplies Charged to Patients	1,384,467						71
72	Impl. Dev. Charged to Patients	1,989,230						72
73	Drugs Charged to Patients	4,126,648						73
74	Renal Dialysis	440,583						74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	4,046,296						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	57,871,112						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	14,484						190
191	Research	75,419						191
192	Physicians' Private Offices	370,179						192
194	MARKETING	670,492						194
194.02	COMMUNITY RELATIONS	231,757						194.02
194.03	SENIOR CENTER	32,916						194.03
194.04	PHYSICIAN CLINICS	173,192						194.04
194.05	POB	5,772,334						194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG	16,067						194.06
194.07	GUEST TRAYS & CATERING MEALS	8,515						194.07

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	65,236,467						202

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		295,783	139,144	434,927	434,927		5
7	Operation of Plant		612,897	288,323	901,220	49,160	950,380	7
8	Laundry & Linen Service		24,240	11,403	35,643	3,310	6,404	8
9	Housekeeping		39,298	18,487	57,785	10,585	10,382	9
10	Dietary		154,722	72,785	227,507	12,065	40,875	10
11	Cafeteria							11
13	Nursing Administration		21,867	10,287	32,154	6,138	5,777	13
14	Central Services & Supply		29,919	14,075	43,994	3,665	7,904	14
15	Pharmacy		29,142	13,709	42,851	13,314	7,699	15
16	Medical Records & Library		46,277	21,770	68,047	12,665	12,225	16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		336,932	158,502	495,434	60,617	89,011	30
31	Intensive Care Unit		97,992	46,098	144,090	14,638	25,888	31
40	Subprovider - IPF		84,120	39,572	123,692	12,570	22,223	40
41	Subprovider - IRF		180,855	85,079	265,934	14,699	47,778	41
43	Nursery		71,280	33,532	104,812	12,682	18,831	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		180,954	85,125	266,079	34,705	47,804	50
50.01	GASTRO INTESTINAL SERVICES		26,557	12,493	39,050	3,180	7,016	50.01
51	Recovery Room		19,494	9,170	28,664	3,598	5,150	51
52	Delivery Room & Labor Room		278,493	131,011	409,504	17,456	73,573	52
53	Anesthesiology		5,622	2,645	8,267	2,099	1,485	53
54	Radiology-Diagnostic		147,320	69,303	216,623	9,969	38,919	54
56	Radioisotope		10,948	5,150	16,098	2,937	2,892	56
56.01	ULTRA SOUND		8,334	3,921	12,255	4,612	2,202	56.01
57	CT Scan		11,725	5,516	17,241	2,554	3,097	57
58	MRI		10,693	5,030	15,723	1,613	2,825	58
59	Cardiac Catheterization		49,285	23,185	72,470	6,526	13,020	59
60	Laboratory		94,022	44,231	138,253	16,800	24,839	60
63	Blood Storing, Processing & Trans.		3,913	1,841	5,754	1,235	1,034	63
65	Respiratory Therapy		8,391	3,947	12,338	6,731	2,217	65
66	Physical Therapy		82,580	38,848	121,428	8,542	21,816	66
67	Occupational Therapy					4,823		67
68	Speech Pathology		6,611	3,110	9,721	1,543	1,746	68
69	Electrocardiology		29,114	13,696	42,810	2,213	7,691	69
70	Electroencephalography					61		70
71	Medical Supplies Charged to Patients					7,147		71
72	Impl. Dev. Charged to Patients					10,401		72
73	Drugs Charged to Patients					12,160		73
74	Renal Dialysis					2,909		74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		156,049	73,410	229,459	21,251	41,225	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		3,155,429	1,484,398	4,639,827	411,173	593,548	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,613	1,229	3,842	53	690	190
191	Research					503		191
192	Physicians' Private Offices							192
194	MARKETING		8,292	3,901	12,193	4,307	2,191	194
194.02	COMMUNITY RELATIONS		7,105	3,343	10,448	1,417	1,877	194.02
194.03	SENIOR CENTER					219		194.03
194.04	PHYSICIAN CLINICS		17,742	8,346	26,088	797	4,687	194.04
194.05	POB		1,314,958	618,590	1,933,548	16,351	347,387	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG					107		194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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	
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		4,506,139	2,119,807	6,625,946	434,927	950,380	202

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service	45,357						8
9	Housekeeping	514	79,266					9
10	Dietary		3,470	283,917				10
11	Cafeteria			103,291	103,291			11
13	Nursing Administration		490		2,098	46,657		13
14	Central Services & Supply		671		1,462		57,696	14
15	Pharmacy		654		3,857			15
16	Medical Records & Library		1,038		3,115			16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	10						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	21,937	7,557	85,403	25,871	16,747		30
31	Intensive Care Unit	2,612	2,198	9,875	4,983	3,226		31
40	Subprovider - IPF	3,038	1,887	19,325	5,821	3,768		40
41	Subprovider - IRF	2,236	4,057	17,150	5,213	3,375		41
43	Nursery		1,599		4,350	2,816		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,725	4,059		8,012	5,186		50
50.01	GASTRO INTESTINAL SERVICES		596		688	445		50.01
51	Recovery Room	1,398	437		1,027	665		51
52	Delivery Room & Labor Room		6,247		5,725	3,706		52
53	Anesthesiology		126		905	586		53
54	Radiology-Diagnostic	3,054	3,304		3,812			54
56	Radioisotope		246		345			56
56.01	ULTRA SOUND		187		1,567			56.01
57	CT Scan		263		809			57
58	MRI		240		435			58
59	Cardiac Catheterization		1,105		1,161	752		59
60	Laboratory	8	2,109		3,278			60
63	Blood Storing, Processing & Trans.		88					63
65	Respiratory Therapy	402	188		3,093			65
66	Physical Therapy	2,114	1,852		3,633			66
67	Occupational Therapy	53			1,529			67
68	Speech Pathology		148		416			68
69	Electrocardiology		653		860	557		69
70	Electroencephalography				35	23		70
71	Medical Supplies Charged to Patients						23,500	71
72	Impl. Dev. Charged to Patients						34,196	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	4,111	3,500		7,423	4,805		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	45,212	48,969	235,044	101,523	46,657	57,696	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		59					190
191	Research							191
192	Physicians' Private Offices			47,774				192
194	MARKETING		186		457			194
194.02	COMMUNITY RELATIONS		159		160			194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS		398		1,151			194.04
194.05	POB	145	29,495					194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS			1,099				194.07

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	
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	45,357	79,266	283,917	103,291	46,657	57,696	202

	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
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	68,375						15
16	Medical Records & Library		97,090					16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd			10				22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		16,662		819,239		819,239	30
31	Intensive Care Unit		2,820		210,330		210,330	31
40	Subprovider - IPF		2,901		195,225		195,225	40
41	Subprovider - IRF		1,056		361,498		361,498	41
43	Nursery		1,320		146,410		146,410	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		6,120		375,690		375,690	50
50.01	GASTRO INTESTINAL SERVICES		1,039		52,014		52,014	50.01
51	Recovery Room		1,477		42,416		42,416	51
52	Delivery Room & Labor Room		2,533		518,744		518,744	52
53	Anesthesiology		1,670		15,138		15,138	53
54	Radiology-Diagnostic		2,287		277,968		277,968	54
56	Radioisotope		634		23,152		23,152	56
56.01	ULTRA SOUND		2,353		23,176		23,176	56.01
57	CT Scan		7,919		31,883		31,883	57
58	MRI		815		21,651		21,651	58
59	Cardiac Catheterization		2,081		97,115		97,115	59
60	Laboratory		9,438		194,725		194,725	60
63	Blood Storing, Processing & Trans.		653		8,764		8,764	63
65	Respiratory Therapy		1,089		26,058		26,058	65
66	Physical Therapy		2,176		161,561		161,561	66
67	Occupational Therapy		1,250		7,655		7,655	67
68	Speech Pathology		268		13,842		13,842	68
69	Electrocardiology		1,458		56,242		56,242	69
70	Electroencephalography		47		166		166	70
71	Medical Supplies Charged to Patients		2,537		33,184		33,184	71
72	Impl. Dev. Charged to Patients		2,472		47,069		47,069	72
73	Drugs Charged to Patients	68,375	9,632		90,167		90,167	73
74	Renal Dialysis		207		3,116		3,116	74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		12,176		323,950		323,950	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	68,375	97,090		4,178,148		4,178,148	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				4,644		4,644	190
191	Research				503		503	191
192	Physicians' Private Offices				47,774		47,774	192
194	MARKETING				19,334		19,334	194
194.02	COMMUNITY RELATIONS				14,061		14,061	194.02
194.03	SENIOR CENTER				219		219	194.03
194.04	PHYSICIAN CLINICS				33,121		33,121	194.04
194.05	POB				2,326,926		2,326,926	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG				107		107	194.06
194.07	GUEST TRAYS & CATERING MEALS				1,099		1,099	194.07

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	
194.08	HOSPICE							194.08
200	Cross Foot Adjustments			10	10		10	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	68,375	97,090	10	6,625,946		6,625,946	202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	318,997						1
2	Cap Rel Costs-Mvble Equip		318,997					2
4	Employee Benefits Department			30,054,092				4
5	Administrative & General	20,939	20,939	2,741,267	-10,854,553	54,382,030		5
7	Operation of Plant	43,388	43,388	1,184,443		6,146,538	254,670	7
8	Laundry & Linen Service	1,716	1,716			413,914	1,716	8
9	Housekeeping	2,782	2,782	761,220		1,323,419	2,782	9
10	Dietary	10,953	10,953	860,383		1,508,452	10,953	10
11	Cafeteria							11
13	Nursing Administration	1,548	1,548	605,716		767,448	1,548	13
14	Central Services & Supply	2,118	2,118	149,819		458,237	2,118	14
15	Pharmacy	2,063	2,063	1,086,717		1,664,724	2,063	15
16	Medical Records & Library	3,276	3,276	1,096,116		1,583,474	3,276	16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	23,852	23,852	5,649,548		7,581,576	23,852	30
31	Intensive Care Unit	6,937	6,937	1,338,150		1,830,159	6,937	31
40	Subprovider - IPF	5,955	5,955	1,140,233		1,571,693	5,955	40
41	Subprovider - IRF	12,803	12,803	1,207,753		1,837,830	12,803	41
43	Nursery	5,046	5,046	1,164,099		1,585,671	5,046	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	12,810	12,810	1,885,274		4,339,271	12,810	50
50.01	GASTRO INTESTINAL SERVICES	1,880	1,880	204,826		397,621	1,880	50.01
51	Recovery Room	1,380	1,380	337,113		449,882	1,380	51
52	Delivery Room & Labor Room	19,715	19,715	1,368,823		2,182,520	19,715	52
53	Anesthesiology	398	398	139,759		262,461	398	53
54	Radiology-Diagnostic	10,429	10,429	874,314		1,246,458	10,429	54
56	Radioisotope	775	775	116,387		367,233	775	56
56.01	ULTRA SOUND	590	590	454,482		576,659	590	56.01
57	CT Scan	830	830	220,492		319,331	830	57
58	MRI	757	757	137,114		201,639	757	58
59	Cardiac Catheterization	3,489	3,489	428,076		815,937	3,489	59
60	Laboratory	6,656	6,656	531,518		2,100,572	6,656	60
63	Blood Storing, Processing & Trans.	277	277			154,470	277	63
65	Respiratory Therapy	594	594	642,347		841,571	594	65
66	Physical Therapy	5,846	5,846	797,928		1,067,956	5,846	66
67	Occupational Therapy			406,810		603,009		67
68	Speech Pathology	468	468	107,322		192,914	468	68
69	Electrocardiology	2,061	2,061	187,828		276,655	2,061	69
70	Electroencephalography			6,240		7,608		70
71	Medical Supplies Charged to Patients					893,543		71
72	Impl. Dev. Charged to Patients					1,300,446		72
73	Drugs Charged to Patients					1,520,352		73
74	Renal Dialysis					363,656		74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	11,047	11,047	1,852,632		2,657,097	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	29,684,749	-10,854,553	51,411,996	159,051	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	185	185			6,577	185	190
191	Research			63,523		62,870		191
192	Physicians' Private Offices							192
194	MARKETING	587	587	108,815		538,534	587	194
194.02	COMMUNITY RELATIONS	503	503	110,659		177,217	503	194.02
194.03	SENIOR CENTER					27,439		194.03
194.04	PHYSICIAN CLINICS	1,256	1,256	75,259		99,616	1,256	194.04
194.05	POB	93,088	93,088			2,044,387	93,088	194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG			11,087		13,394		194.06

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	4,506,139	2,119,807	6,252,568		10,854,553	7,373,375	202
203	Unit Cost Multiplier (Wkst. B, Part I)	14.125960	6.645226	0.208044		0.199598	28.952664	203
204	Cost to be allocated (Per Wkst. B, Part II)					434,927	950,380	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.007998	3.731810	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	NURSING ADMINIS-TRATION FTES)	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service	573,524						8
9	Housekeeping	6,499	250,172					9
10	Dietary		10,953	194,020				10
11	Cafeteria			70,586	32,296			11
13	Nursing Administration		1,548		656	22,535		13
14	Central Services & Supply		2,118		457		10,000	14
15	Pharmacy		2,063		1,206			15
16	Medical Records & Library		3,276		974			16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	122						22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	277,411	23,852	58,362	8,089	8,089		30
31	Intensive Care Unit	33,034	6,937	6,748	1,558	1,558		31
40	Subprovider - IPF	38,413	5,955	13,206	1,820	1,820		40
41	Subprovider - IRF	28,271	12,803	11,720	1,630	1,630		41
43	Nursery		5,046		1,360	1,360		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	47,095	12,810		2,505	2,505		50
50.01	GASTRO INTESTINAL SERVICES		1,880		215	215		50.01
51	Recovery Room	17,675	1,380		321	321		51
52	Delivery Room & Labor Room		19,715		1,790	1,790		52
53	Anesthesiology		398		283	283		53
54	Radiology-Diagnostic	38,612	10,429		1,192			54
56	Radioisotope		775		108			56
56.01	ULTRA SOUND		590		490			56.01
57	CT Scan		830		253			57
58	MRI		757		136			58
59	Cardiac Catheterization		3,489		363	363		59
60	Laboratory	99	6,656		1,025			60
63	Blood Storing, Processing & Trans.		277					63
65	Respiratory Therapy	5,084	594		967			65
66	Physical Therapy	26,729	5,846		1,136			66
67	Occupational Therapy	670			478			67
68	Speech Pathology		468		130			68
69	Electrocardiology		2,061		269	269		69
70	Electroencephalography				11	11		70
71	Medical Supplies Charged to Patients						4,073	71
72	Impl. Dev. Charged to Patients						5,927	72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	51,980	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)	571,694	154,553	160,622	31,743	22,535	10,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		185					190
191	Research							191
192	Physicians' Private Offices			32,647				192
194	MARKETING		587		143			194
194.02	COMMUNITY RELATIONS		503		50			194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS		1,256		360			194.04
194.05	POB	1,830	93,088					194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES	NURSING ADMINIS-TRATION FTES)	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
194.07	GUEST TRAYS & CATERING MEALS			751				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)	546,213	1,674,307	2,199,959	800,362	992,065	636,522	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.952380	6.692623	11.338826	24.782078	44.023297	63.652200	203
204	Cost to be allocated (Per Wkst. B, Part II)	45,357	79,266	283,917	103,291	46,657	57,696	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.079085	0.316846	1.463339	3.198260	2.070424	5.769600	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHARGES	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
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	100						15
16	Medical Records & Library		354,345,725					16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd			15				22
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		60,813,006	15				30
31	Intensive Care Unit		10,292,722					31
40	Subprovider - IPF		10,586,300					40
41	Subprovider - IRF		3,853,706					41
43	Nursery		4,816,684					43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		22,337,353					50
50.01	GASTRO INTESTINAL SERVICES		3,792,309					50.01
51	Recovery Room		5,391,761					51
52	Delivery Room & Labor Room		9,244,656					52
53	Anesthesiology		6,096,420					53
54	Radiology-Diagnostic		8,345,056					54
56	Radioisotope		2,313,277					56
56.01	ULTRA SOUND		8,588,696					56.01
57	CT Scan		28,901,960					57
58	MRI		2,975,302					58
59	Cardiac Catheterization		7,593,976					59
60	Laboratory		34,445,029					60
63	Blood Storing, Processing & Trans.		2,382,252					63
65	Respiratory Therapy		3,974,021					65
66	Physical Therapy		7,942,935					66
67	Occupational Therapy		4,560,452					67
68	Speech Pathology		976,412					68
69	Electrocardiology		5,322,985					69
70	Electroencephalography		170,387					70
71	Medical Supplies Charged to Patients		9,260,237					71
72	Impl. Dev. Charged to Patients		9,022,335					72
73	Drugs Charged to Patients	100	35,153,579					73
74	Renal Dialysis		754,020					74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		44,437,897					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	354,345,725	15				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	MARKETING							194
194.02	COMMUNITY RELATIONS							194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS							194.04
194.05	POB							194.05

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS CHARGES	I&R PROGRAM COSTS ASSIGNED TIME				
		15	16	22				
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,100,423	2,040,444	116				202
203	Unit Cost Multiplier (Wkst. B, Part I)	21,004.230000	0.005758	7.733333				203
204	Cost to be allocated (Per Wkst. B, Part II)	68,375	97,090	10				204
205	Unit Cost Multiplier (Wkst. B, Part II)	683.750000	0.000274	0.666667				205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	11,777,875		11,777,875	9,426	11,787,301	30
31	Intensive Care Unit	2,717,165		2,717,165		2,717,165	31
40	Subprovider - IPF	2,470,174		2,470,174	9,426	2,479,600	40
41	Subprovider - IRF	2,955,183		2,955,183	20,332	2,975,515	41
43	Nursery	2,203,344		2,203,344		2,203,344	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,007,825		6,007,825	21,654	6,029,479	50
50.01	GASTRO INTESTINAL SERVICES	580,627		580,627		580,627	50.01
51	Recovery Room	658,834		658,834		658,834	51
52	Delivery Room & Labor Room	3,497,287		3,497,287		3,497,287	52
53	Anesthesiology	383,610		383,610		383,610	53
54	Radiology-Diagnostic	1,981,357		1,981,357		1,981,357	54
56	Radioisotope	484,153		484,153		484,153	56
56.01	ULTRA SOUND	774,387		774,387		774,387	56.01
57	CT Scan	585,342		585,342		585,342	57
58	MRI	289,371		289,371		289,371	58
59	Cardiac Catheterization	1,171,865		1,171,865	6,577	1,178,442	59
60	Laboratory	2,980,927		2,980,927		2,980,927	60
63	Blood Storing, Processing & Trans.	208,893		208,893		208,893	63
65	Respiratory Therapy	1,082,408		1,082,408		1,082,408	65
66	Physical Therapy	1,588,843		1,588,843		1,588,843	66
67	Occupational Therapy	762,111		762,111		762,111	67
68	Speech Pathology	256,945		256,945		256,945	68
69	Electrocardiology	454,497		454,497		454,497	69
70	Electroencephalography	10,865		10,865		10,865	70
71	Medical Supplies Charged to Patients	1,384,467		1,384,467		1,384,467	71
72	Impl. Dev. Charged to Patients	1,989,230		1,989,230		1,989,230	72
73	Drugs Charged to Patients	4,126,648		4,126,648		4,126,648	73
74	Renal Dialysis	440,583		440,583		440,583	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	4,046,296		4,046,296		4,046,296	91
92	Observation Beds (Non-Distinct Part)	1,058,948		1,058,948		1,058,948	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	58,930,060		58,930,060	67,415	58,997,475	200
201	Less Observation Beds	1,058,948		1,058,948		1,058,948	201
202	Total (line 200 minus line 201)	57,871,112		57,871,112		57,938,527	202

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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	54,822,422		54,822,422				30
31	Intensive Care Unit	10,292,722		10,292,722				31
40	Subprovider - IPF	10,586,300		10,586,300				40
41	Subprovider - IRF	3,853,706		3,853,706				41
43	Nursery	4,816,684		4,816,684				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,827,738	13,509,615	22,337,353	0.268959	0.268959	0.269928	50
50.01	GASTRO INTESTINAL SERVICES	1,048,560	2,743,749	3,792,309	0.153106	0.153106	0.153106	50.01
51	Recovery Room	2,204,422	3,187,339	5,391,761	0.122193	0.122193	0.122193	51
52	Delivery Room & Labor Room	8,493,780	750,876	9,244,656	0.378304	0.378304	0.378304	52
53	Anesthesiology	1,951,143	4,145,277	6,096,420	0.062924	0.062924	0.062924	53
54	Radiology-Diagnostic	1,928,106	6,416,950	8,345,056	0.237429	0.237429	0.237429	54
56	Radioisotope	981,348	1,331,929	2,313,277	0.209293	0.209293	0.209293	56
56.01	ULTRA SOUND	1,592,722	6,995,974	8,588,696	0.090164	0.090164	0.090164	56.01
57	CT Scan	9,531,224	19,370,736	28,901,960	0.020253	0.020253	0.020253	57
58	MRI	1,094,264	1,881,038	2,975,302	0.097258	0.097258	0.097258	58
59	Cardiac Catheterization	5,462,896	2,131,080	7,593,976	0.154315	0.154315	0.155181	59
60	Laboratory	20,445,531	13,999,498	34,445,029	0.086542	0.086542	0.086542	60
63	Blood Storing, Processing & Trans.	1,960,151	422,101	2,382,252	0.087687	0.087687	0.087687	63
65	Respiratory Therapy	3,666,222	307,799	3,974,021	0.272371	0.272371	0.272371	65
66	Physical Therapy	4,456,283	3,486,652	7,942,935	0.200032	0.200032	0.200032	66
67	Occupational Therapy	4,027,383	533,069	4,560,452	0.167113	0.167113	0.167113	67
68	Speech Pathology	953,662	22,750	976,412	0.263152	0.263152	0.263152	68
69	Electrocardiology	2,616,394	2,706,591	5,322,985	0.085384	0.085384	0.085384	69
70	Electroencephalography	155,466	14,921	170,387	0.063767	0.063767	0.063767	70
71	Medical Supplies Charged to Patients	3,893,262	5,366,975	9,260,237	0.149507	0.149507	0.149507	71
72	Impl. Dev. Charged to Patients	5,190,522	3,831,813	9,022,335	0.220478	0.220478	0.220478	72
73	Drugs Charged to Patients	26,157,777	8,995,802	35,153,579	0.117389	0.117389	0.117389	73
74	Renal Dialysis	733,775	20,245	754,020	0.584312	0.584312	0.584312	74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	6,580,128	37,857,769	44,437,897	0.091055	0.091055	0.091055	91
92	Observation Beds (Non-Distinct Part)		5,990,584	5,990,584	0.176769	0.176769	0.176769	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	208,324,593	146,021,132	354,345,725				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	208,324,593	146,021,132	354,345,725				202

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
40	Subprovider - IPF						40
41	Subprovider - IRF						41
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
50.01	GASTRO INTESTINAL SERVICES						50.01
51	Recovery Room						51
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
56	Radioisotope						56
56.01	ULTRA SOUND						56.01
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
60	Laboratory						60
63	Blood Storing, Processing & Trans.						63
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)						200
201	Less Observation Beds						201
202	Total (line 200 minus line 201)						202

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE V (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	54,822,422		54,822,422				30
31	Intensive Care Unit	10,292,722		10,292,722				31
40	Subprovider - IPF	10,586,300		10,586,300				40
41	Subprovider - IRF	3,853,706		3,853,706				41
43	Nursery	4,816,684		4,816,684				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,827,738	13,509,615	22,337,353				50
50.01	GASTRO INTESTINAL SERVICES	1,048,560	2,743,749	3,792,309				50.01
51	Recovery Room	2,204,422	3,187,339	5,391,761				51
52	Delivery Room & Labor Room	8,493,780	750,876	9,244,656				52
53	Anesthesiology	1,951,143	4,145,277	6,096,420				53
54	Radiology-Diagnostic	1,928,106	6,416,950	8,345,056				54
56	Radioisotope	981,348	1,331,929	2,313,277				56
56.01	ULTRA SOUND	1,592,722	6,995,974	8,588,696				56.01
57	CT Scan	9,531,224	19,370,736	28,901,960				57
58	MRI	1,094,264	1,881,038	2,975,302				58
59	Cardiac Catheterization	5,462,896	2,131,080	7,593,976				59
60	Laboratory	20,445,531	13,999,498	34,445,029				60
63	Blood Storing, Processing & Trans.	1,960,151	422,101	2,382,252				63
65	Respiratory Therapy	3,666,222	307,799	3,974,021				65
66	Physical Therapy	4,456,283	3,486,652	7,942,935				66
67	Occupational Therapy	4,027,383	533,069	4,560,452				67
68	Speech Pathology	953,662	22,750	976,412				68
69	Electrocardiology	2,616,394	2,706,591	5,322,985				69
70	Electroencephalography	155,466	14,921	170,387				70
71	Medical Supplies Charged to Patients	3,893,262	5,366,975	9,260,237				71
72	Impl. Dev. Charged to Patients	5,190,522	3,831,813	9,022,335				72
73	Drugs Charged to Patients	26,157,777	8,995,802	35,153,579				73
74	Renal Dialysis	733,775	20,245	754,020				74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	6,580,128	37,857,769	44,437,897				91
92	Observation Beds (Non-Distinct Part)		5,990,584	5,990,584				92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	208,324,593	146,021,132	354,345,725				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	208,324,593	146,021,132	354,345,725				202

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	11,777,875		11,777,875	9,426	11,787,301	30
31	Intensive Care Unit	2,717,165		2,717,165		2,717,165	31
40	Subprovider - IPF	2,470,174		2,470,174	9,426	2,479,600	40
41	Subprovider - IRF	2,955,183		2,955,183	20,332	2,975,515	41
43	Nursery	2,203,344		2,203,344		2,203,344	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,007,825		6,007,825	21,654	6,029,479	50
50.01	GASTRO INTESTINAL SERVICES	580,627		580,627		580,627	50.01
51	Recovery Room	658,834		658,834		658,834	51
52	Delivery Room & Labor Room	3,497,287		3,497,287		3,497,287	52
53	Anesthesiology	383,610		383,610		383,610	53
54	Radiology-Diagnostic	1,981,357		1,981,357		1,981,357	54
56	Radioisotope	484,153		484,153		484,153	56
56.01	ULTRA SOUND	774,387		774,387		774,387	56.01
57	CT Scan	585,342		585,342		585,342	57
58	MRI	289,371		289,371		289,371	58
59	Cardiac Catheterization	1,171,865		1,171,865	6,577	1,178,442	59
60	Laboratory	2,980,927		2,980,927		2,980,927	60
63	Blood Storing, Processing & Trans.	208,893		208,893		208,893	63
65	Respiratory Therapy	1,082,408		1,082,408		1,082,408	65
66	Physical Therapy	1,588,843		1,588,843		1,588,843	66
67	Occupational Therapy	762,111		762,111		762,111	67
68	Speech Pathology	256,945		256,945		256,945	68
69	Electrocardiology	454,497		454,497		454,497	69
70	Electroencephalography	10,865		10,865		10,865	70
71	Medical Supplies Charged to Patients	1,384,467		1,384,467		1,384,467	71
72	Impl. Dev. Charged to Patients	1,989,230		1,989,230		1,989,230	72
73	Drugs Charged to Patients	4,126,648		4,126,648		4,126,648	73
74	Renal Dialysis	440,583		440,583		440,583	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	4,046,296		4,046,296		4,046,296	91
92	Observation Beds (Non-Distinct Part)	1,058,948		1,058,948		1,058,948	92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	58,930,060		58,930,060	67,415	58,997,475	200
201	Less Observation Beds	1,058,948		1,058,948		1,058,948	201
202	Total (line 200 minus line 201)	57,871,112		57,871,112	67,415	57,938,527	202

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	54,822,422		54,822,422				30
31	Intensive Care Unit	10,292,722		10,292,722				31
40	Subprovider - IPF	10,586,300		10,586,300				40
41	Subprovider - IRF	3,853,706		3,853,706				41
43	Nursery	4,816,684		4,816,684				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,827,738	13,509,615	22,337,353	0.268959	0.268959	0.269928	50
50.01	GASTRO INTESTINAL SERVICES	1,048,560	2,743,749	3,792,309	0.153106	0.153106	0.153106	50.01
51	Recovery Room	2,204,422	3,187,339	5,391,761	0.122193	0.122193	0.122193	51
52	Delivery Room & Labor Room	8,493,780	750,876	9,244,656	0.378304	0.378304	0.378304	52
53	Anesthesiology	1,951,143	4,145,277	6,096,420	0.062924	0.062924	0.062924	53
54	Radiology-Diagnostic	1,928,106	6,416,950	8,345,056	0.237429	0.237429	0.237429	54
56	Radioisotope	981,348	1,331,929	2,313,277	0.209293	0.209293	0.209293	56
56.01	ULTRA SOUND	1,592,722	6,995,974	8,588,696	0.090164	0.090164	0.090164	56.01
57	CT Scan	9,531,224	19,370,736	28,901,960	0.020253	0.020253	0.020253	57
58	MRI	1,094,264	1,881,038	2,975,302	0.097258	0.097258	0.097258	58
59	Cardiac Catheterization	5,462,896	2,131,080	7,593,976	0.154315	0.154315	0.155181	59
60	Laboratory	20,445,531	13,999,498	34,445,029	0.086542	0.086542	0.086542	60
63	Blood Storing, Processing & Trans.	1,960,151	422,101	2,382,252	0.087687	0.087687	0.087687	63
65	Respiratory Therapy	3,666,222	307,799	3,974,021	0.272371	0.272371	0.272371	65
66	Physical Therapy	4,456,283	3,486,652	7,942,935	0.200032	0.200032	0.200032	66
67	Occupational Therapy	4,027,383	533,069	4,560,452	0.167113	0.167113	0.167113	67
68	Speech Pathology	953,662	22,750	976,412	0.263152	0.263152	0.263152	68
69	Electrocardiology	2,616,394	2,706,591	5,322,985	0.085384	0.085384	0.085384	69
70	Electroencephalography	155,466	14,921	170,387	0.063767	0.063767	0.063767	70
71	Medical Supplies Charged to Patients	3,893,262	5,366,975	9,260,237	0.149507	0.149507	0.149507	71
72	Impl. Dev. Charged to Patients	5,190,522	3,831,813	9,022,335	0.220478	0.220478	0.220478	72
73	Drugs Charged to Patients	26,157,777	8,995,802	35,153,579	0.117389	0.117389	0.117389	73
74	Renal Dialysis	733,775	20,245	754,020	0.584312	0.584312	0.584312	74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	6,580,128	37,857,769	44,437,897	0.091055	0.091055	0.091055	91
92	Observation Beds (Non-Distinct Part)		5,990,584	5,990,584	0.176769	0.176769	0.176769	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	208,324,593	146,021,132	354,345,725				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	208,324,593	146,021,132	354,345,725				202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	6,007,825	375,690	5,632,135		50
50.01	GASTRO INTESTINAL SERVICES	580,627	52,014	528,613		50.01
51	Recovery Room	658,834	42,416	616,418		51
52	Delivery Room & Labor Room	3,497,287	518,744	2,978,543		52
53	Anesthesiology	383,610	15,138	368,472		53
54	Radiology-Diagnostic	1,981,357	277,968	1,703,389		54
56	Radioisotope	484,153	23,152	461,001		56
56.01	ULTRA SOUND	774,387	23,176	751,211		56.01
57	CT Scan	585,342	31,883	553,459		57
58	MRI	289,371	21,651	267,720		58
59	Cardiac Catheterization	1,171,865	97,115	1,074,750		59
60	Laboratory	2,980,927	194,725	2,786,202		60
63	Blood Storing, Processing & Trans.	208,893	8,764	200,129		63
65	Respiratory Therapy	1,082,408	26,058	1,056,350		65
66	Physical Therapy	1,588,843	161,561	1,427,282		66
67	Occupational Therapy	762,111	7,655	754,456		67
68	Speech Pathology	256,945	13,842	243,103		68
69	Electrocardiology	454,497	56,242	398,255		69
70	Electroencephalography	10,865	166	10,699		70
71	Medical Supplies Charged to Patients	1,384,467	33,184	1,351,283		71
72	Impl. Dev. Charged to Patients	1,989,230	47,069	1,942,161		72
73	Drugs Charged to Patients	4,126,648	90,167	4,036,481		73
74	Renal Dialysis	440,583	3,116	437,467		74
	OUTPATIENT SERVICE COST CENTERS					
91	Emergency	4,046,296	323,950	3,722,346		91
92	Observation Beds (Non-Distinct Part)	1,058,948	73,599	985,349		92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	36,806,319	2,519,045	34,287,274		200
201	Less Observation Beds	1,058,948	73,599	985,349		201
202	Total	35,747,371	2,445,446	33,301,925		202

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		6,007,825	22,337,353	0.268959	50
50.01	GASTRO INTESTINAL SERVICES		580,627	3,792,309	0.153106	50.01
51	Recovery Room		658,834	5,391,761	0.122193	51
52	Delivery Room & Labor Room		3,497,287	9,244,656	0.378304	52
53	Anesthesiology		383,610	6,096,420	0.062924	53
54	Radiology-Diagnostic		1,981,357	8,345,056	0.237429	54
56	Radioisotope		484,153	2,313,277	0.209293	56
56.01	ULTRA SOUND		774,387	8,588,696	0.090164	56.01
57	CT Scan		585,342	28,901,960	0.020253	57
58	MRI		289,371	2,975,302	0.097258	58
59	Cardiac Catheterization		1,171,865	7,593,976	0.154315	59
60	Laboratory		2,980,927	34,445,029	0.086542	60
63	Blood Storing, Processing & Trans.		208,893	2,382,252	0.087687	63
65	Respiratory Therapy		1,082,408	3,974,021	0.272371	65
66	Physical Therapy		1,588,843	7,942,935	0.200032	66
67	Occupational Therapy		762,111	4,560,452	0.167113	67
68	Speech Pathology		256,945	976,412	0.263152	68
69	Electrocardiology		454,497	5,322,985	0.085384	69
70	Electroencephalography		10,865	170,387	0.063767	70
71	Medical Supplies Charged to Patients		1,384,467	9,260,237	0.149507	71
72	Impl. Dev. Charged to Patients		1,989,230	9,022,335	0.220478	72
73	Drugs Charged to Patients		4,126,648	35,153,579	0.117389	73
74	Renal Dialysis		440,583	754,020	0.584312	74
	OUTPATIENT SERVICE COST CENTERS					
91	Emergency		4,046,296	44,437,897	0.091055	91
92	Observation Beds (Non-Distinct Part)		1,058,948	5,990,584	0.176769	92
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		36,806,319	269,973,891		200
201	Less Observation Beds		1,058,948	5,990,584		201
202	Total		35,747,371	263,983,307		202

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	819,239		819,239	17,398	47.09	4,665	219,675	30
31	Intensive Care Unit	210,330		210,330	1,831	114.87	494	56,746	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	195,225		195,225	3,583	54.49	1,330	72,472	40
41	Subprovider - IRF	361,498		361,498	3,180	113.68	1,563	177,682	41
42	Subprovider I								42
43	Nursery	146,410		146,410	1,965	74.51			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,732,702		1,732,702	27,957		8,052	526,575	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	375,690	22,337,353	0.016819	2,646,533	44,512	50
50.01	GASTRO INTESTINAL SERVICES	52,014	3,792,309	0.013716	413,117	5,666	50.01
51	Recovery Room	42,416	5,391,761	0.007867	495,545	3,898	51
52	Delivery Room & Labor Room	518,744	9,244,656	0.056113	6,830	383	52
53	Anesthesiology	15,138	6,096,420	0.002483	495,757	1,231	53
54	Radiology-Diagnostic	277,968	8,345,056	0.033309	744,922	24,813	54
56	Radioisotope	23,152	2,313,277	0.010008	395,633	3,959	56
56.01	ULTRA SOUND	23,176	8,588,696	0.002698	523,292	1,412	56.01
57	CT Scan	31,883	28,901,960	0.001103	2,889,261	3,187	57
58	MRI	21,651	2,975,302	0.007277	363,680	2,646	58
59	Cardiac Catheterization	97,115	7,593,976	0.012788	1,825,983	23,351	59
60	Laboratory	194,725	34,445,029	0.005653	6,294,839	35,585	60
63	Blood Storing, Processing & Tra	8,764	2,382,252	0.003679	330,131	1,215	63
65	Respiratory Therapy	26,058	3,974,021	0.006557	960,349	6,297	65
66	Physical Therapy	161,561	7,942,935	0.020340	686,426	13,962	66
67	Occupational Therapy	7,655	4,560,452	0.001679	637,667	1,071	67
68	Speech Pathology	13,842	976,412	0.014176	82,345	1,167	68
69	Electrocardiology	56,242	5,322,985	0.010566	1,120,758	11,842	69
70	Electroencephalography	166	170,387	0.000974	64,673	63	70
71	Medical Supplies Charged to Pat	33,184	9,260,237	0.003583	674,043	2,415	71
72	Impl. Dev. Charged to Patients	47,069	9,022,335	0.005217	1,932,778	10,083	72
73	Drugs Charged to Patients	90,167	35,153,579	0.002565	6,932,606	17,782	73
74	Renal Dialysis	3,116	754,020	0.004133	243,720	1,007	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	323,950	44,437,897	0.007290	2,151,617	15,685	91
92	Observation Beds (Non-Distinct	73,599	5,990,584	0.012286			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,519,045	269,973,891		32,912,505	233,232	200

(A) Worksheet A line numbers

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

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	17,398		4,665		30
31	Intensive Care Unit	1,831		494		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	3,583		1,330		40
41	Subprovider - IRF	3,180		1,563		41
42	Subprovider I					42
43	Nursery	1,965				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	27,957		8,052		200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,337,353			2,646,533		2,673,589		50
50.01	GASTRO INTESTINAL SERVICES	3,792,309			413,117		738,214		50.01
51	Recovery Room	5,391,761			495,545		754,822		51
52	Delivery Room & Labor Room	9,244,656			6,830				52
53	Anesthesiology	6,096,420			495,757		577,549		53
54	Radiology-Diagnostic	8,345,056			744,922		744,653		54
56	Radioisotope	2,313,277			395,633		437,979		56
56.01	ULTRA SOUND	8,588,696			523,292		199,464		56.01
57	CT Scan	28,901,960			2,889,261		2,969,482		57
58	MRI	2,975,302			363,680		452,814		58
59	Cardiac Catheterization	7,593,976			1,825,983		604,164		59
60	Laboratory	34,445,029			6,294,839		1,778,695		60
63	Blood Storing, Processing & Tra	2,382,252			330,131		71,584		63
65	Respiratory Therapy	3,974,021			960,349		38,665		65
66	Physical Therapy	7,942,935			686,426		35,231		66
67	Occupational Therapy	4,560,452			637,667		31,747		67
68	Speech Pathology	976,412			82,345		3,132		68
69	Electrocardiology	5,322,985			1,120,758		1,003,734		69
70	Electroencephalography	170,387			64,673		7,462		70
71	Medical Supplies Charged to Pat	9,260,237			674,043		625,690		71
72	Impl. Dev. Charged to Patients	9,022,335			1,932,778		1,323,652		72
73	Drugs Charged to Patients	35,153,579			6,932,606		1,557,264		73
74	Renal Dialysis	754,020			243,720		13,500		74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	44,437,897			2,151,617		3,366,331		91
92	Observation Beds (Non-Distinct	5,990,584					892,757		92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	269,973,891			32,912,505		20,902,174		200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.268959	2,673,589			719,086			50
50.01	GASTRO INTESTINAL SERVICES	0.153106	738,214			113,025			50.01
51	Recovery Room	0.122193	754,822			92,234			51
52	Delivery Room & Labor Room	0.378304							52
53	Anesthesiology	0.062924	577,549			36,342			53
54	Radiology-Diagnostic	0.237429	744,653			176,802			54
56	Radioisotope	0.209293	437,979			91,666			56
56.01	ULTRA SOUND	0.090164	199,464			17,984			56.01
57	CT Scan	0.020253	2,969,482			60,141			57
58	MRI	0.097258	452,814			44,040			58
59	Cardiac Catheterization	0.154315	604,164			93,232			59
60	Laboratory	0.086542	1,778,695			153,932			60
63	Blood Storing, Processing & Tra	0.087687	71,584			6,277			63
65	Respiratory Therapy	0.272371	38,665			10,531			65
66	Physical Therapy	0.200032	35,231			7,047			66
67	Occupational Therapy	0.167113	31,747			5,305			67
68	Speech Pathology	0.263152	3,132			824			68
69	Electrocardiology	0.085384	1,003,734			85,703			69
70	Electroencephalography	0.063767	7,462			476			70
71	Medical Supplies Charged to Pat	0.149507	625,690			93,545			71
72	Impl. Dev. Charged to Patients	0.220478	1,323,652			291,836			72
73	Drugs Charged to Patients	0.117389	1,557,264		9,747	182,806		1,144	73
74	Renal Dialysis	0.584312	13,500			7,888			74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.091055	3,366,331			306,521			91
92	Observation Beds (Non-Distinct	0.176769	892,757			157,812			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		20,902,174		9,747	2,755,055		1,144	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		20,902,174		9,747	2,755,055		1,144	202

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	375,690	22,337,353	0.016819	4,672	79	50
50.01	GASTRO INTESTINAL SERVICES	52,014	3,792,309	0.013716			50.01
51	Recovery Room	42,416	5,391,761	0.007867	2,522	20	51
52	Delivery Room & Labor Room	518,744	9,244,656	0.056113			52
53	Anesthesiology	15,138	6,096,420	0.002483	26,219	65	53
54	Radiology-Diagnostic	277,968	8,345,056	0.033309	12,185	406	54
56	Radioisotope	23,152	2,313,277	0.010008	2,932	29	56
56.01	ULTRA SOUND	23,176	8,588,696	0.002698	7,691	21	56.01
57	CT Scan	31,883	28,901,960	0.001103	33,366	37	57
58	MRI	21,651	2,975,302	0.007277			58
59	Cardiac Catheterization	97,115	7,593,976	0.012788			59
60	Laboratory	194,725	34,445,029	0.005653	194,425	1,099	60
63	Blood Storing, Processing & Tra	8,764	2,382,252	0.003679			63
65	Respiratory Therapy	26,058	3,974,021	0.006557			65
66	Physical Therapy	161,561	7,942,935	0.020340	4,791	97	66
67	Occupational Therapy	7,655	4,560,452	0.001679	2,770	5	67
68	Speech Pathology	13,842	976,412	0.014176	567	8	68
69	Electrocardiology	56,242	5,322,985	0.010566	32,898	348	69
70	Electroencephalography	166	170,387	0.000974	1,244	1	70
71	Medical Supplies Charged to Pat	33,184	9,260,237	0.003583	511	2	71
72	Impl. Dev. Charged to Patients	47,069	9,022,335	0.005217	638	3	72
73	Drugs Charged to Patients	90,167	35,153,579	0.002565	664,025	1,703	73
74	Renal Dialysis	3,116	754,020	0.004133			74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	323,950	44,437,897	0.007290	9,474	69	91
92	Observation Beds (Non-Distinct		5,990,584				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,445,446	269,973,891		1,000,930	3,992	200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,337,353			4,672				50
50.01	GASTRO INTESTINAL SERVICES	3,792,309							50.01
51	Recovery Room	5,391,761			2,522				51
52	Delivery Room & Labor Room	9,244,656							52
53	Anesthesiology	6,096,420			26,219				53
54	Radiology-Diagnostic	8,345,056			12,185		3,584		54
56	Radioisotope	2,313,277			2,932		5,112		56
56.01	ULTRA SOUND	8,588,696			7,691		983		56.01
57	CT Scan	28,901,960			33,366				57
58	MRI	2,975,302					4,152		58
59	Cardiac Catheterization	7,593,976							59
60	Laboratory	34,445,029			194,425				60
63	Blood Storing, Processing & Tra	2,382,252							63
65	Respiratory Therapy	3,974,021							65
66	Physical Therapy	7,942,935			4,791				66
67	Occupational Therapy	4,560,452			2,770				67
68	Speech Pathology	976,412			567				68
69	Electrocardiology	5,322,985			32,898		10,607		69
70	Electroencephalography	170,387			1,244				70
71	Medical Supplies Charged to Pat	9,260,237			511		175		71
72	Impl. Dev. Charged to Patients	9,022,335			638				72
73	Drugs Charged to Patients	35,153,579			664,025		4,103		73
74	Renal Dialysis	754,020							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	44,437,897			9,474				91
92	Observation Beds (Non-Distinct	5,990,584							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	269,973,891			1,000,930		28,716		200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.268959							50
50.01	GASTRO INTESTINAL SERVICES	0.153106							50.01
51	Recovery Room	0.122193							51
52	Delivery Room & Labor Room	0.378304							52
53	Anesthesiology	0.062924							53
54	Radiology-Diagnostic	0.237429	3,584			851			54
56	Radioisotope	0.209293	5,112			1,070			56
56.01	ULTRA SOUND	0.090164	983			89			56.01
57	CT Scan	0.020253							57
58	MRI	0.097258	4,152			404			58
59	Cardiac Catheterization	0.154315							59
60	Laboratory	0.086542							60
63	Blood Storing, Processing & Tra	0.087687							63
65	Respiratory Therapy	0.272371							65
66	Physical Therapy	0.200032							66
67	Occupational Therapy	0.167113							67
68	Speech Pathology	0.263152							68
69	Electrocardiology	0.085384	10,607			906			69
70	Electroencephalography	0.063767							70
71	Medical Supplies Charged to Pat	0.149507	175			26			71
72	Impl. Dev. Charged to Patients	0.220478							72
73	Drugs Charged to Patients	0.117389	4,103		346	482		41	73
74	Renal Dialysis	0.584312							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.091055							91
92	Observation Beds (Non-Distinct	0.176769							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		28,716		346	3,828		41	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		28,716		346	3,828		41	202

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	375,690	22,337,353	0.016819	616	10	50
50.01	GASTRO INTESTINAL SERVICES	52,014	3,792,309	0.013716			50.01
51	Recovery Room	42,416	5,391,761	0.007867			51
52	Delivery Room & Labor Room	518,744	9,244,656	0.056113			52
53	Anesthesiology	15,138	6,096,420	0.002483			53
54	Radiology-Diagnostic	277,968	8,345,056	0.033309	78,242	2,606	54
56	Radioisotope	23,152	2,313,277	0.010008	4,249	43	56
56.01	ULTRA SOUND	23,176	8,588,696	0.002698	3,836	10	56.01
57	CT Scan	31,883	28,901,960	0.001103	123,999	137	57
58	MRI	21,651	2,975,302	0.007277			58
59	Cardiac Catheterization	97,115	7,593,976	0.012788			59
60	Laboratory	194,725	34,445,029	0.005653	671,936	3,798	60
63	Blood Storing, Processing & Tra	8,764	2,382,252	0.003679	32,033	118	63
65	Respiratory Therapy	26,058	3,974,021	0.006557	117,668	772	65
66	Physical Therapy	161,561	7,942,935	0.020340	1,458,637	29,669	66
67	Occupational Therapy	7,655	4,560,452	0.001679	1,349,399	2,266	67
68	Speech Pathology	13,842	976,412	0.014176	377,479	5,351	68
69	Electrocardiology	56,242	5,322,985	0.010566	16,429	174	69
70	Electroencephalography	166	170,387	0.000974			70
71	Medical Supplies Charged to Pat	33,184	9,260,237	0.003583	446	2	71
72	Impl. Dev. Charged to Patients	47,069	9,022,335	0.005217	638	3	72
73	Drugs Charged to Patients	90,167	35,153,579	0.002565	963,292	2,471	73
74	Renal Dialysis	3,116	754,020	0.004133	98,996	409	74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	323,950	44,437,897	0.007290			91
92	Observation Beds (Non-Distinct		5,990,584				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,445,446	269,973,891		5,297,895	47,839	200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,337,353			616				50
50.01	GASTRO INTESTINAL SERVICES	3,792,309							50.01
51	Recovery Room	5,391,761							51
52	Delivery Room & Labor Room	9,244,656							52
53	Anesthesiology	6,096,420							53
54	Radiology-Diagnostic	8,345,056			78,242		4,628		54
56	Radioisotope	2,313,277			4,249				56
56.01	ULTRA SOUND	8,588,696			3,836		536		56.01
57	CT Scan	28,901,960			123,999		13,482		57
58	MRI	2,975,302							58
59	Cardiac Catheterization	7,593,976							59
60	Laboratory	34,445,029			671,936		1,378		60
63	Blood Storing, Processing & Tra	2,382,252			32,033				63
65	Respiratory Therapy	3,974,021			117,668				65
66	Physical Therapy	7,942,935			1,458,637				66
67	Occupational Therapy	4,560,452			1,349,399				67
68	Speech Pathology	976,412			377,479				68
69	Electrocardiology	5,322,985			16,429				69
70	Electroencephalography	170,387							70
71	Medical Supplies Charged to Pat	9,260,237			446				71
72	Impl. Dev. Charged to Patients	9,022,335			638				72
73	Drugs Charged to Patients	35,153,579			963,292		2,266		73
74	Renal Dialysis	754,020			98,996				74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	44,437,897							91
92	Observation Beds (Non-Distinct	5,990,584							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	269,973,891			5,297,895		22,290		200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.268959							50
50.01	GASTRO INTESTINAL SERVICES	0.153106							50.01
51	Recovery Room	0.122193							51
52	Delivery Room & Labor Room	0.378304							52
53	Anesthesiology	0.062924							53
54	Radiology-Diagnostic	0.237429	4,628			1,099			54
56	Radioisotope	0.209293							56
56.01	ULTRA SOUND	0.090164	536			48			56.01
57	CT Scan	0.020253	13,482			273			57
58	MRI	0.097258							58
59	Cardiac Catheterization	0.154315							59
60	Laboratory	0.086542	1,378			119			60
63	Blood Storing, Processing & Tra	0.087687							63
65	Respiratory Therapy	0.272371							65
66	Physical Therapy	0.200032							66
67	Occupational Therapy	0.167113							67
68	Speech Pathology	0.263152							68
69	Electrocardiology	0.085384							69
70	Electroencephalography	0.063767							70
71	Medical Supplies Charged to Pat	0.149507							71
72	Impl. Dev. Charged to Patients	0.220478							72
73	Drugs Charged to Patients	0.117389	2,266		6,098	266		716	73
74	Renal Dialysis	0.584312							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.091055							91
92	Observation Beds (Non-Distinct	0.176769							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		22,290		6,098	1,805		716	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		22,290		6,098	1,805		716	202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	819,239		819,239	17,398	47.09	2,167	102,044	30
31	Intensive Care Unit	210,330		210,330	1,831	114.87	113	12,980	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	195,225		195,225	3,583	54.49	1,489	81,136	40
41	Subprovider - IRF	361,498		361,498	3,180	113.68	204	23,191	41
42	Subprovider I								42
43	Nursery	146,410		146,410	1,965	74.51	432	32,188	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,732,702		1,732,702	27,957		4,405	251,539	200

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	375,690	22,337,353	0.016819			50
50.01	GASTRO INTESTINAL SERVICES	52,014	3,792,309	0.013716			50.01
51	Recovery Room	42,416	5,391,761	0.007867			51
52	Delivery Room & Labor Room	518,744	9,244,656	0.056113			52
53	Anesthesiology	15,138	6,096,420	0.002483			53
54	Radiology-Diagnostic	277,968	8,345,056	0.033309			54
56	Radioisotope	23,152	2,313,277	0.010008			56
56.01	ULTRA SOUND	23,176	8,588,696	0.002698			56.01
57	CT Scan	31,883	28,901,960	0.001103			57
58	MRI	21,651	2,975,302	0.007277			58
59	Cardiac Catheterization	97,115	7,593,976	0.012788			59
60	Laboratory	194,725	34,445,029	0.005653			60
63	Blood Storing, Processing & Tra	8,764	2,382,252	0.003679			63
65	Respiratory Therapy	26,058	3,974,021	0.006557			65
66	Physical Therapy	161,561	7,942,935	0.020340			66
67	Occupational Therapy	7,655	4,560,452	0.001679			67
68	Speech Pathology	13,842	976,412	0.014176			68
69	Electrocardiology	56,242	5,322,985	0.010566			69
70	Electroencephalography	166	170,387	0.000974			70
71	Medical Supplies Charged to Pat	33,184	9,260,237	0.003583			71
72	Impl. Dev. Charged to Patients	47,069	9,022,335	0.005217			72
73	Drugs Charged to Patients	90,167	35,153,579	0.002565			73
74	Renal Dialysis	3,116	754,020	0.004133			74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	323,950	44,437,897	0.007290			91
92	Observation Beds (Non-Distinct	73,599	5,990,584	0.012286			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,519,045	269,973,891				200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	17,398		2,167		30
31	Intensive Care Unit	1,831		113		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	3,583		1,489		40
41	Subprovider - IRF	3,180		204		41
42	Subprovider I					42
43	Nursery	1,965		432		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	27,957		4,405		200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,337,353							50
50.01	GASTRO INTESTINAL SERVICES	3,792,309							50.01
51	Recovery Room	5,391,761							51
52	Delivery Room & Labor Room	9,244,656							52
53	Anesthesiology	6,096,420							53
54	Radiology-Diagnostic	8,345,056							54
56	Radioisotope	2,313,277							56
56.01	ULTRA SOUND	8,588,696							56.01
57	CT Scan	28,901,960							57
58	MRI	2,975,302							58
59	Cardiac Catheterization	7,593,976							59
60	Laboratory	34,445,029							60
63	Blood Storing, Processing & Tra	2,382,252							63
65	Respiratory Therapy	3,974,021							65
66	Physical Therapy	7,942,935							66
67	Occupational Therapy	4,560,452							67
68	Speech Pathology	976,412							68
69	Electrocardiology	5,322,985							69
70	Electroencephalography	170,387							70
71	Medical Supplies Charged to Pat	9,260,237							71
72	Impl. Dev. Charged to Patients	9,022,335							72
73	Drugs Charged to Patients	35,153,579							73
74	Renal Dialysis	754,020							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	44,437,897							91
92	Observation Beds (Non-Distinct	5,990,584							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	269,973,891							200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.268959							50
50.01	GASTRO INTESTINAL SERVICES	0.153106							50.01
51	Recovery Room	0.122193							51
52	Delivery Room & Labor Room	0.378304							52
53	Anesthesiology	0.062924							53
54	Radiology-Diagnostic	0.237429							54
56	Radioisotope	0.209293							56
56.01	ULTRA SOUND	0.090164							56.01
57	CT Scan	0.020253							57
58	MRI	0.097258							58
59	Cardiac Catheterization	0.154315							59
60	Laboratory	0.086542							60
63	Blood Storing, Processing & Tra	0.087687							63
65	Respiratory Therapy	0.272371							65
66	Physical Therapy	0.200032							66
67	Occupational Therapy	0.167113							67
68	Speech Pathology	0.263152							68
69	Electrocardiology	0.085384							69
70	Electroencephalography	0.063767							70
71	Medical Supplies Charged to Pat	0.149507							71
72	Impl. Dev. Charged to Patients	0.220478							72
73	Drugs Charged to Patients	0.117389							73
74	Renal Dialysis	0.584312							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.091055							91
92	Observation Beds (Non-Distinct	0.176769							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	375,690	22,337,353	0.016819			50
50.01	GASTRO INTESTINAL SERVICES	52,014	3,792,309	0.013716			50.01
51	Recovery Room	42,416	5,391,761	0.007867			51
52	Delivery Room & Labor Room	518,744	9,244,656	0.056113			52
53	Anesthesiology	15,138	6,096,420	0.002483			53
54	Radiology-Diagnostic	277,968	8,345,056	0.033309			54
56	Radioisotope	23,152	2,313,277	0.010008			56
56.01	ULTRA SOUND	23,176	8,588,696	0.002698			56.01
57	CT Scan	31,883	28,901,960	0.001103			57
58	MRI	21,651	2,975,302	0.007277			58
59	Cardiac Catheterization	97,115	7,593,976	0.012788			59
60	Laboratory	194,725	34,445,029	0.005653			60
63	Blood Storing, Processing & Tra	8,764	2,382,252	0.003679			63
65	Respiratory Therapy	26,058	3,974,021	0.006557			65
66	Physical Therapy	161,561	7,942,935	0.020340			66
67	Occupational Therapy	7,655	4,560,452	0.001679			67
68	Speech Pathology	13,842	976,412	0.014176			68
69	Electrocardiology	56,242	5,322,985	0.010566			69
70	Electroencephalography	166	170,387	0.000974			70
71	Medical Supplies Charged to Pat	33,184	9,260,237	0.003583			71
72	Impl. Dev. Charged to Patients	47,069	9,022,335	0.005217			72
73	Drugs Charged to Patients	90,167	35,153,579	0.002565			73
74	Renal Dialysis	3,116	754,020	0.004133			74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	323,950	44,437,897	0.007290			91
92	Observation Beds (Non-Distinct		5,990,584				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,445,446	269,973,891				200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,337,353							50
50.01	GASTRO INTESTINAL SERVICES	3,792,309							50.01
51	Recovery Room	5,391,761							51
52	Delivery Room & Labor Room	9,244,656							52
53	Anesthesiology	6,096,420							53
54	Radiology-Diagnostic	8,345,056							54
56	Radioisotope	2,313,277							56
56.01	ULTRA SOUND	8,588,696							56.01
57	CT Scan	28,901,960							57
58	MRI	2,975,302							58
59	Cardiac Catheterization	7,593,976							59
60	Laboratory	34,445,029							60
63	Blood Storing, Processing & Tra	2,382,252							63
65	Respiratory Therapy	3,974,021							65
66	Physical Therapy	7,942,935							66
67	Occupational Therapy	4,560,452							67
68	Speech Pathology	976,412							68
69	Electrocardiology	5,322,985							69
70	Electroencephalography	170,387							70
71	Medical Supplies Charged to Pat	9,260,237							71
72	Impl. Dev. Charged to Patients	9,022,335							72
73	Drugs Charged to Patients	35,153,579							73
74	Renal Dialysis	754,020							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	44,437,897							91
92	Observation Beds (Non-Distinct	5,990,584							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	269,973,891							200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.268959							50
50.01	GASTRO INTESTINAL SERVICES	0.153106							50.01
51	Recovery Room	0.122193							51
52	Delivery Room & Labor Room	0.378304							52
53	Anesthesiology	0.062924							53
54	Radiology-Diagnostic	0.237429							54
56	Radioisotope	0.209293							56
56.01	ULTRA SOUND	0.090164							56.01
57	CT Scan	0.020253							57
58	MRI	0.097258							58
59	Cardiac Catheterization	0.154315							59
60	Laboratory	0.086542							60
63	Blood Storing, Processing & Tra	0.087687							63
65	Respiratory Therapy	0.272371							65
66	Physical Therapy	0.200032							66
67	Occupational Therapy	0.167113							67
68	Speech Pathology	0.263152							68
69	Electrocardiology	0.085384							69
70	Electroencephalography	0.063767							70
71	Medical Supplies Charged to Pat	0.149507							71
72	Impl. Dev. Charged to Patients	0.220478							72
73	Drugs Charged to Patients	0.117389							73
74	Renal Dialysis	0.584312							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.091055							91
92	Observation Beds (Non-Distinct	0.176769							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	375,690	22,337,353	0.016819			50
50.01	GASTRO INTESTINAL SERVICES	52,014	3,792,309	0.013716			50.01
51	Recovery Room	42,416	5,391,761	0.007867			51
52	Delivery Room & Labor Room	518,744	9,244,656	0.056113			52
53	Anesthesiology	15,138	6,096,420	0.002483			53
54	Radiology-Diagnostic	277,968	8,345,056	0.033309			54
56	Radioisotope	23,152	2,313,277	0.010008			56
56.01	ULTRA SOUND	23,176	8,588,696	0.002698			56.01
57	CT Scan	31,883	28,901,960	0.001103			57
58	MRI	21,651	2,975,302	0.007277			58
59	Cardiac Catheterization	97,115	7,593,976	0.012788			59
60	Laboratory	194,725	34,445,029	0.005653			60
63	Blood Storing, Processing & Tra	8,764	2,382,252	0.003679			63
65	Respiratory Therapy	26,058	3,974,021	0.006557			65
66	Physical Therapy	161,561	7,942,935	0.020340			66
67	Occupational Therapy	7,655	4,560,452	0.001679			67
68	Speech Pathology	13,842	976,412	0.014176			68
69	Electrocardiology	56,242	5,322,985	0.010566			69
70	Electroencephalography	166	170,387	0.000974			70
71	Medical Supplies Charged to Pat	33,184	9,260,237	0.003583			71
72	Impl. Dev. Charged to Patients	47,069	9,022,335	0.005217			72
73	Drugs Charged to Patients	90,167	35,153,579	0.002565			73
74	Renal Dialysis	3,116	754,020	0.004133			74
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	323,950	44,437,897	0.007290			91
92	Observation Beds (Non-Distinct		5,990,584				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,445,446	269,973,891				200

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
50.01	GASTRO INTESTINAL SERVICES									50.01
51	Recovery Room									51
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56	Radioisotope									56
56.01	ULTRA SOUND									56.01
57	CT Scan									57
58	MRI									58
59	Cardiac Catheterization									59
60	Laboratory									60
63	Blood Storing, Processing & Tra									63
65	Respiratory Therapy									65
66	Physical Therapy									66
67	Occupational Therapy									67
68	Speech Pathology									68
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	22,337,353							50
50.01	GASTRO INTESTINAL SERVICES	3,792,309							50.01
51	Recovery Room	5,391,761							51
52	Delivery Room & Labor Room	9,244,656							52
53	Anesthesiology	6,096,420							53
54	Radiology-Diagnostic	8,345,056							54
56	Radioisotope	2,313,277							56
56.01	ULTRA SOUND	8,588,696							56.01
57	CT Scan	28,901,960							57
58	MRI	2,975,302							58
59	Cardiac Catheterization	7,593,976							59
60	Laboratory	34,445,029							60
63	Blood Storing, Processing & Tra	2,382,252							63
65	Respiratory Therapy	3,974,021							65
66	Physical Therapy	7,942,935							66
67	Occupational Therapy	4,560,452							67
68	Speech Pathology	976,412							68
69	Electrocardiology	5,322,985							69
70	Electroencephalography	170,387							70
71	Medical Supplies Charged to Pat	9,260,237							71
72	Impl. Dev. Charged to Patients	9,022,335							72
73	Drugs Charged to Patients	35,153,579							73
74	Renal Dialysis	754,020							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	44,437,897							91
92	Observation Beds (Non-Distinct	5,990,584							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	269,973,891							200

(A) Worksheet A line numbers

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

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.268959							50
50.01	GASTRO INTESTINAL SERVICES	0.153106							50.01
51	Recovery Room	0.122193							51
52	Delivery Room & Labor Room	0.378304							52
53	Anesthesiology	0.062924							53
54	Radiology-Diagnostic	0.237429							54
56	Radioisotope	0.209293							56
56.01	ULTRA SOUND	0.090164							56.01
57	CT Scan	0.020253							57
58	MRI	0.097258							58
59	Cardiac Catheterization	0.154315							59
60	Laboratory	0.086542							60
63	Blood Storing, Processing & Tra	0.087687							63
65	Respiratory Therapy	0.272371							65
66	Physical Therapy	0.200032							66
67	Occupational Therapy	0.167113							67
68	Speech Pathology	0.263152							68
69	Electrocardiology	0.085384							69
70	Electroencephalography	0.063767							70
71	Medical Supplies Charged to Pat	0.149507							71
72	Impl. Dev. Charged to Patients	0.220478							72
73	Drugs Charged to Patients	0.117389							73
74	Renal Dialysis	0.584312							74
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.091055							91
92	Observation Beds (Non-Distinct	0.176769							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,398	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,398	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)	15,835	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)	4,665	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)	11,787,301	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)	11,787,301	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)	11,787,301	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	677.51	38
39	Program general inpatient routine service cost (line 9 x line 38)	3,160,584	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)	3,160,584	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	2,717,165	1,831	1,483.98	494	733,086	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)	4,435,740	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	8,329,410	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	276,421	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	233,232	51
52	Total Program excludable cost (sum of lines 50 and 51)	509,653	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	7,819,757	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,563	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					677.51	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,058,948	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	819,239	11,787,301	0.069502	1,058,948	73,599	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,583	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,583	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)	3,583	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)	1,330	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)	2,479,600	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)	2,479,600	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)	2,479,600	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	692.05	38
39	Program general inpatient routine service cost (line 9 x line 38)	920,427	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)	920,427	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	108,408	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,028,835	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	72,472	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,992	51
52	Total Program excludable cost (sum of lines 50 and 51)	76,464	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	952,371	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,180	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,180	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)	3,180	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)	1,563	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)	2,975,515	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)	2,975,515	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)	2,975,515	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	935.70	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,462,499	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)	1,462,499	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	904,644	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,367,143	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	177,682	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	47,839	51
52	Total Program excludable cost (sum of lines 50 and 51)	225,521	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	2,141,622	53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,398	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,398	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)	15,835	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)	2,167	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,965	15
16	Nursery days (title V or XIX only)	432	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)	11,777,875	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)	11,777,875	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)	11,777,875	37

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					676.97	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,466,994	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)					1,466,994	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)	2,203,344	1,965	1,121.29	432	484,397	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	2,717,165	1,831	1,483.98	113	167,690	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)					2,119,081	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					147,212	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)					147,212	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-0240** **WORKSHEET D-1 PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,563	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

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

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,583	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,583	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)	3,583	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)	1,489	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)	2,470,174	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)	2,470,174	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)	2,470,174	37

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	689.42	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,026,546	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)	1,026,546	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)	1,026,546	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	81,136	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)	81,136	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,180	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,180	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)	3,180	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)	204	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)	2,955,183	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)	2,955,183	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)	2,955,183	37

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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:	**[XX] Title XIX - I/P**	**[XX] IRF**		**[XX] Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS	1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	929.30	38
39	Program general inpatient routine service cost (line 9 x line 38)	189,577	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)	189,577	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)	189,577	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	23,191	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)	23,191	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53
	TARGET AMOUNT AND LIMIT COMPUTATION		
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		18,270,054		30
31	Intensive Care Unit		2,944,876		31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.269928	2,646,533	714,373	50
50.01	GASTRO INTESTINAL SERVICES	0.153106	413,117	63,251	50.01
51	Recovery Room	0.122193	495,545	60,552	51
52	Delivery Room & Labor Room	0.378304	6,830	2,584	52
53	Anesthesiology	0.062924	495,757	31,195	53
54	Radiology-Diagnostic	0.237429	744,922	176,866	54
56	Radioisotope	0.209293	395,633	82,803	56
56.01	ULTRA SOUND	0.090164	523,292	47,182	56.01
57	CT Scan	0.020253	2,889,261	58,516	57
58	MRI	0.097258	363,680	35,371	58
59	Cardiac Catheterization	0.155181	1,825,983	283,358	59
60	Laboratory	0.086542	6,294,839	544,768	60
63	Blood Storing, Processing & Trans.	0.087687	330,131	28,948	63
65	Respiratory Therapy	0.272371	960,349	261,571	65
66	Physical Therapy	0.200032	686,426	137,307	66
67	Occupational Therapy	0.167113	637,667	106,562	67
68	Speech Pathology	0.263152	82,345	21,669	68
69	Electrocardiology	0.085384	1,120,758	95,695	69
70	Electroencephalography	0.063767	64,673	4,124	70
71	Medical Supplies Charged to Patients	0.149507	674,043	100,774	71
72	Impl. Dev. Charged to Patients	0.220478	1,932,778	426,135	72
73	Drugs Charged to Patients	0.117389	6,932,606	813,812	73
74	Renal Dialysis	0.584312	243,720	142,409	74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.091055	2,151,617	195,915	91
92	Observation Beds (Non-Distinct Part)	0.176769			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		32,912,505	4,435,740	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		32,912,505		202

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF		3,875,620		40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.269928	4,672	1,261	50
50.01	GASTRO INTESTINAL SERVICES	0.153106			50.01
51	Recovery Room	0.122193	2,522	308	51
52	Delivery Room & Labor Room	0.378304			52
53	Anesthesiology	0.062924	26,219	1,650	53
54	Radiology-Diagnostic	0.237429	12,185	2,893	54
56	Radioisotope	0.209293	2,932	614	56
56.01	ULTRA SOUND	0.090164	7,691	693	56.01
57	CT Scan	0.020253	33,366	676	57
58	MRI	0.097258			58
59	Cardiac Catheterization	0.155181			59
60	Laboratory	0.086542	194,425	16,826	60
63	Blood Storing, Processing & Trans.	0.087687			63
65	Respiratory Therapy	0.272371			65
66	Physical Therapy	0.200032	4,791	958	66
67	Occupational Therapy	0.167113	2,770	463	67
68	Speech Pathology	0.263152	567	149	68
69	Electrocardiology	0.085384	32,898	2,809	69
70	Electroencephalography	0.063767	1,244	79	70
71	Medical Supplies Charged to Patients	0.149507	511	76	71
72	Impl. Dev. Charged to Patients	0.220478	638	141	72
73	Drugs Charged to Patients	0.117389	664,025	77,949	73
74	Renal Dialysis	0.584312			74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.091055	9,474	863	91
92	Observation Beds (Non-Distinct Part)	0.176769			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,000,930	108,408	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,000,930		202

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

		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		2,006,610		41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.269928	616	166	50
50.01	GASTRO INTESTINAL SERVICES	0.153106			50.01
51	Recovery Room	0.122193			51
52	Delivery Room & Labor Room	0.378304			52
53	Anesthesiology	0.062924			53
54	Radiology-Diagnostic	0.237429	78,242	18,577	54
56	Radioisotope	0.209293	4,249	889	56
56.01	ULTRA SOUND	0.090164	3,836	346	56.01
57	CT Scan	0.020253	123,999	2,511	57
58	MRI	0.097258			58
59	Cardiac Catheterization	0.155181			59
60	Laboratory	0.086542	671,936	58,151	60
63	Blood Storing, Processing & Trans.	0.087687	32,033	2,809	63
65	Respiratory Therapy	0.272371	117,668	32,049	65
66	Physical Therapy	0.200032	1,458,637	291,774	66
67	Occupational Therapy	0.167113	1,349,399	225,502	67
68	Speech Pathology	0.263152	377,479	99,334	68
69	Electrocardiology	0.085384	16,429	1,403	69
70	Electroencephalography	0.063767			70
71	Medical Supplies Charged to Patients	0.149507	446	67	71
72	Impl. Dev. Charged to Patients	0.220478	638	141	72
73	Drugs Charged to Patients	0.117389	963,292	113,080	73
74	Renal Dialysis	0.584312	98,996	57,845	74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.091055			91
92	Observation Beds (Non-Distinct Part)	0.176769			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,297,895	904,644	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,297,895		202

(A) Worksheet A line numbers

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

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.268959			50
50.01	GASTRO INTESTINAL SERVICES	0.153106			50.01
51	Recovery Room	0.122193			51
52	Delivery Room & Labor Room	0.378304			52
53	Anesthesiology	0.062924			53
54	Radiology-Diagnostic	0.237429			54
56	Radioisotope	0.209293			56
56.01	ULTRA SOUND	0.090164			56.01
57	CT Scan	0.020253			57
58	MRI	0.097258			58
59	Cardiac Catheterization	0.154315			59
60	Laboratory	0.086542			60
63	Blood Storing, Processing & Trans.	0.087687			63
65	Respiratory Therapy	0.272371			65
66	Physical Therapy	0.200032			66
67	Occupational Therapy	0.167113			67
68	Speech Pathology	0.263152			68
69	Electrocardiology	0.085384			69
70	Electroencephalography	0.063767			70
71	Medical Supplies Charged to Patients	0.149507			71
72	Impl. Dev. Charged to Patients	0.220478			72
73	Drugs Charged to Patients	0.117389			73
74	Renal Dialysis	0.584312			74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.091055			91
92	Observation Beds (Non-Distinct Part)	0.176769			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes:

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.268959			50
50.01	GASTRO INTESTINAL SERVICES	0.153106			50.01
51	Recovery Room	0.122193			51
52	Delivery Room & Labor Room	0.378304			52
53	Anesthesiology	0.062924			53
54	Radiology-Diagnostic	0.237429			54
56	Radioisotope	0.209293			56
56.01	ULTRA SOUND	0.090164			56.01
57	CT Scan	0.020253			57
58	MRI	0.097258			58
59	Cardiac Catheterization	0.154315			59
60	Laboratory	0.086542			60
63	Blood Storing, Processing & Trans.	0.087687			63
65	Respiratory Therapy	0.272371			65
66	Physical Therapy	0.200032			66
67	Occupational Therapy	0.167113			67
68	Speech Pathology	0.263152			68
69	Electrocardiology	0.085384			69
70	Electroencephalography	0.063767			70
71	Medical Supplies Charged to Patients	0.149507			71
72	Impl. Dev. Charged to Patients	0.220478			72
73	Drugs Charged to Patients	0.117389			73
74	Renal Dialysis	0.584312			74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.091055			91
92	Observation Beds (Non-Distinct Part)	0.176769			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes:

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
41	Subprovider - IRF				41
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.268959			50
50.01	GASTRO INTESTINAL SERVICES	0.153106			50.01
51	Recovery Room	0.122193			51
52	Delivery Room & Labor Room	0.378304			52
53	Anesthesiology	0.062924			53
54	Radiology-Diagnostic	0.237429			54
56	Radioisotope	0.209293			56
56.01	ULTRA SOUND	0.090164			56.01
57	CT Scan	0.020253			57
58	MRI	0.097258			58
59	Cardiac Catheterization	0.154315			59
60	Laboratory	0.086542			60
63	Blood Storing, Processing & Trans.	0.087687			63
65	Respiratory Therapy	0.272371			65
66	Physical Therapy	0.200032			66
67	Occupational Therapy	0.167113			67
68	Speech Pathology	0.263152			68
69	Electrocardiology	0.085384			69
70	Electroencephalography	0.063767			70
71	Medical Supplies Charged to Patients	0.149507			71
72	Impl. Dev. Charged to Patients	0.220478			72
73	Drugs Charged to Patients	0.117389			73
74	Renal Dialysis	0.584312			74
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.091055			91
92	Observation Beds (Non-Distinct Part)	0.176769			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,481,798			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	5,231,398			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)	37,700			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	2,017,135			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	116.72			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	0.15			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	0.15			12
13	Total allowable FTE count for the prior year	0.61			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	0.60			14
15	Sum of lines 12 through 14 divided by 3	0.45			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	0.45			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.003855			19
20	Prior year resident to bed ratio (see instructions)	0.005231			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.003855			21
22	IME payment adjustment (see instructions)	14,131			22
22.01	IME payment adjustment - Managed Care (see instructions)	4,246			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)	-1.85			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)	14,131			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	4,246			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1057			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.4378			31
32	Sum of lines 30 and 31	0.5435			32
33	Allowable disproportionate share percentage (see instructions)	0.3405			33
34	Disproportionate share adjustment (see instructions)	571,461			34
		Prior to		**On or after**	
	Uncompensated Care Adjustment	**October 1 (1.00)**	**(1.01)**	**October 1 (2.00)**	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000208798	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,688,955		1,412,872	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	425,710		1,056,751	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,482,461			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

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)	8,818,949			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)	8,823,195			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	613,410			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)	17,643			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	1,036			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)	9,455,284			59
60	Primary payer payments	11,793			60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	9,443,491			61
62	Deductibles billed to program beneficiaries	720,184			62
63	Coinsurance billed to program beneficiaries	143,172			63
64	Allowable bad debts (see instructions)	540,661			64
65	Adjusted reimbursable bad debts (see instructions)	351,430			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	326,111			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	8,931,565			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)	-9,896			70.93
70.94	HRR adjustment amount (see instructions)	-16,200			70.94
71	Amount due provider (see instructions)	8,905,469			71
71.01	Sequestration adjustment (see instructions)	178,109			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	8,414,607			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	312,753			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	283,321			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
	HSP Bonus Payment Amount	**Prior to 10/1**	**On or After 10/1**		
100	HSP bonus amount (see instructions)				100
	HVBP Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
	HRR Adjustment for HSP Bonus Payment	**Prior to 10/1**	**On or After 10/1**		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	1,144			1
2	Medical and other services reimbursed under OPPS (see instructions)	2,755,055			2
3	OPPS payments	2,316,649			3
4	Outlier payment (see instructions)	20,622			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	1,144			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	9,747			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)	9,747			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)	9,747			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	8,603			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	1,144			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	2,337,271			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	430,015			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,908,400			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	4,154			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,912,554			30
31	Primary payer payments	4,830			31
32	Subtotal (line 30 minus line 31)	1,907,724			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)	151,803			34
35	Adjusted reimbursable bad debts (see instructions)	98,672			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	87,403			36
37	Subtotal (see instructions)	2,006,396			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)	2,006,396			40
40.01	Sequestration adjustment (see instructions)	40,128			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	1,879,291			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	86,977			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	41			1
2	Medical and other services reimbursed under OPPS (see instructions)	3,828			2
3	OPPS payments	3,426			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	41			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	346			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)	346			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)	346			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	305			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	41			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	3,426			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	671			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)	2,796			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,796			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	2,796			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	2,796			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)	2,796			40
40.01	Sequestration adjustment (see instructions)	56			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,741			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-1			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	716			1
2	Medical and other services reimbursed under OPPS (see instructions)	1,805			2
3	OPPS payments	1,172			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	716			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	6,098			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)	6,098			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)	6,098			18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)	5,382			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	716			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	1,172			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	227			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,661			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,661			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	1,661			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)	1,661			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,661			40
40.01	Sequestration adjustment (see instructions)	33			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	941			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	687			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				8,441,899		2,034,473	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	02/01/2018	43,735	02/01/2018	8,723	3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	06/18/2018	71,027	06/18/2018	163,905	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		-27,292		-155,182	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)				8,414,607		1,879,291	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		312,753		86,977	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				8,727,360		1,966,268	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,019,685		2,741	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,019,685		2,741	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		1			6.01
	based on the cost report (1)		.02				-1	6.02
7	Total Medicare program liability (see instructions)				1,019,686		2,740	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,242,491		941	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	02/01/2018	10,106			3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		10,106			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)				2,252,597		941	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		1,507		687	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,254,104		1,628	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	1,131,217	1
2	Net IPF PPS Outlier payment	3,476	2
3	Net IPF PPS ECT payment	7,825	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)	9.816438	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)	1,142,518	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)	1,142,518	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	1,142,518	18
19	Deductibles	63,672	19
20	Subtotal (line 18 minus line 19)	1,078,846	20
21	Coinsurance	38,350	21
22	Subtotal (line 20 minus line 21)	1,040,496	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)	1,040,496	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)	1,040,496	31
31.01	Sequestration adjustment (see instructions)	20,810	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	1,019,685	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	1	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)	3,476	50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

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

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

PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

		1	1.01	
1	Net Federal PPS payment (see instructions)	2,175,278		1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0.066600		2
3	Inpatient Rehabilitation LIP payments (see instructions)	187,074		3
4	Outlier payments	38,765		4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2)			5.01
6	New teaching program adjustment (see instructions)			6
7	Current year unweighted FTE count of I&R excludnig FTEs in the new program growth period of a 'new teaching program' (see instructions)			7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)			8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)			9
10	Average daily census (see instructions)	8.712329		10
11	Teaching Adjustment Factor (see instructions)			11
12	Teaching Adjustment (see instructions)			12
13	Total PPS Payment (see instructions)	2,401,117		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)	2,401,117		17
18	Primary payer payments			18
19	Subtotal (line 17 less line 18)	2,401,117		19
20	Deductibles	5,264		20
21	Subtotal (line 19 minus line 20)	2,395,853		21
22	Coinsurance	95,747		22
23	Subtotal (line 21 minus line 22)	2,300,106		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)	2,300,106		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)	2,300,106		32
32.01	Sequestration adjustment (see instructions)	46,002		32.01
32.02	Demonstration payment adjustment amount after sequestration			32.02
33	Interim payments	2,252,597		33
34	Tentative settlement (for contractor use only)			34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33 and 34)	1,507		35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	131,444		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)	38,765		50
51	Outlier reconciliation adjustment amount (see instructions)			51
52	The rate used to calculate the Time Value of Money (see instructions)			52
53	Time Value of Money (see instructions)			53

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-0240** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	2,119,081		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,119,081		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,119,081		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,119,081		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)	2,119,081		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

Check Applicable Boxes:

[ ] Title V	[ ] Hospital	[ ] NF	[ ] PPS
[XX] Title XIX	[XX] Subprovider IPF	[ ] ICF/IID	[ ] TEFRA
	[ ] SNF		[XX] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	1,026,546		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	1,026,546		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	1,026,546		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,026,546		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	1,026,546		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

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

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	189,577		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	189,577		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	189,577		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	189,577		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)	189,577		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			36.33	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			-34.33	4
4.01	ACA §5503 increase to the direct GME FTE 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)			0.15	6
7	Enter the lesser of line 5 or line 6			0.15	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.12	0.00	0.12	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	0.12	0.00	0.12	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	0.12	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.61	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.60	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.44	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	0.44	0.00		17
18	Per resident amount	120,410.78	117,176.71		18
19	Approved amount for resident costs	52,981		52,981	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)			52,981	25
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	8,052	2,451		26
27	Total inpatient days (see instructions)	24,687	24,687		27
28	Ratio of inpatient days to total inpatient days	0.326164	0.099283		28
29	Program direct GME amount	17,280	5,260		29
30	Reduction for direct GME payments for Medicare Advantage		743		30
31	Net Program direct GME amount			21,797	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)			754,020	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)			11,725,388	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)			11,793	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			11,713,595	41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)			2,762,589	42
43	Primary payer payments (see instructions)			4,830	43
44	Total Part B reasonable cost (line 42 minus line 43)			2,757,759	44
45	Total reasonable cost (sum of lines 41 and 44)			14,471,354	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.809433	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.190567	47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			21,797	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			17,643	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			4,154	50

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

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

	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996				1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)				3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)				4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)				5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00	9
10	Weighted dental and podiatric resident FTE count for the current year		0.00		10
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)	4,148	10,256		26
27	Total inpatient days (see instructions)	24,687	24,687		27
28	Ratio of inpatient days to total inpatient days	0.168024	0.415441		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
	Part A Reasonable Cost				
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
	Part B Reasonable Cost				
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	-576,198				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	15,789,015				4
5	Other receivables	598,141				5
6	Allowances for uncollectible notes and accounts receivable	-2,062,242				6
7	Inventory	1,737,254				7
8	Prepaid expenses	323,791				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	15,809,761				11
	FIXED ASSETS					
12	Land	9,300,000				12
13	Land improvements	260,000				13
14	Accumulated depreciation					14
15	Buildings	19,352,635				15
16	Accumulated depreciation	-11,254,757				16
17	Leasehold improvements	2,300				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,708,259				23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	72,676				29
30	Total fixed assets (sum of lines 12-29)	22,441,113				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	299,330				34
35	Total other assets (sum of lines 31-34)	299,330				35
36	Total assets (sum of lines 11, 30 and 35)	38,550,204				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	4,048,311				37
38	Salaries, wages and fees payable	4,895,888				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	283,920				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	106,811				44
45	Total current liabilities (sum of lines 37 thru 44)	9,334,930				45
	LONG TERM LIABILITIES					
46	Mortgage payable	88,887,329				46
47	Notes payable	43,457				47
48	Unsecured loans					48
49	Other long term liabilities	2,531,524				49
50	Total long term liabilities (sum of lines 46 thru 49)	91,462,310				50
51	Total liabilities (sum of lines 45 and 50)	100,797,240				51
	CAPITAL ACCOUNTS					
52	General fund balance	-62,247,036				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	-62,247,036				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	38,550,204				60

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		-48,920,315			1
2	Net income (loss) (from Worksheet G-3, line 29)		-10,282,068			2
3	Total (sum of line 1 and line 2)		-59,202,383			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)		-59,202,383			11
12	Deductions (debit adjustments) (specify)					12
13	CHANGE IN RETAINED EARNINGS	3,044,093				13
14	RECONCILING ITEM	560				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		3,044,653			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		-62,247,036			19

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

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	59,639,106		59,639,106	1
2	Subprovider IPF	10,586,300		10,586,300	2
3	Subprovider IRF	3,853,706		3,853,706	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)	74,079,112		74,079,112	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	10,292,722		10,292,722	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	10,292,722		10,292,722	16
17	Total inpatient routine care services (sum of lines 10 and 16)	84,371,834		84,371,834	17
18	Ancillary services	117,372,631	102,172,781	219,545,412	18
19	Outpatient services	6,580,128	43,848,353	50,428,481	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)	208,324,593	146,021,134	354,345,727	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		67,052,480	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		67,052,480	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	354,345,727	1
2	Less contractual allowances and discounts on patients' accounts	299,402,440	2
3	Net patient revenues (line 1 minus line 2)	54,943,287	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	67,052,480	4
5	Net income from service to patients (line 3 minus line 4)	-12,109,193	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests		14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	7,749	21
22	Rental of hosptial space	817,115	22
23	Governmental appropriations		23
24	Other (OTHER OPERATING REVENUE)	1,002,261	24
25	Total other income (sum of lines 6-24)	1,827,125	25
26	Total (line 5 plus line 25)	-10,282,068	26
29	Net income (or loss) for the period (line 26 minus line 28)	-10,282,068	29

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

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

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	546,007	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	2,428	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)	49.11	3
4	Number of interns & residents (see instructions)	0.45	4
5	Indirect medical education percentage (see instructions)	0.26	5
6	Indirect medical education adjustment (see instructions)	1,420	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1057	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.4378	8
9	Sum of lines 7 and 8	0.5435	9
10	Allowable disproportionate share percentage (see instructions)	0.1164	10
11	Disproportionate share adjustment (see instructions)	63,555	11
12	Total prospective capital payments (see instructions)	613,410	12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
41	Subprovider - IRF							41
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
50.01	GASTRO INTESTINAL SERVICES							50.01
51	Recovery Room							51
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56	Radioisotope							56
56.01	ULTRA SOUND							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
63	Blood Storing, Processing & Trans.							63
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
191	Research							191
192	Physicians' Private Offices							192
194	MARKETING							194
194.02	COMMUNITY RELATIONS							194.02
194.03	SENIOR CENTER							194.03
194.04	PHYSICIAN CLINICS							194.04
194.05	POB							194.05
194.06	TRITON HLTH CAREER SCHOLARSHIP PROG							194.06

WESTLAKE COMMUNITY HOSPITAL Provider CCN: 14-0240	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/20/2018 Run Time: 12:06 Version: 2018.04 (09/26/2018)

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		
194.07	GUEST TRAYS & CATERING MEALS							194.07
194.08	HOSPICE							194.08
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202