Heal th Financia	al Systems	WESTVIEW HOSPI	TAL	In Lieu	of Form CMS-2552-10
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	re to report can res	ult in all interim	FORM APPROVED
payments made	since the beginning of the co	st reporting period being d	eemed overpayments (42 USC 1395g).	OMB NO. 0938-0050
HOSPI TAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX C SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 150129	From 01/01/2014	
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 5/27/20	15 Time: 6:14 pm
use only	2. [] Manually submitted co	st report			
	3. [0] If this is an amended 4. [F] Medicare Utilization.	report enter the number of Enter "F" for full or "L"	f times the provider for low.	resubmitted this co	ost report
Contractor use only	<pre>5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended</pre>		this Provider CCN 12		
PART II - CERT	I FI CATI ON				

MISREPRESENTATION OF 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 IDENTIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WESTVIEW HOSPITAL (150129) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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. , 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.



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Officer or Administrator of Provider(s)
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Title

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			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	·	1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	690, 009	334, 508	-7, 056	0	1.00
2.00	Subprovider - IPF	0	755	0		0	2.00
3.00	Subprovider - IRF	0	9, 748	0		0	3.00
4.00	SUBPROVI DER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	700, 512	334, 508	-7,056	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the 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 the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		TVLEW HOSPI	Provi de	r CCN:	150129	Peri od:	in Lie		et S-2	2552-10
100111					0011.	100127	From 01/0	1/2014 1/2014	Part I		
	1.00	2	00	3.	00			4.00	5/27/2	015 6:1	3 pm
	Hospital and Hospital Health Care Co		00		00			4.00			
1.00	Street: 3630 GUION ROAD	P0 Box:									1.00
2.00	City: INDIANAPOLIS	State: I Component Na		p Code: 4		Coun Provi der	ty: MARION Date	Daym	ent Syst	om (P	2.00
		component na			umber	Type	Certifie		, 0, or		
								V	XVIII	1]
	Hospital and Hospital-Based Componen	1.00 t Identification		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospi tal	WESTVI EW HOSPI TA		50129 2	6900	1	01/01/197	5 N	Р	0	3.00
4.00	Subprovider - IPF	GERI PSYCH	1		6900	4	09/01/199		P	N	4.00
5.00 6.00	Subprovider - IRF Subprovider - (Other)	REHAB	15	5T129 2	6900	5	09/01/200	4 N	P	0	5.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00 10.00	Hospi tal-Based SNF Hospi tal-Based NF										9.00
11.00	Hospi tal -Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00 14.00	Separately Certified ASC Hospital-Based Hospice										13.00
	Hospital-Based Health Clinic - RHC										15.00
	Hospital-Based Health Clinic - FQHC										16.00
	Hospital-Based (CMHC) Hospital-Based (CORF)										17.00
	Renal Dialysis										18.00
19.00	Other										19.00
							Fro		Tc 2.		-
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/31	/2014	20.00
21.00	Type of Control (see instructions) Inpatient PPS Information							2			21.00
22.00	Does this facility qualify and is it	currently receiv	/ing paymen	ts for di	spropo	rtionate	N		١	1	22.00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				06(C)(2) (PI CKI E					
22. 01	Did this hospital receive interim un	compensated care	payments f	or this o			N		١	I	22. 01
	period? Enter in column 1, "Y" for yer reporting period occurring prior to										
	for no for the portion of the cost r										
~~ ~~	(see instructions)										00.00
22.02	Is this a newly merged hospital that determined at cost report settlement						N		Ν	I	22.02
	or "N" for no, for the portion of the										
	in column 2, "Y" for yes or "N" for I	no, for the porti	on of the	cost repo	orting	period c	n				
22.03	or after October 1. Did this hospital receive a geograph	ic reclassificati	on from ur	ban to ru	iral as	a resul	t N		N	1	22.03
	of the OMB standards for delineating	statistical area	as adopted	by CMS ir	n FY201	5? Enter					
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column 1										
	cost reporting period occurring on o	5			•						
	hospital contain at least 100 but no			unted in	accord	lance wit	h				
23.00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			/or 25 be	elow? I	n column		0			23.00
	1, enter 1 if date of admission, 2 i	f census days, or	- 3 if date	of disch	narge.	ls the		-			
	method of identifying the days in th used in the prior cost reporting per										
	in the prior cost reporting per		In-State	In-Stat	e 0.	ut-of	Out-of	Medi ca		ther	
			Medicaid	Medicai eligibl		tate	State Medicaid	HMO da	- I	di cai d	
			paid days	unpai d			eligible			days	
				days	`		unpai d				
24 00	If this provider is an IPPS hospital	enter the	1.00	2.00	0	3.00	4.00	5.00	0	5.00	24.00
∠4.00	in-state Medicaid paid days in colum						0			0	24.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu	t unpaid days in									
25.00	column 5, and other Medicaid days in				22				(1)		25.00
25.00	If this provider is an IRF, enter the Medicaid paid days in column 1, the		165		32	0	0		61		25.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid days in column										
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	umn 4, Medicaid									

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		OSPI TAL Provi der (CCN: 150129 F	eri od:	n Lieu	Workshe		
				rom 01/01/ o 12/31/	2014 2014	Part I Date/Ti	me Pre	pared:
				Urban/Rur		5/27/20) <u>15 6:1</u>	3 pm
				1. 00		2. (U	1
6.00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for			inning of the		1			26.00
7.00 Enter your standard geographic classification (not wa	nge) sta	atus at the end	of the cost		1			27.00
reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi			plicable,					
5.00 If this is a sole community hospital (SCH), enter the			H status in		0			35.00
effect in the cost reporting period.				Begi nni	าต.	Endi	na.	
				1.00	ig.	2. (
6.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number					36.00
7.00 If this is a Medicare dependent hospital (MDH), enter		umber of period	s MDH status		0			37.00
in effect in the cost reporting period. 8.00 Enter applicable beginning and ending dates of MDH st	atus. S	Subscript line	38 for number					38.00
of periods in excess of one and enter subsequent date								
				Y/N 1.00		Y/ 2. (-
9.00 Does this facility qualify for the inpatient hospital				N		N		39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req								
CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	or "N"	for no. (see i	nstructions)					40.00
0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob				N		N		40.00
no in column 2, for discharges on or after October 1.	(see i	nstructions)			V	XVIII	XIX	
						2.00	3.00	
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital paymen	t for a	di sproporti opat	e share in ac	cordance	N	N	N	45.00
with 42 CFR Section §412.320? (see instructions)								45.0
6.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					Ν	N	N	46.0
Pt. III.	⊑, Г		,	thi ough				
7.00 Is this a new hospital under 42 CFR §412.300 PPS capi 8.00 Is the facility electing full federal capital payment					N N	N N	N N	47.0
Teaching Hospitals								1
6.00 Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	Y			56.00
7.00 If line 56 is yes, is this the first cost reporting p	period o	durina which re	sidents in an	round				57 0
		3	sidents in up	Ji oveu	N			57.0
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont		- "N" for no in	column 1. If	column 1	N			57.0
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	th of th (", comp	r "N" for no in his cost report plete Worksheet	column 1. lf ing period?	column 1 Enter "Y"	N			57.0
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	th of th (", comp , if ap	r "N" for no in nis cost report plete Worksheet pplicable.	column 1. If ing period? E-4. If colu	column 1 Enter "Y" nn 2 is	N			
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OSPITAL AND HOSPITAL HEALTH CARE COMPLE	K IDENTIFICATION DA	TA Provi der	FI		Date/Time Pre 5/27/2015 6:1	pared:
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, specify special ty, if any, and the number for each new program. (see instruc column 1, the program name, enter program code, enter in column 3, t unweighted count and enter in colu FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify program special ty, if any, and the residents for each expanded progra instructions) Enter in column 1, t enter in column 2, the program cod 3, the IME FTE unweighted count 	of FTE residents tions) Enter in in column 2, the he IME FTE mn 4, direct GME each expanded number of FTE m. (see he program name, e, enter in column d enter in column			o. oc o. oc		61. 1
					1.00	-
ACA Provisions Affecting the Healt	h Resources and Ser	rvices Administration	(HRSA)		1.00	
2.00 Enter the number of FTE residents				od for which	0.00	62.00
your hospital received HRSA PCRE f 2.01 Enter the number of FTE residents during in this cost reporting peri Teaching Hospitals that Claim Resi	that rotated from a od of HRSA THC prog	a Teaching Health Cent gram. (see instruction		your hospital	0.00	62. 0 ⁻
3.00 Has your facility trained resident "Y" for yes or "N" for no in colum	s in nonprovider se	ettings during this co	instructions)		Y	63.0
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te			
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after Jul			inis base year	is your cost r	reporting	
4.00 Enter in column 1, if line 63 is y in the base year period, the numbe resident FTEs attributable to rota settings. Enter in column 2 the n resident FTEs that trained in your of (column 1 divided by (column 1	es, or your facilit r of unweighted nor tions occurring in umber of unweighted hospital. Enter ir	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 17	3. 25	0. 049708	64.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tui	.,,,	
	1.00 MILY MEDICINE	2.00 1350	3.00	4.00	5.00 0.254717	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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			1.08	3. 16		

Heal th	Financial Systems	WES	STVIEW HOSPI	TAL		I	n Lie	u of Form	n CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D	ATA	Provi der	CCN: 150129	Period: From 01/01,		Workshe Part I		
						To 12/31,	/2014	Date/Ti 5/27/20	me Pre 15 6:1	pared: 3 pm
					Unwei ghted FTEs	Unwei gh FTEs		Ratio (c (col. 1		
					Nonprovi der			2))		
					Si te 1.00	2.00)	3.0	0	
	Section 5504 of the ACA Current		n Nonprovide	er Setting						
66.00	<u>beginning on or after July 1, 20</u> Enter in column 1 the number of		ry care resi	dent	0.	50	2. 02	0.	198413	66.00
	FTEs attributable to rotations of Enter in column 2 the number of									
	FTEs that trained in your hospit	al. Enter in column	3 the ratio							
	(column 1 divided by (column 1 +	- column 2)). (see in Program Name	structions) Program	n Code	Unweighted	Unwei gh	ited	Ratio (c	ol 3/	
			l i i ogi di		FTĔs	FTES	in	(col. 3	+ col.	
					Nonprovi der Si te	Hospi t	al	4)))	
(7.00		1.00	2. (00	3.00	4.00		5.0		(7.00
67.00	Enter in column 1, the program name associated with each of	FAMILY MEDICINE	1350		2.	39	4.64	0.	339972	67.00
	your primary care programs in									
	which you trained residents. 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)									
							1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility F Is this facility an Inpatient Ps		IPF), or doe	s it cont	ain an IPF su	oprovi der?	Y			70. 00
71 00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th		nnroved CME	tooching	program in th	most	N		0	71.00
71.00	recent cost report filed on or k								0	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF									
	Column 3: If column 2 is Y, ente	er 1, 2, or 3, in col	umn 3. (see	instructi	ons) If this	cost				
	reporting period covers the begi or subsequent academic years of					ne fifth				
	instructions) For cost reporting reporting period covers the begi									
	teaching program in existence, e	-		•	emic year or	the new				
75 00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		v (IRF) or	does it c	ontain an IRE		Y			75.00
	subprovider? Enter "Y" for yes	and "N" for no.								
76.00	If line 75 yes: Column 1: Did th recent cost reporting period end	3		0.	0		N		0	76.00
	no. Column 2: Did this facility	train residents in a	new teachir	ng program	in accordanc	e with 42				
	CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see ir									
	of the fourth year, enter 4 in c teaching program in existence, e	column 3, or if the f	ifth or subs	sequent ac	ademic years	of the new				
	on or after October 1, 2012, if		,		51	3 3				
	any subsequent academic year of instructions)	the new teaching pro	gram in exis	stence, en	ter 6 in colu	nn 3. (see				
							-			
	Long Term Care Hospital PPS							1.0	0	
	Is this a long term care hospita							N		80.00
σι. UU	Is this a LTCH co-located withir "Y" for yes and "N" for no.	another nospital to	part or al	i or the	LUSI reportin	y period? E	nter	N		81.00
85 00	TEFRA Providers Is this a new hospital under 42	CER Section 8/12 404	f)(1)(1) TE	DA2 Ento	r "V" for yes	or "N" for	no	N		85.00
	Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider	(excluded ur				110.			85.00 86.00

Health Financial Systems WESTVIEW			In Lie	u of Form CMS-:	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Pre	
			_	5/27/2015 6:1	
			V 1.00	XI X 2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospit	al services? Er	nter "Y" for	N	Y	90.00
<pre>yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app</pre>	the cost report	t either in	Ν	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (c instructions) Enter "Y" for yes or "N" for no in the applic	dual certificati			N	92.00
93.00 Does this facility operate an ICF/MR facility for purposes "Y" for yes or "N" for no in the applicable column.			N	N	93.00
 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the application of the second second			N 0.00	N 0.00	94.00 95.00
 95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column. 			N 0.00	N 0.00	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	oplicable columr	1.	0.00	0.00	97.00
105.00 Does this hospital qualify as a Critical Access Hospital (C 106.00 If this facility qualifies as a CAH, has it elected the all		nod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligi for I &R training programs? Enter "Y" for yes or "N" for r			N		107.00
instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst.	Vkst. B, Pt. I,	col. 25 and			
this facility is a CAH, do I&Rs in an approved medical educ CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or					
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	e CRNA fee sched	dul e? See 42	N		108. 00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"					109.00
for yes or "N" for no for each therapy.					
110.00 Did this hospital participate in the Rural Community Hospit		on project (41	OA Demo)for	1.00 N	110.00
the current cost reporting period? Enter "Y" for yes or "N"			1.00	0 2.00 3.00	-
Miscellaneous Cost Reporting Information				-	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes c is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide Pub. 15-1, §2208.1.	2. If column 2 i ent for long ter	s "E", enter rm care (inclu	in column Ides	0	115.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			"N" for Y		116. OC 117. OC
no. 118.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1 i	f the policy	is 1		118. 00
		Premiums	Losses	Insurance	
		1 00			-
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00 0	118.01
	contor other t		1 0		
		than the	1 0	0	
 118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol 	edule listing co d Harmless prov	than the ost centers /ision in ACA	1 0	0	118. 02 119. 00
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol \$3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that o Hold Harmless provision in ACA \$3121 and applicable amendments	edule listing co d Harmless prov n column 1, "Y" qualifies for th	than the ost centers /ision in ACA ' for yes or ne Outpatient	1 0 1.00 N	2.00	118. 02 119. 00
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4.00 If this is an organ procurement of and termination date, if applicab		r the UPU number i	n column I				134.0
ALL Providers							
0.00 Are there any related organization chapter 10? Enter "Y" for yes or				s	Y		140. 0
are claimed, enter in column 2 th	<u>e home office chain numb</u>	<u>per. (see instruct</u>					
<u> </u>		<u>2.00</u> on lines 141 thro	uah 143 the	name and	3.00 address	of the	-
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Enter "Y" for yes or "N" for no i the approval date (mm/dd/yyyy) ir 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif no. Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	gy changed from the prev n column 1. (See CMS Pub icolumn 2. ical basis? Enter "Y" fo fallocation? Enter "Y" ied cost finding method? ider that qualifies for "N" for no for each comp ampus hospital that has Name 0	 b. 15-2, § 4020) I b. 15-2, § 4020) I b. ryes or "N" for for yes or "N" for for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from conent for Part A N N	f yes, enterno. no. pr no. ss or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	er Ti · 3 Cation of (See 42 Cation of Cation of	N Y N N tle V .000 the lowe CFR §413 N N N N N N N N N As? CBSA	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N FTE/Campus 5.00	147. 0 148. 0 149. 0 155. 0 156. 0 156. 0 158. 0 158. 0 159. 0 160. 0 161. 0
Enter "Y" for yes or "N" for no i the approval date (mm/dd/yyyy) ir 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif no. Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful use	rgy changed from the prevon column 1. (See CMS Public column 2. ical basis? Enter "Y" for fallocation? Enter "Y" ied cost finding method?	b. 15-2, § 4020) I for yes or "N" for for yes or "N" for Part A 1.00 an exemption from conent for Part A N N N N N N N N N N N N N N N N N N N	f yes, enterno. no. pr no. es or "N" for Part B 2.00 n the applic and Part B. N N N N N N N N N N N N N	er Ti - 3 Cation of (See 42 Ferent CBS 7 7 7 7 7 7 7 7 7 7 7 7 7	N Y N N tle V .000 the lowe CFR §413 N N N N N N N As? CBSA 4.00	Ti tl e XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. 0 148. 0 149. 0 155. 0 156. 0 157. 0 158. 0 159. 0 161. 1 165. 0 161. 0 161. 0 165. 0 166. 0
Enter "Y" for yes or "N" for no i the approval date (mm/dd/yyyy) ir 7.00 Was there a change in the statist 8.00 Was there a change in the order of 9.00 Was there a change to the simplif no. Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	gy changed from the prev n column 1. (See CMS Pub icolumn 2. ical basis? Enter "Y" fo f allocation? Enter "Y" ied cost finding method? ider that qualifies for "N" for no for each comp "N" for no for each comp ampus hospital that has Name 0 1 1) incentive in the Amer r under Section §1886(n) 05 is "Y") and is a mear	 b. 15-2, § 4020) I b. 15-2, § 4020) I b. or yes or "N" for for yes or "N" for yes Part A 1.00 an exemption from from the part A N <	f yes, enterno. no. pr no. es or "N" for Part B 2.00 n the applic and Part B. N N N N N N N N N N N N N	er Ti - 3 Cation of (See 42 Ferent CBS 7 7 7 7 7 7 7 7 7 7 7 7 7	N Y N N tle V .000 the lowe CFR §413 N N N N N N N As? CBSA 4.00	Ti tl e XI X 4.00 er of costs 5.13) N N N N N N N N N N N N N	147. (148. (149. (149. (155. (156. (157. (160. (161. (161. (161. (165. (161. (165. (165. (165. (166. (161. (165. (166. (

Health Financial Systems	WESTVIEW HOSPI	TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 150129	Period: From 01/01/2014	Worksheet S-2 Part I)
		Date/Time Pre 5/27/2015 6:1	epared: 3 pm		
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	jinning date and ending date	for the reporting	07/01/2014	09/30/2014	170.00
				1.00	
171.00 If line 167 is "Y", does this provid Medicare cost plans reported on Wkst (see instructions)	N	171.00			

5711	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI UNNALKE Provider	- CCN: 150129	Period: From 01/01/2014 To 12/31/2014	1 Date/Time Pr	epared
				Y/N	5/27/2015 6: Date	<u>13 pm</u>
				1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	onses. Enter N for all NO r	esponses. Ente	er all dates in	the	_
00	Provider Organization and Operation Has the provider changed ownership immediatel	v prior to the boginning of	the cost	N		1.0
50	reporting period? If yes, enter the date of t					1.1
			Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic		N			2.
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related	, chain home offices, drug to the provider or its	N			3.
	officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions)					
			Y/N	Type 2 00	Date 2.00	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled,	Y	A		4.
00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		N			5.
50	those on the filed financial statements? If y		IN			5.
		· · ·	•	Y/N	Legal Oper.	
	Approved Educational Activition			1.00	2.00	_
00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool?Column 2: If ves. is t	he provider is	s N		6.
	the legal operator of the program?		p			
00	Are costs claimed for Allied Health Programs?			N		7.
00	Were nursing school and/or allied health prog cost reporting period? If yes, see instruction		ed during the	N		8.
00	Are costs claimed for Intern-Resident program		st report? If	Y		9.
~~	yes, see instructions.					10
00	Was an Intern-Resident program been initiated period? If yes, see instructions.	or renewed in the current	cost reporting	g Y		10.
00	Are GME cost directly assigned to cost center		proved	Ν		11.
	Teaching Program on Worksheet A? If yes, see	instructions.			Y/N	-
					1.00	
	Bad Debts				-	
	Is the provider seeking reimbursement for bac				Y	12.
00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	of correction policy change	during this co	ost reporting	N	13.
00	If line 12 is yes, were patient deductibles a	and/or co-payments waived? I	fyes, see ins	structions.	N	14.
_	Bed Complement				1	
00	Did total beds available change from the pric	or cost reporting period? If		tructions. art A	N Part B	15.
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data Was the cost report prepared using the PS&R		N		N	14
00	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		N		N	16.
~~	instructions)				N	17
00	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		N		N	17.
00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		N		N	18.
00	claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	19.
. 00	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.					19.
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe		N		N	20.

Heal th	Financial Systems	WESTVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period:	Worksheet S-2	2
					From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	narad
					12/31/2014	5/27/2015 6:	
				Pai	rt A	Part B	
		Descr	i pti on	Y/N	Date	Y/N	
		(0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see			N		Ν	21.00
	instructions.						
			-				
	Γ					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			-
22.00	Capital Related Cost Have assets been relifed for Medicare purpose		, instructions			N	22.00
	Have changes occurred in the Medicare depreci			sals made durir	a the cost	N	22.00
23.00	reporting period? If yes, see instructions.	ation expense	uue to apprais		ig the cost	IN	23.00
24.00	Were new leases and/or amendments to existing	g Leases entere	ed into during	this cost repo	orting period?	Ν	24.00
	If yes, see instructions				_		
25.00	Have there been new capitalized leases entere instructions.	ed into during	the cost repor	rting period? I	f yes, see	Ν	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acqu	uired during th	ne cost reporti	ng period? If	yes, see	Ν	26.00
27.00	instructions.	and during the	a cost roportir	a poriod2 lf.	voc cubmit	Ν	27.00
27.00	Has the provider's capitalization policy char copy.	iged duiling the	e cost reportir	ig period: IT S	es, subili t	N	27.00
	Interest Expense						
28.00	Were new Loans, mortgage agreements or letter	rs of credit er	ntered into dur	ring the cost r	reporting	Ν	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation a	account and/or	bond funds (De	ebt Service Res	erve Fund)	Y	29.00
	treated as a funded depreciation account? If	yes, see instr	ructions				
30.00	Has existing debt been replaced prior to its instructions.	scheduled matu	urity with new	debt? If yes,	see	Ν	30.00
31.00	Has debt been recalled before scheduled matur	rity without is	ssuance of new	debt? If yes,	see	Ν	31.00
	instructions.						
22.00	Purchased Services	ationt core co	nui ann furmi chr	d through cont	reatual	N	1 22 00
32.00	Have changes or new agreements occurred in pa arrangements with suppliers of services? If y			ed thiough com	Iactual	IN	32.00
33.00	If line 32 is yes, were the requirements of S			ng to competiti	ve bidding? If	Ν	33.00
	no, see instructions.						
24.00	Provider-Based Physicians				al abuai ai an 2	N/	24.00
34.00	Are services furnished at the provider facili If yes, see instructions.	ty under an ar	rrangement witr	n provider-base	ed physicians?	Y	34.00
35.00	If line 34 is yes, were there new agreements	or amended exi	sting agreemer	nts with the pr	ovi der-based	Ν	35.00
	physicians during the cost reporting period?			•	1		
					Y/N	Date	
					1.00	2.00	
36.00	Home Office Costs Were home office costs claimed on the cost re	oport2			N		36.00
	If line 36 is yes, has a home office cost sta	•	repared by the	home office?	N		37.00
	If yes, see instructions.						
38.00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the 1				N		38.00
39.00	If line 36 is yes, did the provider render se				Ν		39.00
40.00	see instructions.		hama 661 a.2	16	N		40.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the	nome office?	Tr yes, see	N		40.00
			1.	00	2.	00	
	Cost Report Preparer Contact Information Enter the first name, last name and the title	e/nosition	ANDREW		MCMULLEN		41.00
Ŧ1. 00	held by the cost report preparer in columns				MONULLIN		1
	respectively.						
42.00	Enter the employer/company name of the cost i	report	COMMUNITY HEAL	TH NETWORK			42.00
43.00	preparer. Enter the telephone number and email address	of the cost	317-690-2021		AMCMULLEN@ECOM	MUNI TY, COM	43.00
	report preparer in columns 1 and 2, respectiv						

Heal th	Financial Systems	WESTVIEW HOS	SPITAL	In Lieu	u of Form CMS-2	552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provider CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prep 5/27/2015 6:13	
		Part B		· · · · · ·		
		Date				
		4.00				
14 00	PS&R Data					16.00
16.00	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)					10.00
17.00	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)					17.00
	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 this cost report? If yes, see instructions.					18.00
	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.					19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20. 00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.					21.00
			3.00			
	Cost Report Preparer Contact Information		3.00			
41.00	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		. REIMBURSEMENT ANALYST			41.00
42.00	Enter the employer/company name of the cost i	report				42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					43.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	WESTVIEW H			CCN: 150129		eri od:	u of Form CMS-2 Worksheet S-3	
						Fr	om 01/01/2014 12/31/2014	Part I Date/Time Pre	nared
							12/31/2014	5/27/2015 6: 1	
								I/P Days / O/P	
								Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	
		Line Number		<u> </u>	Avai I abl e		4.00	5.00	
1 00	Userital Adults & Dada (aslumas E. (. 7 and	1.00		2.00 18	3.00	70	4.00	5.00	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00		18	6, 5	/0	0.00	0	1.00
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO I PF Subprovider								3.00
4.00	HMO IRF Subprovider								4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF							0	6.00
7.00	Total Adults and Peds. (exclude observation			18	6, 5	70	0.00	0	7.00
	beds) (see instructions)								
8.00	INTENSIVE CARE UNIT	31.00		4	1, 4	60	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00		0		0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33.00		0		0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00		0		0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY	43.00				~ ~		0	13.00
14.00	Total (see instructions)			22	8, 0	30	0.00	0	14.00
15.00	CAH visits	10.00		2	-	20		0	15.00
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF	40. 00 41. 00		2		30		0	16.00 17.00
18.00	SUBPROVI DER - TRF	41.00		0		90 0		0	17.00
19.00	SKILLED NURSING FACILITY	42.00		0		0		0	19.00
20.00	NURSING FACILITY	44.00		0		0		0	20.00
21.00	OTHER LONG TERM CARE	46.00		0		0		0	21.00
22.00	HOME HEALTH AGENCY	101.00		0		Ŭ		0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00							23.00
24.00	HOSPI CE	116.00		0		0			24.00
24.10	HOSPICE (non-distinct part)	30.00							24.10
25.00	CMHC - CMHC	99.00						0	25.00
25.10	CMHC - CORF	99. 10						0	25. 10
26.00	RURAL HEALTH CLINIC	88.00						0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00						0	26. 25
27.00	Total (sum of lines 14-26)			30					27.00
28.00	Observation Bed Days							0	28.00
29.00	Ambulance Trips								29.00
30.00	Employee discount days (see instruction)								30.00
31.00	Employee discount days - IRF								31.00
32.00	Labor & delivery days (see instructions)			0		0			32.00
32. 01	Total ancillary labor & delivery room								32.01
22 00	outpatient days (see instructions)								22.00
33.00	LTCH non-covered days				I				33.00

IOSPI ⁻	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150129		eriod: rom 01/01/2014 p 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/27/2015 6:1	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,072	123		20			1.00
. 00	HMO and other (see instructions)	475	79					2.00
. 00	HMO IPF Subprovider	0	0					3.00
. 00	HMO IRF Subprovider	0	41					4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0			5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0			6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 072	123	2, 32	20			7.00
3. 00	INTENSIVE CARE UNIT	185	0	30	93			8.0
. 00	CORONARY CARE UNI T	0	0		0			9.0
0. 00	BURN INTENSIVE CARE UNIT	0	0		0			10. C
1.00	SURGI CAL I NTENSI VE CARE UNI T	0	0		0			11.0
2.00	OTHER SPECIAL CARE (SPECIFY)							12.0
3.00	NURSERY		0		0			13.0
4.00	Total (see instructions)	1, 257	123	2, 7	13	14.30	296.47	14. C
5.00	CAH visits	0	0		0			15.0
6.00	SUBPROVIDER - IPF	351	0	3!	51	0,00	2.45	16.0
7.00	SUBPROVIDER - IRF	605	217	1, 00	66	0.00	7.62	17.0
8.00	SUBPROVI DER	0	0		0	0,00	0,00	
9.00	SKILLED NURSING FACILITY	0	0		0	0.00	0.00	19. (
0.00	NURSING FACILITY		0		0	0,00	0,00	
1.00	OTHER LONG TERM CARE				0	0.00	0.00	21.0
2.00	HOME HEALTH AGENCY	0	0		0	0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P.)					0.00	0.00	
4.00	HOSPI CE	0	0		0	0.00	0.00	
4. 10	HOSPICE (non-distinct part)	0	0		0			24.
5.00	СМНС – СМНС	0	0		0	0.00	0.00	25.0
5. 10	CMHC - CORF	0	0		0	0.00	0.00	25. 1
6.00	RURAL HEALTH CLINIC	0	0		0	0.00	0.00	26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	26. :
7.00	Total (sum of lines 14-26)					14.30	306.54	
B. 00	Observation Bed Days		8	54	41			28.0
9.00	Ambul ance Trips	О	-					29. (
0. 00	Employee discount days (see instruction)				0			30.0
1.00	Employee discount days - IRF				0			31. (
2.00	Labor & delivery days (see instructions)	О	0		0			32. (
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)		-		0			32.0
3.00	LTCH non-covered days	0						33.

alth Financial Systems DSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	WESTVIEW HO		CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Worksheet S-3 Part I Date/Time Pre	pared
	Full Time		Di s	charges	5/27/2015 6:1	3 pm
Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Workers				Patients	
	11.00	12.00	13.00	14.00	15.00	
 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) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY OT Total (see instructions) 	0.00	0	1	26 53 30 0 26 53		1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14.
 5.00 CAH visits 5.00 SUBPROVIDER - IPF 7.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER - IRF 8.00 SUBPROVIDER 9.00 SKILLED NURSING FACILITY 9.00 NURSING FACILITY 1.00 OTHER LONG TERM CARE 2.00 HOME HEALTH AGENCY 8.00 AMBULATORY SURGICAL CENTER (D. P.) 4.10 HOSPICE 4.10 HOSPICE (non-distinct part) 5.00 CMHC - CMHC 5.10 CMHC - CORF 5.00 RURAL HEALTH CLINIC 5.25 FEDERALLY QUALIFIED HEALTH CENTER 7.00 Total (sum of lines 14-26) 8.00 Ambulance Trips 0.00 Employee discount days (see instruction) 1.00 Employee discount days (see instructions) 2.01 Total ancillary labor & delivery room outpatient days (see instructions) 3.00 LTCH non-covered days 	0.00 0.00	0 0 0		26 0 55 17 0 0	31 91 0	15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 24. 25. 26. 27. 28. 29. 30. 31. 32. 32. 33.

SPI T	Financial Systems AL WAGE INDEX INFORMATION		WESTVIEW I		F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-3 Worksheet S-3 Part II Date/Time Prep 5/27/2015 6:13	pared:
		Worksheet A Line Number	Reported	Reclassificati on of Salaries (from Worksheet A-6)	Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	<u>5 piii</u>
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see	200.00	21, 901, 353	-104, 982	21, 796, 371	667, 338.00	32.66	1.0
0	instructions)		0	0		0.00	0.00	2.0
0	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.0
00	Non-physician anesthetist Part		0	0	0	0.00	0.00	3.0
0	B Physician-Part A -		0	0	0	0.00	0. 00	4.0
	Administrative		J. J					
)1)0	Physicians - Part A - Teaching		0	0	0	0.00 0.00	0. 00 0. 00	
0	Physician-Part B Non-physician-Part B		0				0.00	
0	Interns & residents (in an	21.00	944, 958	0	944, 958			7.0
	approved program)							
)1	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.0
0	Home office personnel		0	0	0	0.00	0.00	8.0
0	SNF	44.00	0	0	0	0.00	0.00	
00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		7, 668, 668	-38, 562	7, 630, 106	194, 788. 00	39. 17	10. 0
00	Contract Labor: Direct Patient		617, 530	0	617, 530	6, 744. 00	91. 57	11.0
00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12. 0
00	management and other management and administrative		0	0		0.00	0.00	12.0
00	services Contract Labor: Physician-Part		107, 250	0	107, 250	1, 372. 00	78. 17	13.0
	A - Administrative							
00	Home office salaries &		934, 095	0	934, 095	16, 067. 00	58.14	14.0
00	wage-related costs Home office: Physician Part A		0	o	0	0.00	0.00	15.0
	- Administrative			-				
00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.0
	WAGE-RELATED COSTS							
00	Wage-related costs (core) (see		3, 509, 004	0	3, 509, 004			17. C
00	instructions) Wage-related costs (other)		0	0	0			18. C
00	(see instructions)		0	0				10.0
	Excluded areas		1, 684, 753					19. C
00	Non-physician anesthetist Part		0	0	0			20. C
00	Non-physician anesthetist Part		0	0	0			21. C
	В							
00	Physician Part A - Administrative		0	0	0			22.0
01	Physician Part A - Teaching		0	0	0			22. C
00	Physician Part B		20, 697	0	20, 697			23. C
00			20,077					
00	Wage-related costs (RHC/FQHC)		0	0	0			
00	Interns & residents (in an		0 190, 296	0	0 190, 296			
00		S	0	0	0 190, 296			
00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4.00	0 190, 296 201, 664	0	201, 664	6, 740. 00	29. 92	25. 0 26. 0
00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General		0 190, 296 201, 664 2, 029, 994	0	201, 664 2, 018, 409	6, 740. 00 67, 415. 00	29. 94	25. 0 26. 0 27. 0
00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General under	4.00	0 190, 296 201, 664	0	201, 664	6, 740. 00 67, 415. 00	29. 94	27. C
00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General	4.00	0 190, 296 201, 664 2, 029, 994	0	201, 664 2, 018, 409	6, 740. 00 67, 415. 00	29. 94	25. 0 26. 0 27. 0 28. 0
00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant	4.00 5.00 6.00 7.00	0 190, 296 201, 664 2, 029, 994	0 -11, 585 0 0	201, 664 2, 018, 409	6, 740. 00 67, 415. 00 2, 204. 00 0. 00 15, 521. 00	29. 94 85. 69 0. 00 30. 92	25. (26. (27. (28. (29. (30. (
00 00 00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service	4.00 5.00 6.00 7.00 8.00	0 190, 296 201, 664 2, 029, 994 188, 871 0 479, 893 0	0 -11, 585 0 0 0 0 0 0	201, 664 2, 018, 409 188, 871 0 479, 893 0	6, 740. 00 67, 415. 00 2, 204. 00 0. 00 15, 521. 00 0. 00	29. 94 85. 69 0. 00 30. 92 0. 00	25. (26. (27. (28. (29. (30. (31. (
00 00 00 00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping	4.00 5.00 6.00 7.00	0 190, 296 201, 664 2, 029, 994 188, 871 0 479, 893 0 259, 130	0 -11, 585 0 0 0 0 0 -360	201, 664 2, 018, 409 188, 871 0 479, 893 0 258, 770	6, 740. 00 67, 415. 00 2, 204. 00 0. 00 15, 521. 00 0. 00 22, 806. 00	29.94 85.69 0.00 30.92 0.00 11.35	25. (26. (27. (28. (30. (31. (32. (
00 00 00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service	4.00 5.00 6.00 7.00 8.00	0 190, 296 201, 664 2, 029, 994 188, 871 0 479, 893 0	0 -11, 585 0 0 0 0 0 -360	201, 664 2, 018, 409 188, 871 0 479, 893 0	6, 740. 00 67, 415. 00 2, 204. 00 0. 00 15, 521. 00 0. 00 22, 806. 00	29. 94 85. 69 0. 00 30. 92 0. 00	25. 26. 27. 28. 29. 30. 31. 32.
00 00 00 00 00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract (see instructions) Dietary	4.00 5.00 6.00 7.00 8.00	0 190, 296 201, 664 2, 029, 994 188, 871 0 479, 893 0 259, 130	0 -11, 585 0 0 0 0 0 -360	201, 664 2, 018, 409 188, 871 0 479, 893 0 258, 770 82, 040	6, 740. 00 67, 415. 00 2, 204. 00 0. 00 15, 521. 00 0. 00 22, 806. 00 2, 080. 00 3, 885. 00	29. 94 85. 69 0. 00 30. 92 0. 00 11. 35 39. 44 19. 02	25. (26. (27. (28. (30. (31. (32. (33. (33. (34. (
00 00 00 00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract (see instructions) Dietary Dietary under contract (see	4.00 5.00 6.00 7.00 8.00 9.00	0 190, 296 201, 664 2, 029, 994 188, 871 0 479, 893 0 259, 130 82, 040	0 -11, 585 0 0 0 0 -360 0	201, 664 2, 018, 409 188, 871 0 479, 893 0 258, 770 82, 040	6, 740.00 67, 415.00 2, 204.00 0.00 15, 521.00 0.00 22, 806.00 2, 080.00	29.94 85.69 0.00 30.92 0.00 11.35 39.44	25. (26. (27. (28. (30. (31. (32. (33. (33. (34. (
00 00 00 00 00 00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping Housekeeping under contract (see instructions) Dietary Dietary under contract (see instructions)	4.00 5.00 6.00 7.00 8.00 9.00 10.00	0 190, 296 201, 664 2, 029, 994 188, 871 0 479, 893 0 259, 130 82, 040	0 -11, 585 0 0 0 -360 0 -370, 335 0	201, 664 2, 018, 409 188, 871 0 479, 893 0 258, 770 82, 040 73, 892 0	6, 740. 00 67, 415. 00 2, 204. 00 15, 521. 00 0. 00 22, 806. 00 2, 080. 00 3, 885. 00 0. 00	29. 94 85. 69 0. 00 30. 92 0. 00 11. 35 39. 44 19. 02 0. 00	25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35.
00 00 00 00 00 00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract (see instructions) Dietary Dietary under contract (see	4.00 5.00 6.00 7.00 8.00 9.00	0 190, 296 201, 664 2, 029, 994 188, 871 0 479, 893 0 259, 130 82, 040	0 -11, 585 0 0 0 0 -360 0	201, 664 2, 018, 409 188, 871 0 479, 893 0 258, 770 82, 040 73, 892 0 369, 803 0	6, 740. 00 67, 415. 00 2, 204. 00 0. 00 15, 521. 00 0. 00 22, 806. 00 2, 080. 00 3, 885. 00 0. 00 19, 304. 00 0. 00	29. 94 85. 69 0. 00 30. 92 0. 00 11. 35 39. 44 19. 02	25. (26. (27. (28. (30. (31. (32. (33. (34. (35. (36. (
00 00 00 00 00 00 00 00 00 00 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department Administrative & General Administrative & General under contract (see inst.) Maintenance & Repairs Operation of Plant Laundry & Linen Service Housekeeping Housekeeping under contract (see instructions) Dietary Dietary Dietary under contract (see instructions) Cafeteria	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	0 190, 296 201, 664 2, 029, 994 188, 871 0 479, 893 0 259, 130 82, 040	0 -11, 585 0 0 0 -360 0 -370, 335 0 369, 803 0 -10, 278	201, 664 2, 018, 409 188, 871 0 479, 893 0 258, 770 82, 040 73, 892 0 369, 803 0 92, 398	6, 740. 00 67, 415. 00 2, 204. 00 0. 00 15, 521. 00 0. 00 22, 806. 00 2, 080. 00 3, 885. 00 0. 00 19, 304. 00 0. 00 3, 390. 00	29.94 85.69 0.00 30.92 0.00 11.35 39.44 19.02 0.00 19.16 0.00 27.26	25. (26. (27. (28. (30. (31. (32. (33. (35. (35. (35. (37. (38. (38. (

Health Financial Systems		WESTVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					rom 01/01/2014		
					Го 12/31/2014	Date/Time Pre 5/27/2015 6:1	
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical	16.00	274, 839	-810	274, 029	9 14, 433. 00	18. 99	41.00
Records Library							
42.00 Social Service	17.00	C	0	(0.00	0.00	42.00
43.00 Other General Service	18.00	C	0	(0.00	0.00	43.00

Heal th	Financial Systems	WESTVI EW	HOSPITAL		In Lie	eu of Form CMS-2	2552-10	
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014	Worksheet S-3 Part III	
						To 12/31/2014		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		21, 227, 306	-104, 982	21, 122, 32	4 641, 880. 00	32. 91	1.00
	instructions)							
2.00	Excluded area salaries (see		7, 668, 668	-38, 562	7, 630, 10	6 194, 788. 00	39. 17	2.00
	instructions)							
3.00	Subtotal salaries (line 1		13, 558, 638	-66, 420	13, 492, 21	8 447, 092. 00	30. 18	3.00
4 00	minus line 2)		4 (50 075		4 (50.07		(0, (0	4 00
4.00	Subtotal other wages & related		1, 658, 875	0	1, 658, 87	5 24, 183. 00	68.60	4.00
5.00	costs (see inst.)		2 500 004	0	2 500 00		24.01	5.00
5.00	Subtotal wage-related costs (see inst.)		3, 509, 004	0	3, 509, 00	4 0.00	26. 01	5.00
6.00	Total (sum of lines 3 thru 5)		18, 726, 517	-66, 420	18, 660, 09	7 471, 275.00	39, 59	6.00
7.00	Total overhead cost (see		4, 585, 269					
7.00	instructions)		4, 363, 209	-24, 555	4, 500, 75	177, 874.00	23.04	7.00
		I I		1	I	I	1 1	

4.00 Qualified Defined Benefit Plan Cost (see instructions) 303,950 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 0 5.00 01X/TSA Plan Administration Fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 0 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 6.00 0 8.00 Health Insurance (Purchased or Self Funded) 2,217,187 8.00 0 9.00 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 9.00 10.00 Differ femployee is owner or beneficiary) 0 12.00 Accident Insurance (If employee is owner or beneficiary) 12.00 13.00 13.00 13.00 10 sability Insurance (If employee is owner or beneficiary) 14.00 14.00 10.01 Keriement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 16.00 10.00 IffeA Employeers Portion Only 0 18.00 0 18.00 18.00 10.00 Unemployment Insurance Federal Unemployment Taxes	Heal th	Financial Systems	WESTVIEW HOSPI	TAL		In Lie	eu of Form CMS-2	2552-10
PART IV - WACE RELATED COSTS Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 780.190 2.00 As Shel tered Annuity (TSA) Employer Contribution 0 2.00 3.00 Nonqual if ed Defined Benefit P I an Cost (see instructions) 0 3.00 3.00 0.00 Qualified Defined Benefit P I an Cost (see instructions) 0 3.00 3.00 0.00 Legal /Accounting/Management Fees-Pension P Ian 0 5.00 0 6.00 7.00 Employee Gure Andmin stration Fees 0 6.00 6.00 6.00 8.00 Health Insurance (Purchased or Self Funded) 2.217,187 8.00 9.00 9.00 0.00 Description Drug P1 an 0 9.00 9.00 17.302 13.00 17.302 10.00 17.3720 17.302 10.00 17.3720 10.00 17.3702 10.00 17.3702 10.00 17.3702 13.753 11.00 17.3702 13.703 11.00 12.00 17.3702 13.705 11.00	HOSPIT	AL WAGE RELATED COSTS		Provider C	CN: 150129	From 01/01/2014	Part IV Date/Time Pre	pared:
PART IV - WAGE RELATED COSTS Part A - Core List RETIREMENT COST RETIREMENT COST 1.00 2.00 Tax Shel tered Annuity (TSA) Employer Contribution 2.00 Tax Shel tered Annuity (TSA) Employer Contributions) 0.00 0.00 0.01 0.01 0.01 0.02 0.03 0.03 0.00 0.01 0.01 0.01 0.02 0.01 0.01 0.01 0.01 0.01 0.02 0.01 0.01 0.02 0.01 0.02 0.01 0.02 0.01 0.02 0.02 0.03 0.04 0.05 0.06 0.06 0.07 0.08 0.01 0.02 0.03								
PART IV - WAGE RELATED COSTS Part IV - WAGE RELATED COST Part IX - Core List RETIREMENT COST 1.00 401K Employer Contributions 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 0.00 Ulified Defined Benefit Plan Cost (see instructions) 0 0.00 Ulified Defined Benefit Plan Cost (see instructions) 0 0.01 Administration fees 0 0.00 Legal /Accounting/Management Fees-Pension Plan 0 0.00 Description Drug Plan 0 0.00 Dental, Hearing and Vision Plan 0 0.00 Description Drug Plan 0 0.00 Description Drug Plan 0 0.00 Description Drug Plan 0 0.01.00 Life Insurance (If employee is owner or beneficiary) 33,702 0.01.00 Life Insurance (If employee is owner or beneficiary) 17,37,372 0.01.00 Life Insurance (If employee is owner or beneficiary) 17,455,582 0.01.00 Life Insurance (If employee is owner or beneficiary) 18,00 0.0								
Part A - Core List RETIREMENT COST 1.00 401K Employer Contributions 780,190 2.00 Tax Sheltered Annuity (TSA) Employer Contribution 0 0.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 0.01 Qualified Defined Benefit Plan Cost (see instructions) 303,950 0.01 OUX/TSA Plan Administration fees 0 0.00 Legal /Accounting/Management Fees-Pension Plan 0 0.00 PLAN ADMINISTRATIVE (COST Cost 0 0.01 Defined Benefit Plan diministration Fees 0 0.01 Legal /Accounting /Management Fees-Pension Plan 0 0.01 Definition Drug Plan 0 6.00 0.01 Prescription Drug Plan 2,17,187 8.00 0.02 Derati, Hearing and Vision Plan 2,370,210.00 12.00 0.02 Accident Insurance (If employee is owner or beneficiary) 13,753 11.00 0.01 Destinity Insurance (If employee is owner or beneficiary) 0 12.00 0.03 Destinity Insurance (If employee is owner or beneficiary) 0 13,703 15.00 0.04 Norker		DADT LV WACE DELATED COSTS					1.00	
RETIREMENT COST1.00401K Employer Contributions780,1901.002.00Tax Shel tered Annuity (TSA) Employer Contribution0.013.00Nonquali Fied Defined Benefit Plan Cost (see instructions)0.03.004.00Quali Fied Defined Benefit Plan Cost (see instructions)303,9505.00401K/TSA Plan Administration fees06.00Legal /Accounting/Management Fees-Pension Plan06.00Employee Managed Care Program Administration Fees07.00Employee Managed Care Program Administration Fees07.00Employee Managed Care Program Administration Fees08.00Heal th Insurance (Purchased or Self Funded)2, 217, 1878.00Prescription Drug Plan09,0010.00Dental, Hearing and Vision Plan23, 70210.00Disability Insurance (If employee is owner or beneficiary)113, 75311.00Life Insurance (If employee is owner or beneficiary)12, 0010.00Disability Insurance (If employee is owner or beneficiary)14, 0010.00Norter's Compensation Insurance78, 57110.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.010.00Medicare Taxes - Employers Portion Only18, 405, 58210.00Medicare Taxes - Employers Portion Only010.00Medicare Taxes - Employeent Taxes000Vorkers' Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see010.00<								
1.00401K Employer Contributions780,1901.002.00Tax Shel tered Annui ty (TSA) Employer Contribution02.003.00Nonquali fiel defined Benefit P Ian Cost (see instructions)03.03,950Valai Field Defined Benefit P Ian Cost (see instructions)303,9504.00Valai Field Defined Benefit P Ian Cost (see instructions)00Valai Field Defined Benefit P Ian2, 217, 1870Valai								
2.00Tax Sheltered Annuity (TSA) Employer Contribution02.003.00Nonqualified Defined Benefit Plan Cost (see instructions)303,9504.00Qualified Defined Benefit Plan Cost (see instructions)303,950PLAN ADMINISTRATIVE COSTS (Paid to External Organization)5.005.00401K/TSA Plan Administration Fees06.00Legal /Accounting/Management Fees-Pension Plan07.00Employee Managed Care Program Administration Fees07.00Health Insurance (Purchased or Self Funded)2,217,1878.00Non curculation of the plane09.00Prescription Drug Plan2,3,70210.00Dental, Hearing and Vision Plan011.00Life Insurance (If employee is owner or beneficiary)12.0012.00Accident Insurance (If employee is owner or beneficiary)12.0013.00Disability Insurance (If employee is owner or beneficiary)14.0014.00Uorg-Ferr Care Insurance (If employee is owner or beneficiary)14.0015.00'Workers' Compensation Insurance76.57116.00Kedi care Taxes - Employers Portion Only14.95,58217.00FicA-Employers Portion Only18.0019.00Unemployers Portion Only18.0019.00Unemployers Portion Only18.0019.00Unemployers Portion Only14.95,58210.00State or Federal Unemployment Taxes000Unemployers Cost and Allowances001.00State or Federal Unemployment Taxes0<	1 00						780 190	1 00
3.00 Nonqualified Defined Benefit Plan Cost (see instructions) 0 3.00 0.00 4.00 Qualified Defined Benefit Plan Cost (see instructions) 303,950 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 0 5.00 401K/TSA Plan Administration fees 0 6.00 6.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 6.00 7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 2, 217, 187 8.00 9.00 Prescription Drug Plan 0 9.00 10.00 Life Insurance (If employee is owner or beneficiary) 31, 753 11.00 11.00 Life Insurance (If employee is owner or beneficiary) 13, 753 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 14.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 14.00 14.00 Workers' Compensation Insurance 78,571 15.00 15.00 Workers' Compensation Only 1,495,582 17.00 16.00 Retirement Insurance 0 14.00			oution					
4.00 Qualified Defined Benefit Plan Cost (see instructions) 303,950 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 0 5.00 01K/TSA Plan Administration fees 0 5.00 0.00 Legal /Accounting/Management Fees-Pension Plan 0 6.00 6.00 6.00 1.00 Employee Managed Care Program Administration Fees 0 7.00 6.00 7.00 HEALTH AND INSURANCE COST 0 7.00 0 0 9.00 9.00 Prescription Drug Plan 0 9.00 0 0 9.00 10.00 Dental, Hearing and Vision Plan 23,702 10.00 12.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 12.00 12.00 Accident Insurance (If employee is owner or beneficiary) 173,702 13.00 13.00 Disability Insurance (If employee is owner or beneficiary) 14.00 14.00 14.00 Keirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 15.00 Workers': Compensation Insurance 1,495,582 17.00 18.00 18.00 18.00								3.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 5.00 5.00 401K/TSA Plan Administration fees 0 6.00 Legal /Accounting/Management Fees-Pension Plan 0 7.00 Employee Managed Care Program Administration Fees 0 8.00 Healt Th Insurance (Purchased or Self Funded) 2,217,187 9.00 Prescription Drug Plan 0 9.00 0.00 Dental, Hearing and Vision Plan 23,070 10.00 10.00 Dental, Hearing and Vision Plan 23,773 11.00 11.00 Life Insurance (If employee is owner or beneficiary) 31,753 11.00 12.00 Jashii Ity Insurance (If employee is owner or beneficiary) 170,702 13.00 13.00 Isabili Vi Insurance (If employee is owner or beneficiary) 170,702 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 170,702 13.00 15.00 'Workers' Compensation Insurance 0 14.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 17.00 FICA-Employers Portion Only 0 18.00 0							303, 950	4.00
5.00 401K/TSA Pl an Administration fees 0 5.00 6.00 Legal /Accounting/Management Fees-Pension Pl an 0 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
7.00Employee Managed Care Program Administration Fees HEALTH AND INSURANCE COST7.00HEALTH AND INSURANCE COST2,217,1878.009.00Prescription Drug Plan09.0010.00Dental, Hearing and Vision Plan23,70210.0011.00Life Insurance (If employee is owner or beneficiary)31,75311.0012.00Accident Insurance (If employee is owner or beneficiary)012.0013.00Disability Insurance (If employee is owner or beneficiary)014.0014.00Long-Term Care Insurance (If employee is owner or beneficiary)014.0015.00'Workers' Compensation Insurance78,57115.0016.00Retirement Healt th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)014.9017.00FICA-Employers Portion Only018.0019.00Unemployment Insurance275,91419.0020.00State or Federal Unemployment Taxes instructions))021.0021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 	5.00						0	5.00
HEALTH AND INSURANCE COST 2,217,187 8.00 Heal th Insurance (Purchased or Self Funded) 2,217,187 9.00 Prescription Drug Plan 0 10.00 Dental, Hearing and Vision Plan 23,702 11.00 Life Insurance (If employee is owner or beneficiary) 31,753 12.00 Accident Insurance (If employee is owner or beneficiary) 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 173,702 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 15.00 Workers' Compensation Insurance 78,571 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 17.00 FICA-Employers Portion Only 1,495,582 17.00 18.00 Medicare Taxes - Employers Portion Only 18.00 19.00 Unemployment Insurance 275,914 19.00 19.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see 0 01 OTHER 22.00 22.00 22.00 22.00 Day Care Cost and Allowances 0 22.00 22.00	6.00	Legal /Accounting/Management Fees-Pension Pla	an				0	6.00
8.00 Heal th Insurance (Purchased or Sel f Funded) 2, 217, 187 8.00 9.00 Prescription Drug Plan 0, 9, 00 10.00 Dental, Hearing and Vision Plan 23, 702 10. 00 11.00 Life Insurance (If employee is owner or beneficiary) 31, 753 11. 00 12.00 Accident Insurance (If employee is owner or beneficiary) 173, 702 173, 702 13.00 Disability Insurance (If employee is owner or beneficiary) 173, 702 13. 00 15.00 'Workers' Compensation Insurance 78, 571 15. 00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106 0 16. 00 17.00 FICA-Employers Portion Only 1, 495, 582 17. 00 18.00 Medicare Taxes - Employers Portion Only 275, 914 0 19.00 State or Federal Unemployment Taxes 0 20. 00 21. 00 22.00 State or Federal Unemployment Taxes 0 21. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 <t< td=""><td>7.00</td><td>Employee Managed Care Program Administration</td><td>n Fees</td><td></td><td></td><td></td><td>0</td><td>7.00</td></t<>	7.00	Employee Managed Care Program Administration	n Fees				0	7.00
9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 23,702 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 31,753 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 173,702 13.00 15.00 Workers' Compensation Insurance Femployee is owner or beneficiary) 0 14.00 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 Non cumulative portion) TAXES 11.495,582 17.00 17.00 FICA-Employers Portion Only 1,495,582 17.00 18.00 Medicare Taxes - Employment Taxes 0 18.00 00 State or Federal Unemployment Taxes 0 21.00 01 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see Olicions)) 0 22.00 22.00 Day Care Cost and Allowances 0 22.00 24.199		HEALTH AND INSURANCE COST						
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11.00Life Insurance (If employee is owner or beneficiary)31,75311.0012.00Accident Insurance (If employee is owner or beneficiary)012.0013.00Disability Insurance (If employee is owner or beneficiary)173,70213.0014.00Long-Term Care Insurance (If employee is owner or beneficiary)014.0015.00'Workers' Compensation Insurance78,57115.0016.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106.016.00Non cumulative portion)1,495,58217.0018.0019.00Unemployment Insurance275,9149.0019.00Unemployment Insurance275,9149.0020.00State or Federal Unemployment Taxes021.0021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see022.0022.00Day Care Cost and Allowances022.0023.0024.0023.00Tuition Reimbursement24,19923.0024.0024.00Part B - Other than Core Related Cost5,404,75024.00	9.00						0	9.00
12.00Accident Insurance (If employee is owner or beneficiary)12.0013.00Disability Insurance (If employee is owner or beneficiary)173,70214.00Long-Term Care Insurance (If employee is owner or beneficiary)015.00'Workers' Compensation Insurance78,57116.00Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.016.00Retirement Taxes017.00FICA-Employers Portion Only1,495,58217.00FICA-Employers Portion Only018.00Medicare Taxes - Employers Portion Only019.00Unemployment Insurance275,91420.00State or Federal Unemployment Taxes00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see011.00Executives Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see022.00Day Care Cost and Allowances022.0023.00Tuition Reimbursement24,19923.0024.00Total Wage Related cost (Sum of Lines 1 -23)5,404,75024.00Part B - Other than Core Related Cost024.00	10.00							
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15.00'Workers' Compensation Insurance78,57115.0016.00Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) TAXES016.0017.00FICA-Employers Portion Only1,495,58217.0018.00Medicare Taxes - Employers Portion Only018.0019.00Unemployment Insurance275,91419.0020.00State or Federal Unemployment Taxes020.000Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see021.0021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see022.0022.00Day Care Cost and Allowances022.0023.0023.00Tuit ion Reimbursement24,19923.0024.00Total Wage Related cost (Sum of Lines 1 -23)5,404,75024.00Part B - Other than Core Related Cost024.00								
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Non cumulative portion)Image: Second Sec								
TAXES17.00FI CA-Employers Portion Only1,495,58217.0018.00Medicare Taxes - Employers Portion Only018.0019.00Unemployment Insurance275,91419.0020.00State or Federal Unemployment Taxes020.00OTHER021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see021.0022.00Day Care Cost and Allowances022.0022.0023.00Tuition Reimbursement24,19923.0024.00Part B - Other than Core Related Cost24.0024.00	16.00		ear, not the extraor	dinary accru	ual require	ed by FASB 106.	0	16.00
17.00FICA-Employers Portion Only1,495,58217.0018.00Medicare Taxes - Employers Portion Only018.0019.00Unemployment Insurance275,91419.0020.00State or Federal Unemployment Taxes020.00OTHER21.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))021.0022.00Day Care Cost and Allowances022.0023.0023.00Tuit ion Reimbursement24,19923.0024.00Total Wage Related cost (Sum of Lines 1 -23)5,404,75024.00								
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19.00Unemployment Insurance275,91419.0020.00State or Federal Unemployment Taxes020.00OTHER020.0021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))021.0022.00Day Care Cost and Allowances022.0023.00Tuit ion Reimbursement24,19923.0024.00Total Wage Related cost (Sum of Lines 1 -23)5,404,750Part B - Other than Core Related Cost024.00								
20.00 State or Federal Unemployment Taxes 0 20.00 OTHER 0 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 24,199 23.00 24.00 Part B - Other than Core Related Cost 5,404,750 24.00								
OTHER 21.00 Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions)) 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 24,199 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 5,404,750 24.00								
21.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see instructions))021.0022.00Day Care Cost and Allowances022.0023.00Tuition Reimbursement24,19923.0024.00Total Wage Related cost (Sum of Lines 1 -23)5,404,750Part B - Other than Core Related Cost24.00	20.00						0	20.00
22. 00 Day Care Cost and Allowances 0 22. 00 23. 00 Tuition Reimbursement 24, 199 23. 00 24. 00 Total Wage Related cost (Sum of Lines 1 - 23) 5, 404, 750 24. 00 Part B - Other than Core Related Cost 24. 00 24. 00	21.00	Executive Deferred Compensation (Other Than	Retirement Cost Rep	orted on lir	nes 1 throu	ugh 4 above. (see	0	21.00
23.00 Tuition Reimbursement 24,199 23.00 24.00 Total Wage Related cost (Sum of Lines 1 -23) 5,404,750 24.00 Part B - Other than Core Related Cost 24.00 24.00	22 00						0	22 00
24.00 Total Wage Related cost (Sum of lines 1 -23) 5,404,750 24.00 Part B - Other than Core Related Cost 24.00							-	
Part B - Other than Core Related Cost)					
	21.00						0, 101, 700	
	25.00						0	25.00

Heal th	Financial Systems	WESTVIEW HOSPI	TAL			In Lie	u of Form CMS-:	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 15	0129	Peri od:	Worksheet S-3	
						From 01/01/2014	Part V	
						To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
	Cost Center Description					Contract Labor		
						1.00	2,00	
	PART V - Contract Labor and Benefit Cost							
	Hospital and Hospital-Based Component Identifica	ti on:						1
1.00	Total facility's contract labor and benefit cost					0	0	1.00
2.00	Hospi tal					0	0	2.00
3.00	Subprovider - IPF					0	0	3.00
4.00	Subprovider - IRF					0	0	4.00
5.00	Subprovider - (Other)					0	0	5.00
6.00	Swing Beds - SNF					0	0	6.00
7.00	Swing Beds - NF					0	0	7.00
8.00	Hospital-Based SNF					0	0	8.00
9.00	Hospital-Based NF					0	0	9.00
10.00	Hospital-Based OLTC							10.00
11.00	Hospital-Based HHA					0	0	1
12.00	Separately Certified ASC					0	0	
13.00	Hospital-Based Hospice					0	0	13.00
14.00	Hospital-Based Health Clinic RHC					0	0	
15.00	Hospital-Based Health Clinic FQHC					0	0	15.00
16.00	Hospital-Based-CMHC					0	0	16.00
16. 10	Hospital-Based-CMHC 10					0	0	
17.00	Renal Dialysis					0	0	
18.00	Other					0	0	18.00

Heal th	Financial Systems WESTVIEW HOSPI	TAL		In Li€	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150129	Peri od:	Worksheet S-1	0
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
					572772013 0.1	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by li	ne 202 colum	า 8)	0. 276479	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				604, 949	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental		from Medicai	d?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from	Medi cai d			0	
6.00	Medi cai d charges				12, 639, 038	
7.00	Medicaid cost (line 1 times line 6)				3, 494, 429	
8.00	Difference between net revenue and costs for Medicaid program (line 7 min	us sum of li	nes 2 and 5; if	2, 889, 480	8.00
	<pre>< zero then enter zero) State Children's Health Insurance Program (SCHIP) (see instruct)</pre>	lana far a	ach line)			-
9.00	Net revenue from stand-al one SCHIP		ach Trne)		0	9.00
9.00 10.00	Stand-al one SCHIP charges					
11.00	Stand-alone SCHIP cost (line 1 times line 10)					
12.00	Difference between net revenue and costs for stand-alone SCHIP	(line 11 m	inus line 9.	if < zero then	0	
12.00	enter zero)	(THE TIM	inus inne 7,	TT < Zero then		12.00
	Other state or local government indigent care program (see inst	ructions f	or each line)		1
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care				0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local ind	igent care	program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Uncompensated care (see instructions for each line)				-	
17.00	Private grants, donations, or endowment income restricted to fu				0	
18.00	Government grants, appropriations or transfers for support of h				0	1 .0.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and loca 8, 12 and 16)	i indigent	care progra	ms (sum of lines	2, 889, 480	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care			0 0	0	20.00
	charges excluding non-reimbursable cost centers) for the entire					
21.00	Cost of initial obligation of patients approved for charity car	e (line 1		0 0	0	21.00
~~ ~~	times line 20)					
22.00	Partial payment by patients approved for charity care			0 0	-	
23.00	Cost of charity care (line 21 minus line 22)			0 0	0	23.00
					1.00	
24,00	Does the amount in line 20 column 2 include charges for patient	dave bovo	nd a Longth	of ctay limit	1.00	24.00
24.00	imposed on patients covered by Medicaid or other indigent care		nu a rengtn	JI Stay ITMIT		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indige		ogram's Leng	th of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see ins		- <u>-</u>		7, 606, 106	
27.00	Medicare bad debts for the entire hospital complex (see instruc				101, 359	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (li	,	s line 27)		7, 504, 747	
29.00						29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 074, 905	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 964, 385	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	WESTVIEW HC F EXPENSES			eriod:	eu of Form CMS-2 Worksheet A	2552-10
					rom 01/01/2014 o 12/31/2014		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)		
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0	0	1 011 0/4	1 011 0/4	1.00
2.00 3.00	00200 CAP REL COSTS-MVBLE EQUI P 00300 OTHER CAP REL COSTS		0	0			2.00 3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	201, 664 2, 029, 994	3, 738, 029 14, 969, 083	3, 939, 693 16, 999, 077	-1, 904, 260		4.00 5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	479, 893 0	1, 328, 280 4, 316	1, 808, 173 4, 316		2, 061, 075 4, 316	7.00 8.00
9.00	00900 HOUSEKEEPI NG	259, 130	260, 951	520, 081	-646		9.00
10.00	01000 DI ETARY	444, 227	347, 347	791, 574			
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 102, 676	0 25, 736	0 128, 412	658, 957 0	658, 957 128, 412	
14.00	01400 CENTRAL SERVICES & SUPPLY	160, 575	478, 615				
15.00	01500 PHARMACY	361, 360	2, 775, 573			531, 716	
16.00 21.00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRVD	274, 839 944, 958	470, 770 320, 150	745, 609 1, 265, 108	-21, 003 0	724, 606 1, 265, 108	
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	50, 835	45, 283	96, 118		96, 118	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 890, 027	253, 252				
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	324, 303	47, 392 0	371, 695 0	-1, 365 0	370, 330 0	31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	218, 532 446, 030	43, 373	261, 905 569, 437	-972		40.00 41.00
41.00	04100 SUBPROVIDER - TRF	446, 030	123, 407 0	569, 437	-3, 618	565, 819 0	
43.00	04300 NURSERY	0	0	0	0	0	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45.00 46.00
40.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	0	0	0	40.00
50.00	05000 OPERATING ROOM	1, 558, 413	4, 116, 764	5, 675, 177	-2, 658, 302	3, 016, 875	
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	763, 679	375, 619	1, 139, 298	-128, 215	1, 011, 083	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0 104, 187	0 42, 514	0 146, 701	-13, 932	0 132, 769	56.00 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	91, 402	70, 343	161, 745	-26, 819		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	33, 931	2, 106, 547	2, 140, 478	3, 625	2, 144, 103 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	Ŭ	0	0	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY	405, 911	74, 122	480, 033	-38, 164	-	65.00
66.00	06600 PHYSI CAL THERAPY	825, 714	266, 837	1, 092, 551	-291, 824	800, 727	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	124, 753	124, 753	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	407, 610	0 59, 412	467, 022	26, 041 -7, 574	26, 041 459, 448	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	127, 619	24, 479	152, 098		144, 870	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	764, 353	764, 353	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 790, 118 2, 573, 122	1, 790, 118 2, 573, 122	
74.00	07400 RENAL DIALYSIS	0	91, 011	91, 011	-294		
75.00	07500 ASC (NON-DISTINCT PART)	Ó	0	0	0	0	75.00
76.00	03020 ENDOSCOPY CENTER	0	0	0	0	0	76.00
76. 01 76. 05	03950 WOUND OSTOMY 03480 CRCC	184, 150 188, 293	652, 665 28, 655	836, 815 216, 948		828, 423 212, 972	76. 01 76. 05
. 0. 00	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00 90.00
90.00 90.23	09000 CLINIC 09023 CLINIC	0	0	0	0	0	90.00
90. 25	09025 CLI NI C	133, 402	52, 944	186, 346	-12, 856	173, 490	90. 25
90.27	09027 CLINIC	0	0	0	0	0	90.27
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 883, 893	856, 095	2, 739, 988	-15, 067	2, 724, 921	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			I		
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00

Health Financial Systems	WESTVIEW HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Period:	Worksheet A	
				rom 01/01/2014 o 12/31/2014	Date/Time Pre	narod
				0 12/31/2014	5/27/2015 6:1	
Cost Center Description	Sal ari es	Other T	otal (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	05.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	(0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98.00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0	(0	99.00 99.10
99.10 109910 CORF 100.00 10000 L&R SERVICES-NOT APPRVD PRGM	0	0	(Ũ	
101.00 10100 HOME HEALTH AGENCY	0	0				100.00
SPECIAL PURPOSE COST CENTERS	U U	U			0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	C	0	0	105.00
106. 00 10600 HEART ACQUISTITION	0	0	(106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	(0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0	(0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	(0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	o	C	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	C	0	0	111.00
113.00 11300 INTEREST EXPENSE		0	C	0 0	0	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	C	0 0	0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	C	0 0	0	115.00
116. 00 11600 HOSPI CE	0	0	C	0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	14, 897, 247	34, 049, 564	48, 946, 811	1, 534, 912	50, 481, 723	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0 0		190. 00
191. 00 19100 RESEARCH	0	0	C	0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	7,004,106	4, 713, 466	11, 717, 572	-1, 534, 912		
193. 00 19300 NONPALD WORKERS	0	0	C	0 0		193.00
194.0007950 OTHER NONREI MBURSABLE COST CENTERS	0	0	C	0 0		194.00
194.0607956CHN MOB	0	0	C	0		194.06
194.0807958 FOUNDATION OPS	0	-743	-743			194.08
200.00 TOTAL (SUM OF LINES 118-199)	21, 901, 353	38, 762, 287	60, 663, 640	0	60, 663, 640	200. 00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (WESTVIEW		CCN: 150129 Period: Workshe	
				From 01/01/2014 To 12/31/2014 Date/Ti	me Prepared:)15 6:13 pm
	Cost Center Description		Net Expenses For Allocation		
	GENERAL SERVICE COST CENTERS	6.00	7.00		
00	00100 CAP REL COSTS-BLDG & FIXT	46, 266			1.0
00	00200 CAP REL COSTS-MVBLE EQUIP	334, 101			2.0
00 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	-2,040			3.0
00	00500 ADMI NI STRATI VE & GENERAL	-9, 170, 049			5.0
00	00700 OPERATION OF PLANT	-129, 242			7.0
00	00800 LAUNDRY & LINEN SERVICE	0			8.0
00	00900 HOUSEKEEPING	0			9.0
. 00 . 00	01000 DI ETARY 01100 CAFETERI A	-168, 888	120,000		10.0
. 00	01300 NURSI NG ADMI NI STRATI ON	- 108, 888			13.0
	01400 CENTRAL SERVICES & SUPPLY	0			14.0
. 00	01500 PHARMACY	-367			15.0
	01600 MEDICAL RECORDS & LIBRARY	-83, 548			16.0
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	-3, 439			21.0
. 00	02200 I & SERVI CES-OTHER PRGM COSTS APPRVD I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	96, 118		22. 0
. 00	03000 ADULTS & PEDIATRICS	0	2,078,479		30. 0
. 00	03100 INTENSIVE CARE UNIT	0			31. (
. 00	03200 CORONARY CARE UNI T	0	0		32. (
. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33. (
. 00 . 00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	0 260, 933		34. (40. (
. 00	04100 SUBPROVIDER - IRF		565, 819		40.0
. 00	04200 SUBPROVI DER	0	0		42. (
. 00	04300 NURSERY	0	0		43. (
	04400 SKILLED NURSING FACILITY	0	-		44. (
. 00	04500 NURSING FACILITY	0			45.0
. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		46.0
. 00	05000 OPERATI NG ROOM	584,000	3, 600, 875		50.0
. 00	05100 RECOVERY ROOM	0	0		51.0
. 00	05200 DELIVERY ROOM & LABOR ROOM	0			52.0
. 00	05300 ANESTHESI OLOGY	0	, o		53.0
. 00 . 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	-45, 942			54.0
. 00	05600 RADI OLOGI - MERALEO II C	0			56.
. 00	05700 CT SCAN	0	132, 769		57.
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			58.
. 00	05900 CARDI AC CATHETERI ZATI ON	0			59.
. 00 . 01	06000 LABORATORY 06001 BLOOD LABORATORY	-61, 772			60. 60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	-		63.
. 00	06400 I NTRAVENOUS THERAPY	0	-		64.
. 00 . 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-87, 901			65. 66.
. 00	06700 OCCUPATI ONAL THERAPY	0,,,,01	124, 753		67.
. 00	06800 SPEECH PATHOLOGY	0	26, 041		68.
. 00	06900 ELECTROCARDI OLOGY	0	459, 448		69.
. 00	07000 ELECTROENCEPHALOGRAPHY	0	144, 870		70.
. 00 . 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	764, 353 1, 790, 118		71.
	07300 DRUGS CHARGED TO PATIENTS		2, 573, 122		72.
. 00	07400 RENAL DIALYSIS	0	90, 717		74.
. 00	07500 ASC (NON-DISTINCT PART)	0	0		75.
. 00	03020 ENDOSCOPY CENTER	0	0		76.
. 01	03950 WOUND OSTOMY	0			76.
. 05	03480 CRCC OUTPATIENT SERVICE COST CENTERS	0	212, 972		76.
. 00	08800 RURAL HEALTH CLINIC	0	0		88.
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			89.
. 00	09000 CLI NI C	0	0		90. (
23	09023 CLI NI C	0	0		90.
. 25	09025 CLINIC	0	173, 490		90.
. 27 . 00	09027 CLINIC 09100 EMERGENCY	-327,655	0 2, 397, 266		90. 91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-327,000	2, 371, 200		91.0
	OTHER REIMBURSABLE COST CENTERS			I	/2.1
	09400 HOME PROGRAM DI ALYSI S	0	0		94. (
. 00 . 00	09500 AMBULANCE SERVICES	0	0		95.0

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 150129 Period: From 01/01/2014 To 12/31/2014 Worksheet A Date/Time Prepared: 5/27/2015 6:13 pm 07.00 09700 DURABLE MEDICAL EQUIP-SOLD 6.00 7.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 98.00 99.00 98.00 99.00 100.00 <th>Health Financial Systems</th> <th>WESTVIEW F</th> <th>IOSPI TAL</th> <th>In Lie</th> <th>u of Form CMS-2552-10</th>	Health Financial Systems	WESTVIEW F	IOSPI TAL	In Lie	u of Form CMS-2552-10
Cost Center Description Adjustments (See A-8) Net Expenses For Al location 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 98.00 09951 OT 0 97.00 98.00 09951 0 97.00 98.00 09951 0 97.00 98.00 09951 0 0 97.00 98.00 09951 0 0 0 97.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 100.00	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15012	9 Period:	Worksheet A
Cost Center Description Adjustments (See A-B) Net Expenses For Al location [5/27/2015 6:13 pm] 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97.00 <td></td> <td></td> <td></td> <td></td> <td></td>					
Cost Center Description Adjustments (See A-B) For Allocation 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98.00 09951 OTHER REIMBURSABLE COST CENTERS 0 0 99.00 09900 CMHC 99.00 0 99.00 99.10 09910 CORF 0 0 99.00 00 100.00 IAR SERVICES-NOT APPRVD PRGM 0 0 100.00 00 00000 IAR SERVICES-NOT APPRVD PRGM 0 0 100.00 00 0101.00 HOME HEALTH AGENCY 0 0 100.00 05.001 01500 KIDNEY ACQUIS ITION 0 0 100.00 100.00 06.00 10700 LIVER ACQUIS ITION 0 0 107.00 108.00 108.00 10800 LINA ACQUIS ITION 0 0 109.00 109.00 109.00 1000 PANCREAS ACQUIS ITION 0 0 110.00 110.00 110.00 110.00 110.00 110.00 110.00				lo 12/31/2014	Date/lime Prepared:
(See A-8) For Allocation 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 97.00 98.00 98.00 99.00 90.00 99.00 90.00 99.00 90.00 99.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 105.00 106.00 106.00 106.00 106.00	Cost Center Description	Adjustments	Net Expenses		572772015 0. 15 pm
6.00 7.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 98.00 09851 OTHER REIMBURSABLE COST CENTERS 0 0 99.00 09900 CMHC 0 0 99.00 99.10 09900 CMHC 0 0 0 99.00 99.10 01000 IAR SERVI CES-NOT APPRVD PRGM 0 0 0 100.00 1000.01 100.00 1000.01 100.00	COST CENTER DESCRIPTION				
98.00 09851 OTHER REIMBURSABLE COST CENTERS 0 0 99.00 90.00 90.00 100.00 100.00 101.00 101.00 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 107.00 109.00 107.00 <t< td=""><td></td><td></td><td></td><td></td><td></td></t<>					
99.00 09900 CMHC 0 0 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.10 0 0 0 0 0 99.10 00.00 100.00 148 SERVI CES-NOT APPRVD PRGM 0 0 0 0 101.00 101.00 101.00 101.00 101.00 0 <t< td=""><td>97.00 09700 DURABLE MEDICAL EQUIP-SOLD</td><td>0</td><td>0</td><td></td><td>97.00</td></t<>	97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
99.10 09910 CORF 0 0 99.10 100.00 10000 IAR SERVICES-NOT APPRVD PRGM 0 0 100.00 SPECIAL PURPOSE COST CENTERS 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 0 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 106.00 107.00 108.00 109.00 109.00 107.00 108.00 109.00 100.00 110.00 110.00 110.00 110.00 107.00 108.00 107.00 111.00 111.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00<	98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
100.00 1000 1&R SERVICES-NOT APPRVD PRGM 0 0 100.00 01.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 106.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 111.00 111.00 111.00 115.00 115.00 115.00 116.00 <td>99.00 09900 CMHC</td> <td>0</td> <td>0</td> <td></td> <td>99.00</td>	99.00 09900 CMHC	0	0		99.00
101.00 HOME HEALTH AGENCY 0 0 SPECIAL PURPOSE COST CENTERS	99. 10 09910 CORF	0	0		99.10
SPECIAL PURPOSE COST CENTERS 105.00 105000 KI DNEY ACQUI SI TI ON 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 106.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 108.00 109.00 PANCREAS ACQUI SI TI ON 0 0 108.00 109.00 100.00 INTESTI NAL ACQUI SI TI ON 0 0 110.00 101.00 113.00 113.00 113.00 113.00 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 <td>100.00 10000 I&R SERVICES-NOT APPRVD PRGM</td> <td>0</td> <td>0</td> <td></td> <td>100.00</td>	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
105.00 10500 KI DNEY ACQUI SI TI ON 0 0 105.00 106.00 10600 HEART ACQUI SI TI ON 0 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 0 107.00 107.00 108.00 LONG ACQUI SI TI ON 0 0 0 107.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 113.00 1111.00 113.00 1111.00 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 115.00 116.00 116.00 115.00 116.00 116.00 115.00 116.00 116.00 119.00 <td>101.00 10100 HOME HEALTH AGENCY</td> <td>0</td> <td>0</td> <td></td> <td>101.00</td>	101.00 10100 HOME HEALTH AGENCY	0	0		101.00
106.00 10600 HEART ACQUI SI TI ON 0 106.00 107.00 10700 LI VER ACQUI SI TI ON 0 00 108.00 10800 LUNG ACQUI SI TI ON 0 0 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 110.00 INTESTI NAL ACQUI SI TI ON 0 0 109.00 111.00 INTESTI NAL ACQUI SI TI ON 0 0 110.00 111.00 INTESTI NAL ACQUI SI TI ON 0 0 110.00 111.00 INTERTSTI NAL ACQUI SI TI ON 0 0 111.00 111.00 INTEREST EXPENSE 0 0 111.00 113.00 11400 UTI LI ZATI ON REVIEW-SNF 0 0 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 114.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00					
107.00 10700 LIVER ACQUISITION 0 107.00 108.00 10800 LIVER ACQUISITION 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 101.000 INTESTINAL ACQUISITION 0 0 109.00 110.00 INTESTINAL ACQUISITION 0 0 109.00 111.00 INTERSTINAL ACQUISITION 0 0 110.00 111.00 INTERSTINAL ACQUISITION 0 0 110.00 111.00 ISLET ACQUISITION 0 0 111.00 113.00 INTEREST EXPENSE 0 0 113.00 114.00 ILICATION REVIEW-SNF 0 0 114.00 115.00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116.00 ISUBTOTALS (SUM OF LINES 1-117) -9, 116, 476 41, 365, 247 118.00 NONRET MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211, 711 9, 970, 949 192.		0	0		
108.00 10800 LUNG ACQUI SI TI ON 0 0 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 109.00 110.00 1NTESTI NAL ACQUI SI TI ON 0 0 110.00 109.00 111.00 INTESTI NAL ACQUI SI TI ON 0 0 110.00 110.00 111.00 ISLET ACQUI SI TI ON 0 0 0 1110.00 113.00 INTEREST EXPENSE 0 0 1114.00 11400 1140.01 1140.00 114.00 116.00 1		0	0		
109.00 PANCREAS ACQUI SI TI ON 0 0 109.00 110.00 INTESTI NAL ACQUI SI TI ON 0 0 110.00 111.00 INTESTI ACUUI SI TI ON 0 0 110.00 111.00 ISLET ACQUI SI TI ON 0 0 111.00 113.00 INTEREST EXPENSE 0 0 113.00 114.00 ILI LI ZATI ON REVI EW-SNF 0 0 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 115.00 116.00 11600 HOSPI CE 0 0 116.00 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) -9, 116, 476 41, 365, 247 118.00 NONRET MBURSABLE COST CENTERS 190.00 19100 RESEARCH 0 0 191.00 191.00 19100 RESEARCH 0 0 192.00 192.00 193.00 193.00 193.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211, 711 9, 970, 949 192.00 193.00 194.06 07950 <		0	0		
110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 ISLET ACQUISITION 0 0 113.00 11300 INTEREST EXPENSE 0 0 114.00 11400 UTILIZATION REVIEW-SNF 0 0 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 116.00 1060 HOSPICE 0 0 118.00 SUBTOTALS (SUM OF LINES 1-117) -9, 116, 476 41, 365, 247 118.00 NONREI MBURSABLE COST CENTER 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 191.00 191.00 19100 RESEARCH 0 0 192.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211, 711 9, 970, 949 192.00 192.00 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.06 194.06 194.08 07958 FOUNDATION OPS 0 0 194.06 194.06		0	0		
111.00 11100 I SLET ACQUI SI TI ON 0 111.00 113.00 11300 INTEREST EXPENSE 0 0 114.00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 116.00 11600 HOSPI CE 0 0 118.00 SUBTOTALS (SUM OF LINES 1-117) -9, 116, 476 41, 365, 247 118.00 118.00 SUBTOTALS (SUM OF LINES 1-117) -9, 116, 476 41, 365, 247 1190.00 190.00 IPONORE IMBURSABLE COST CENTERS 0 0 190.00 190.00 191.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211, 711 9, 970, 949 192.00 193.00 19300 NONPAI D WORKERS 0 0 193.00 194.06 194.06 07950 OTHER NOREI MBURSABLE COST CENTERS 0 0 194.06 194.08 07958 FOUNDATI ON OPS 0 0 194.06		0	0		
113.00 11300 INTEREST EXPENSE 0 0 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 115.00 116.00 11600 HOSPI CE 0 0 115.00 118.00 SUBTOTALS (SUM OF LINES 1-117) -9, 116, 476 41, 365, 247 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.00 19100 RESEARCH 0 0 190.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211, 711 9, 970, 949 192.00 193.00 19300 NONPAI D WORKERS 0 0 193.00 194.06 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.06 194.08 07958 FOUNDATI ON OPS 0 194.06 194.06		0	0		
114.00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 114.00 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 115.00 116.00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) -9, 116, 476 41, 365, 247 118.00 NONREI MBURSABLE COST CENTERS 190.00 19100 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211, 711 9, 970, 949 192.00 193.00 NONREI MBURSABLE COST CENTERS 0 0 193.00 193.00 194.00 194.06 07956 CHN MOB 0 0 194.00 194.06 194.08 07958 FOUNDATI ON OPS 0 194.08 194.08		0	0		
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 115.00 116.00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) -9, 116, 476 41, 365, 247 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.00 19100 RESEARCH 0 0 191.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211, 711 9, 970, 949 192.00 193.00 193000 NONREI MBURSABLE COST CENTERS 0 0 193.00 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 194.06 07956 CHN MOB 0 0 194.06 194.08 07958 FOUNDATI ON OPS 0 194.08		0	0		
116.00 11600 HOSPICE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1-117) -9,116,476 41,365,247 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.00 19100 RESEARCH 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211,711 9,970,949 192.00 193.00 193000 NONPAI D WORKERS 0 0 193.00 193.00 194.00 079505 OTHER NONREI IMBURSABLE COST CENTERS 0 0 194.00 194.06 07956 CHN MOB 0 0 194.06 194.08 07958 FOUNDATI ON OPS 0 0 194.08		0	0		
SUBTOTALS Subtore Sub		0	0		
NONRE I MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES -211,711 9,970,949 192.00 193.00 103000 NONPAI D WORKERS 0 0 193.00 194.00 07950 OTHER NONBEI MBURSABLE COST CENTERS 0 0 194.00 194.06 07956 CHN MOB 0 0 194.06 194.08 07958 FOUNDATI ON OPS 0 -743 194.08		0	0		
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190.00 191.00 19100 RESEARCH 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES -211, 711 9, 970, 949 192.00 193.00 19300 NONPAI D WORKERS 0 193.00 193.00 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 194.06 07956 CHN MOB 0 194.06 194.08 07958 FOUNDATI ON OPS 0 194.08		-9, 116, 476	41, 365, 247		118.00
191.00 RESEARCH 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES -211, 711 9, 970, 949 192.00 193.00 19300 NONPAI D WORKERS 0 0 193.00 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 194.06 07956 CHN MOB 0 194.06 194.06 194.08 07958 FOUNDATI ON OPS 0 194.08		1			
192.00 PHYSI CI ANS' PRI VATE OFFICES -211,711 9,970,949 192.00 193.00 19300 NONPAI D WORKERS 0 0 193.00 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 194.06 07956 CHN MOB 0 194.06 194.06 194.08 07958 FOUNDATI ON OPS 0 -743 194.08		0	0		
193.00 NONPAI D WORKERS 0 0 193.00 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 194.06 07956 CHN MOB 0 0 194.06 194.08 07958 FOUNDATI ON OPS 0 -743 194.08		0	0		
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194.00 194.06 07956 CHN MOB 0 0 194.06 194.08 07958 FOUNDATI ON OPS 0 -743 194.08		-211, 711	9, 970, 949		
194.06 07956 CHN MOB 194.06 194.08 07958 FOUNDATI ON OPS 0 -743 194.08		0	0		
194. 08 07958 FOUNDATI ON OPS 0 -743 194. 08		0	0		
		0	0		
200.00 101AL (SUM OF LINES 118-199) -9,328,187 51,335,453 [200.00		0			
	200.00 TUTAL (SUM OF LINES 118-199)	-9, 328, 187	51, 335, 453		200.00

	Financial Systems		WESTVIEW H		CCN: 150129 Period:	eu of Form CMS-2552-10 Worksheet A-6
RECEAS				FIOVICE	CCN: 150129 Period: From 01/01/2014 To 12/31/2014	
					10 12/31/2014	5/27/2015 6:13 pm
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Cafeteria Salary					
1.00	<u>CAFETERI</u> A	<u>11.00</u>	<u>369, 803</u> 369, 803	— — — _ō		1.00
	B - Cafeteria Reclass		309, 803	0		
1.00	CAFETERI A	11.00		<u>289, 1</u> 54		1.00
			0	289, 154		
1.00	C - Therapy Salary OCCUPATIONAL THERAPY	67.00	107, 828			1.00
2.00	SPEECH PATHOLOGY	68.00	22, 508			2.00
			130, 336	0		
1 00	D - Therapy Other	(7.00		16 025		1.00
1.00 2.00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	67.00 68.00		16, 925 <u>3, 5</u> 33		1.00
2.00				20, 458		2.00
	E - Plant Operations Expense					
1.00	OPERATION OF PLANT	7.00	0 0	224, 379		1.00
2.00 3.00	LABORATORY	60.00 0.00	0	3, 626 0		2.00 3.00
4.00		0.00	Ő	0		4.00
5.00		0.00	0	0		5.00
6.00 7.00		0.00 0.00	0 0	0		6.00 7.00
7.00 8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0.00 0.00	0 0	0 0		11.00 12.00
12.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16. 00 17. 00		0.00 0.00	0	0		16.00 17.00
18.00		0.00	0	0		18.00
	TOTALS		0	228, 005		
1.00	F - Implantable Device Reclass	<u>5</u> 72.00		1, 790, 118		1.00
1.00	PATIENTS	72.00		1, 790, 116		1.00
			o	1, 790, 118		
	G - Depreciation Expense	1 00		500 100		
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00	0 0	520, 489 1, 514, 532		1.00
3.00		0.00	0	0		3.00
	TOTALS		o	2,035,021		
1 00	H - Interest Expense	1 00	0	70.070		1.00
1.00	CAP_REL_COSTS-BLDG_&_FIXT TOTALS	<u>1.00</u>	0	7 <u>2, 278</u> 72, 278		1.00
	I - Capital Insurance Costs		9	, 2, 2, 0		
1.00	CAP REL COSTS-BLDG & FIXT		0	3 <u>2, 3</u> 88		1.00
	TOTALS J - Other Capital		0	32, 388		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 271, 209		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	О	416, 613		2.00
3.00	ADMI NI STRATI VE & GENERAL	5.00	0	22, 204		3.00
4.00 5.00		0.00 0.00	0 0	0 0		4.00 5.00
5.00 6.00		0.00	0	0		6.00
7.00		0.00	Ō	0		7.00
8.00		0.00	0	0		8.00
9.00 10.00		0.00 0.00	0	0		9.00 10.00
10.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00			0	0		13.00
	TOTALS K - Drugs Charges to Pat		0	1, 710, 026		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2, 573, 122		1.00
2.00		0.00	О	0		2.00
3.00		0.00	0	0		3.00
4.00 5.00		0.00 0.00	0 0	0		4.00 5.00
6.00		0.00	0	0		6.00
7.00		0.00	О	0		7.00
8.00		0.00	0	0		8.00
9.00	<u> </u>	0.00	0	0		9.00

	Financial Systems		WESTVI EW H		001 450400		u of Form CMS	
RECLAS	SEFECATIONS			Provi der	CCN: 150129	Period: From 01/01/2014	Worksheet A	
						To 12/31/2014	Date/Time Pr 5/27/2015 6:	
		Increases					372772013 0	
	Cost Center	Line #	Salary	0ther				
10.00	2.00	3.00	4.00	5.00				10.00
10. 00 11. 00		0.00 0.00	0	0 0				10.00 11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16. 00 17. 00		0.00 0.00	0	0				16.00 17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
	TOTALS		0	2, 573, 122				
	L - Chargeable Medical Suppli			7/1.050				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	764, 353				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00 7.00		0.00 0.00	0	0 0				6.00 7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12. 00 13. 00		0.00 0.00	0	0				12.00 13.00
13.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18.00			<u>0</u>					18.00
	TOTALS M - Rent Expense		U	764, 353				-
1.00	CAP REL COSTS-MVBLE EQUI P	2.00	0	294, 923				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00 6.00		0.00 0.00	0	0 0				5.00 6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00	TOTALS	0.00	0	294, 923				11.00
	N - POB Expense			271,720				-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15, 600				1.00
2.00	OPERATION OF PLANT		0	6 <u>6, 3</u> 55				2.00
	TOTALS Q - STD BENEFIT RECLASS		0	81, 955				-
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	11, 585				1.00
2.00	HOUSEKEEPING	9.00	0	360				2.00
3.00	DI ETARY	10.00	0	532				3.00
4.00	NURSING ADMINISTRATION	13.00	0	10, 278				4.00
5.00 6.00	CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	14.00 16.00	0	968 810				5.00 6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2, 350				7.00
8.00	SUBPROVI DER – I RF	41.00	0	2, 790				8.00
9.00	OPERATING ROOM	50.00	0	8, 442				9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	11, 163				10.00
11.00		66.00	0	9, 358				11.00
12. 00 13. 00	ELECTROCARDI OLOGY WOUND OSTOMY	69.00 76.01	0	3, 137 1, 240				12.00 13.00
13.00 14.00	CRCC	76.01	0	368				13.00
15.00	CLINIC	90.25	0	968				15.00
16.00	EMERGENCY	91.00	0	4, 861				16.00
17.00	PHYSICIANS PRIVATE OFFICES	1 <u>92.</u> 00	<u>0</u>	35, 772				17.00
500 00	TOTALS Grand Total: Increases		0 500, 139	104, 982 9, 996, 783				500.00
550.00	orana rotar. Increases	I I	300, 139	7, 770, 703				1 300.00

ASSI FI CATI ONS				Provi der	CCN: 150129	Period: From 01/01/2014	Worksheet A-6
						To 12/31/2014	Date/Time Prepar 5/27/2015 6:13 p
		Decreases					
C	ost Center 6.00	Line # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00	·	
A - Cafete		7.00	8.00	9.00	10.00		
DI ETARY		10.00	369, 803				1
			369, 803	ō			
	ria Reclass				i		
DIETARY		<u>10.</u> 00		289, 154		-	1
C - Therap	v Salarv		U	289, 154			
PHYSICAL T		66.00	130, 336				1
		00100	100,000				
			130, 336	0			
D - Therap			I		1		
PHYSICAL T	HERAPY	66.00		20, 458			
°	+	+			<u> </u>	-	2
E - Plant	Operations Expense		V	20, 430			
	TIVE & GENERAL	5.00	0	2, 090		0	1
) HOUSEKEEPI	NG	9.00	0	624		0	2
DI ETARY		10.00	0	6, 962		0	
) CENTRAL SE) PHARMACY	RVICES & SUPPLY	14.00 15.00	0	1, 987 452		0	2
ADULTS & P	EDLATRI CS	30.00	0	4,099		0	
		31.00	0	435		0	
SUBPROVI DE	R – IPF	40.00	О	32		0	8
SUBPROVI DE		41.00	0	119		0	ç
00 OPERATING		50.00	0	182, 825		0	10
DO RADI OLOGY-		54.00	0	6, 726		0	11
O MAGNETIC R (MRI)	ESONANCE I MAGI NG	58.00	0	8, 625		0	12
DO PHYSICAL T	HERAPY	66.00	о	463		0	13
0 ELECTROCAR	DI OLOGY	69.00	О	7, 563		0	14
	EPHALOGRAPHY	70.00	0	1, 092		0	15
DO WOUND OSTO	MY	76.01	0	649		0	16
DO CRCC DO EMERGENCY		76. 05 91. 00	0	240 3, 022		0	17
DO EMERGENCY_ TOTALS	+					<u> </u>	10
	table Device Reclass	I	0	220,000			
OPERATING		50.00		1, 790, 118			1
			0	1, 790, 118			
	iation Expense	5 00		4 770 040	1		
D ADMINISTRA D ADULTS & P	TIVE & GENERAL	5. 00 30. 00	0	1, 778, 343 39, 070		9	1
	' PRIVATE OFFICES	192.00	0	217, 608		0	2
TOTALS			o	2,035,021			
H - Intere	st Expense	ľ	·				
	TI_VE_&_GENERAL	5.00	0_	7 <u>2, 2</u> 78		1	1
TOTALS			0	72, 278			
	I Insurance Costs	5.00	0	32, 388	1 4		
D ADMI NI STRA TOTALS	TIVE & GENERAL	5.00	0	3 <u>2, 388</u> 32, 388		2	1
J - Other	Capi tal	I		02,000	I	I	
OPERATI ON	OF PLANT	7.00	0	18, 916		0	1
	RVICES & SUPPLY	14.00	0	121, 774		0	2
D PHARMACY		15.00	0	147, 877		0	3
	CORDS & LI BRARY	16. 00 30. 00	0	20, 132		0	4
) ADULTS & P) INTENSIVE		30.00	0	7, 116 28		0	5
SUBPROVI DE		40.00	0	469		0	
SUBPROVI DE		41.00	Ő	1, 519		0	8
OPERATI NG		50.00	0	103, 653		0	ç
00 RADI OLOGY-		54.00	0	71, 712		0	10
0 PHYSICAL T		66.00 70.00	0	137, 229		0	11
	EPHALOGRAPHY ' PRI VATE OFFI CES	70. 00 192. 00	0	2, 812 1, 076, 789		0	12
TOTALS			o	<u>1, 710, 026</u>		5	
	Charges to Pat			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I		
) HOUSEKEEPI		9.00	0	22		0	1
D PHARMACY		15.00	0	2, 308, 951		0	2
ADULTS & P		30.00	0	3, 768		0	
) I NTENSI VE) SUBPROVI DE		31.00 40.00	0	772		0	2
 SUBPROVI DE SUBPROVI DE 		40.00 41.00	0	2 218		0	
OPERATING		50.00	0	21, 034		0	
	DI AGNOSTI C	54.00	Ö	47, 130		0	8
		57.00	o	1, 412		0	

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

Cost Center 6.00

∕IS-2552-10	u of Form CM	In Lieu			TAL	HOSPI	WESTVI EW	
Prepared:	Worksheet A Date/Time P 5/27/2015 6	od: 01/01/2014 12/31/2014		CCN: 150129	Provi der			
	572172010 0							Decreases
			.	Nkst. A-7 Ref)ther	0	Salary	Line #
				10.00	9.00		8.00	7.00
10.00			D		1)	0	60.00
11.00			o c		8, 930		0	65.00
12.00			o c		581		0	66.00
13.00			o c		11		0	69.00
14.00			o c		294		0	74.00
15.00			o l		3, 399		0	76.01
16.00			o l		2, 122		0	76.05
17.00			o c		12, 136)	0	90.25
18.00			o		5, 179		0	91.00
19.00			D		157, 160		0	192.00
					2, 573, 122		0	
								5
1.00			D		30, 316		0	5.00
2.00			D		192, 703		0	14.00
3.00			D		60		0	15.00
4.00			D		871	2	0	16.00
5.00			D		3, 631	2	0	30.00
4 00			n l		102		0	21 00

	6.00	7.00	8.00	9.00	10.00		
10.00			0.00	9.00			10.00
10.00	LABORATORY	60.00	0	1	0		10.00
11.00	RESPI RATORY THERAPY	65.00	0	8, 930	0		11.00
12.00	PHYSI CAL THERAPY	66.00	0	581	0		12.00
13.00	ELECTROCARDI OLOGY	69.00	0	11	0		13.00
14.00	RENAL DI ALYSI S	74.00	0	294	0		14.00
15.00			0		0		15.00
	WOUND OSTOMY	76.01	0	3, 399	0		1
16.00	CRCC	76.05	0	2, 122	0		16.00
17.00	CLINIC	90.25	0	12, 136	0		17.00
18.00	EMERGENCY	91.00	0	5, 179	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	157, 160	0		19.00
	TOTALS			2, 573, 122			
	L - Chargeable Medical Suppli	05	9	2,070,122	II	4	1
4 00			0	00.01/			1 00
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	30, 316	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	192, 703	0		2.00
3.00	PHARMACY	15.00	0	60	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	871	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3, 631	0		5.00
			0		0		1
6.00	INTENSIVE CARE UNIT	31.00	0	102			6.00
7.00	SUBPROVIDER - IRF	41.00	0	243	0		7.00
8.00	OPERATING ROOM	50.00	0	457, 019	0		8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 647	0		9.00
10.00	CT SCAN	57.00	0	12, 520	0		10.00
11.00	MAGNETIC RESONANCE I MAGING	58.00	0	18, 194	0		11.00
11.00		50.00	U	10, 174	0		11.00
10.00	(MRI)	(5.00		00.004			10.00
12.00	RESPI RATORY THERAPY	65.00	0	29, 234	0		12.00
13.00	PHYSI CAL THERAPY	66.00	0	2, 757	0		13.00
14.00	ELECTROENCEPHALOGRAPHY	70.00	0	512	0		14.00
15.00	WOUND OSTOMY	76.01	0	4, 344	0		15.00
16.00	CRCC	76.05	0	1, 614	0		16.00
17.00	CLINIC	90.25	0 0	720	0		17.00
			-		0		
18.00	EMERGENCY	91.00	0	<u> </u>	<u> </u>		18.00
	TOTALS		0	764, 353]
	M - Rent Expense						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	11, 049	10		1.00
2.00	OPERATION OF PLANT	7.00	0	18, 916			2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	84	0		3.00
					0		1
4.00	PHARMACY	15.00	0	147, 877	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	7, 116	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	28	0		6.00
7.00	SUBPROVI DER – I PF	40.00	0	469	0		7.00
8.00	SUBPROVI DER – I RF	41.00	0	1, 519	0		8.00
9.00	OPERATING ROOM	50.00	0	103, 653	-		9.00
			Ű				1
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	2, 812	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 400	0		11.00
	TOTALS		0	294, 923			
	N - POB Expense						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	81, 955	10		1.00
2.00		0.00		01, 700	0		2.00
2.00			0				2.00
	TOTALS		0	81, 955			-
	Q - STD BENEFIT RECLASS	1			1		4
1.00	ADMI NI STRATI VE & GENERAL	5.00	11, 585	0	-		1.00
2.00	HOUSEKEEPI NG	9.00	360	0	0		2.00
3.00	DI ETARY	10.00	532	0			3.00
4.00	NURSING ADMINISTRATION	13.00	10, 278	0	0		4.00
	CENTRAL SERVICES & SUPPLY			0	0		
5.00		14.00	968	-			5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	810	0	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	2, 350	0	0		7.00
8.00	SUBPROVI DER – I RF	41.00	2, 790	0	0		8.00
9.00	OPERATING ROOM	50.00	8, 442	0			9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	11, 163	0	0		10.00
				0	0		
11.00	PHYSI CAL THERAPY	66.00	9, 358	-			11.00
12.00	ELECTROCARDI OLOGY	69.00	3, 137	0	0		12.00
13.00	WOUND OSTOMY	76.01	1, 240	0	0		13.00
14.00	CRCC	76.05	368	0	0		14.00
15.00	CLINIC	90.25	968	0	0		15.00
16.00	EMERGENCY	91.00	4, 861	0			16.00
				0	0		1
17.00	PHYSICIANS' PRIVATE OFFICES	192.00	35, 772	•			17.00
	TOTALS		104, 982	0			
500.00	Grand Total: Decreases		605, 121	9, 891, 801			500.00

Heal th	Financial Systems	WESTVIEW H	IOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150129		riod: om 01/01/2014	Worksheet A-7 Part I	
					То	12/31/2014	Date/Time Pre	pared:
							5/27/2015 6:1	3 pm
		Destantas	Duraharar	Acquisition Donation	IS	Total	Diamana la and	
		Begi nni ng Bal ances	Purchases	Donation		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	3.00		4.00	5.00	
1.00	Land	1, 910, 000	0		0	0	200, 000	1.00
2.00	Land Improvements	150,000	0		0	0	200,000	
3.00	Buildings and Fixtures	16, 789, 533	0		0	0	395, 842	
4.00	Building Improvements	553, 927	0		0	0	259, 761	
5.00	Fixed Equipment	0	0		0	0	0	
6.00	Movable Equipment	7, 651, 674	0		0	0	34, 554	
7.00	HIT designated Assets	0	0		0	0	0	
8.00	Subtotal (sum of lines 1-7)	27,055,134	0		0	0	890, 157	8.00
9.00	Reconciling Items	0	0		0	0	0	
10.00	Total (line 8 minus line 9)	27,055,134	0		0	0	890, 157	10.00
		Ending Balance	Fully					
		-	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	1, 710, 000	0					1.00
2.00	Land Improvements	150, 000	0					2.00
3.00	Buildings and Fixtures	16, 393, 691	0					3.00
4.00	Building Improvements	294, 166	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	7, 617, 120	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	26, 164, 977	0					8.00
9.00 10.00	Reconciling Items	0	0					9.00 10.00
10.00	Total (line 8 minus line 9)	26, 164, 977	0	I				1 10.00

Heal th	n Financial Systems	WESTVIEW H	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150129	Period: From 01/01/2014	Worksheet A-7 Part II	
					To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
			SL	JMMARY OF CAP	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	WESTVI EW	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
	COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col	instructions)	Insurance	
	1.00	2.00	2) 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	16, 687, 857	C	16, 687, 85	7 0. 686602	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	7, 617, 120					2.00
3.00 Total (sum of lines 1-2)	24, 304, 977		24, 304, 97			3.00
		TION OF OTHER (F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate	Total (sum o cols. 5	f Depreciation	Lease	
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	C)	0 566, 755	1, 286, 809	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	c		0 1, 848, 633		2.00
3.00 Total (sum of lines 1-2)	0	C		0 2, 415, 388	1, 998, 345	3.00
		SI	JMMARY OF CAPI		· · · · ·	
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions) Capi tal -Rel ate	of cols. 9	
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	72, 278	32, 388	1	0 0	1, 958, 230	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0			0 0		2.00
3.00 Total (sum of lines 1-2)	72, 278	-		0 0		3.00
	, ,2,270	02,000	1	- -	1,010,077	0.00

DJUST	MENTS TO EXPENSES			HOSPITAL Provider CCN: 150129	Period: From 01/01/2014	u of Form CMS-2 Worksheet A-8	
					To 12/31/2014	Date/Time Pre 5/27/2015 6:13	
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 0	1. (
00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL				2.00		
	COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP			
00	Investment income - other (chapter 2)		0		0.00	0	3. (
00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. (
00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. (
00	Rental of provider space by		0		0.00	0	6. (
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter	A	-3, 028	CAP REL COSTS-MVBLE EQUIP	2.00	9	7.0
00	21) Tel evi si on and radio servi ce	А	-10, 865	ADMI NI STRATI VE & GENERAL	5.00	0	8.
00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.
0. 00	Provider-based physician adjustment	A-8-2	-327, 655			0	10.
1.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.
2.00	Related organization	A-8-1	1, 765, 591			0	12.
3. 00	transactions (chapter 10) Laundry and linen service		0		0.00		
4.00 5.00	Cafeteria-employees and guests Rental of quarters to employee		-126, 224 0	CAFETERI A	11.00 0.00		
5. 00	and others Sale of medical and surgical		0		0.00		
5. 00	supplies to other than		0		0.00	0	10.
7.00	patients Sale of drugs to other than		0		0.00	0	17.
3. 00	patients Sale of medical records and		0		0.00	0	18.
9.00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.
0. 00	books, etc.) Vending machines		0		0.00	0	20.
	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		
2. 00	Interest expense on Medicare		0		0.00	0	22.
	overpayments and borrowings to repay Medicare overpayments						
3. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
4.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
	therapy costs in excess of limitation (chapter 14)						
5.00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		25.
	(chapter 21)		_			_	
5. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
3.00 9.00	Non-physician Anesthetist Physicians'assistant		0	*** Cost Center Deleted ***	19.00 0.00		28. 29.
	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.
). 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.
1.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
-	pathology costs in excess of limitation (chapter 14)		-				
2. 00	CAH HIT Adjustment for		0		0.00	0	32.
	Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. (

Heal th	Financial Systems		WESTVIEW H	HOSPI TAL	In Li€	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2014 To 12/31/2014		pared:
				Expense Classification o			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	HAF Tax Offset	A	-2, 256, 203	ADMI NI STRATI VE & GENERAL	5.00	0	34.00
38.00	Bad Debt Expense	A	-7, 606, 106	ADMI NI STRATI VE & GENERAL	5.00	0	38.00
38.01	Bad Debt Expense	A	-92, 533	PHYSICIANS' PRIVATE OFFICES	192.00	0	38.01
39.00	Non-Allowable Penalties	A	-496	ADMI NI STRATI VE & GENERAL	5.00	0	39.00
45.06	Misc Revenue	В	-5,009	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	Misc Revenue	В	-129, 242	OPERATION OF PLANT	7.00	0	45.07
45.08	Misc Revenue	В	-367	PHARMACY	15.00	0	45.08
45.09	Misc Revenue	В	-83, 548	MEDICAL RECORDS & LIBRARY	16.00	0	45.09
45.10	Misc Revenue	В	- 300	I&R SERVICES-SALARY &	21.00	0	45.10
				FRINGES APPRVD			
	Misc Revenue	В		LABORATORY	60.00		
45. 16	Misc Rev - Mgd Card Access Fees	В	-14, 182	ADMI NI STRATI VE & GENERAL	5.00	0	45.16
45.20	Equity Investment Gain/Loss	В	-547, 579	ADMINISTRATIVE & GENERAL	5.00	0	45.20
48. 17	Misc Revenue - 35200 (MOW)	В	-42,664	CAFETERIA	11.00	0	48.17
48. 22	Television & Radio Service	A	-4, 978	CAP REL COSTS-BLDG & FIXT	1.00	9	48. 22
48.23	Non Allow Marketing Expense	A	-295, 227	ADMINISTRATIVE & GENERAL	5.00	0	48.23
48.25	VEI Interest Income Loans	В	-18, 269	ADMINISTRATIVE & GENERAL	5.00	0	
48.26	Misc Revenue - Acct 35300	В	-40, 179	ADMINISTRATIVE & GENERAL	5.00	0	48.26
49.00	Purchased Discounts	В	-6, 173	ADMI NI STRATI VE & GENERAL	5.00	0	1 171 00
49.02	Heal thpl ex Subsidy	A		EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	1
49.04	Physician Coverage	A		OPERATING ROOM	50.00		1 1 2 . 0 .
49.09	Physician Recruitment Cost	A	-3, 139	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	49.09
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9, 328, 187				50.00

(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.

Financial Systems	WESTVI EW	HOSPI T	TAL	In Lie	eu of Form CMS-	2552-10
	RELATED ORGANIZATIONS AND HO	ME	Provider CCN: 150129	Peri od:		-1
OFFICE COSTS					Date/Time Pre	
Line No.	Cost Center		Expense Items	Amount of	Amount	
1.00				4.00		
	MENTS REQUIRED AS A RESULT OF	TRANSA	ACTIONS WITH RELATED (ORGANIZATIONS OR	CLAI MED	
		POB			71, 712	1.00
66.00	PHYSI CAL THERAPY	POB		49, 328	137, 229	2.00
192.00	PHYSICIANS' PRIVATE OFFICES	POB		66, 876	186, 054	3.00
1.00	CAP REL COSTS-BLDG & FIXT	CHNW -	HOME OFFICE	51, 244	0	4.00
2.00	CAP REL COSTS-MVBLE EQUIP	CHNW -	HOME OFFICE	337, 129	0	4.01
5.00	ADMINISTRATIVE & GENERAL	CHNW -	HOME OFFICE	1, 630, 239	0	4.02
TOTALS (sum of lines 1-4).				2, 160, 586	394, 995	5.00
Transfer column 6, line 5 to						
Worksheet A-8, column 2,						
line 12.						
	E COSTS Line No. 1.00 A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS: 54.00 66.00 192.00 1.00 2.00 5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	LI NO OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HO COSTS LI NO COSTS COSTS LI NO COSTS CONTERNO A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF HOME OFFICE COSTS: 54. 00 RADIOLOGY-DIAGNOSTIC 66. 00 PHYSICAL THERAPY 192. 00 PHYSICAL THERAPY 193. 00 PHY	IENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME COSTS Line No. Cost Center 1.00 2.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANS/ HOME OFFICE COSTS: 54.00 RADIOLOGY-DIAGNOSTIC 66.00 PHYSICAL THERAPY 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 5.00 ADMINISTRATIVE & GENERAL TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	IENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 150129 Line No. Cost Center Expense I tems 1.00 2.00 3.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED OF HOME OFFICE COSTS: POB 54.00 RADIOLOGY-DIAGNOSTIC POB 66.00 PHYSICAL THERAPY POB 1.00 CAP REL COSTS-BLDG & FIXT CHNW - HOME OFFICE 1.00 CAP REL COSTS-BLDG & FIXT CHNW - HOME OFFICE 1.00 CAP REL COSTS-MVBLE EQUIP CHNW - HOME OFFICE 1.00 CAP REL COSTS-MVBLE EQUIP CHNW - HOME OFFICE CAP REL COSTS - MVBLE A GENERAL CHNW - HOME OFFICE CHNW - HOME OFFICE TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, CHNM - HOME OFFICE	IENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOMEProvider CCN: 150129Period: From 01/01/2014 To 12/31/2014Line No.Cost CenterExpense I temsAmount of AI I owable Cost1.002.003.004.00A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS:POB POB POB POB25,770 49,328 66,87654.00ADIOLOGY-DIAGNOSTIC 66.00POB PHYSICAL THERAPY 2.00POB POB POB POB25,770 49,328 66,87654.00CAP REL COSTS-BLDG & FIXT 2.00CHNW - HOME OFFICE CHNW - HOME OFFICE51,244 337,12910TALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,Condministrative & GENERAL VersionCHNW - HOME OFFICE CHNW - HOME OFFICE1,630,239 2,160,586	IENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOMEProvider CCN: 150129Period: From 01/01/2014 To 12/31/2014Worksheet A-8Line No.Cost CenterExpense I temsAmount of All owable CostMount of All owable CostMount of All owable Cost1.002.003.004.005.00A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF HOME OFFICE COSTS:POB POB25,77071,71254.00 RADIOLOGY-DI AGNOSTIC 00 PHYSI CAL THERAPY 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 5.00 ADMINISTRATIVE & GENERALPOB POB CHNW - HOME OFFICE CHNW - HOME OFFICE25,770 49,32871,712 49,328TOTALS (sum of Lines 1-4). Transfer column 6, Line 5 to Worksheet A-8, column 2,FIXT CHNW 2,00CHNW - HOME OFFICE CHNW - HOME OFFICE1,630,239 2,160,586394,995

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
	Name	Ownershi p	Name	Ownershi p	
1.00	2.00	3.00	4.00	5.00	1
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII

rermbur	Schert under trite Aviir.				
6.00	В	CHNW	70.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

(1) Use the following symbols to indicate 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.

Health Financial Systems WEST	TVIEW HOSPI	TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AN	ND HOME	Provider CCN: 150129	Period: From 01/01/2014	Worksheet A-8-1
OFFICE COSTS				Date/Time Prepared:

			5/27/2015 6:	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	-45, 942	0		1.00
2.00	-87, 901	0		2.00
3.00	-119, 178	0		3.00
4.00	51, 244	9		4.00
4.01	337, 129	9		4.01
4.02	1, 630, 239	0	1	4.02
5.00	1, 765, 591			5.00

* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

nus not	been posted to norksheet n,		
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	TED 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
6.00 7.00 8.00 9.00 10.00 100.00	100.00

(1) Use the following symbols to indicate 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.

Heal th	Financial Syste	ems	WESTVI EW	HOSPI TA	L		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC					CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8	B-2
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Profess Compo		Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4. (00	5.00	6.00	7.00	
1.00		AGGREGATE - EMERGENCY	327, 655		327,655		0 0		1.00
2.00	0.00		0		0		o o	0	2.00
3.00	0.00		0		0		o 0	0	3.00
4.00	0.00		0		0		o o	0	4.00
5.00	0.00		0		0		o o	0	5.00
6.00	0, 00		0		0		0 0	0	6.00
7.00	0, 00		0		0		0 0	0	7.00
8.00	0.00		0		0		0 0	0	8.00
9.00	0, 00		0		0		0 0	0	9.00
10.00	0.00		0		0		0 0	0	10.00
200.00			327, 655		327, 655		0	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	
		I denti fi er	Limit			Memberships &		of Malpractice	
				Lim		Conti nui ng	Share of col.	Insurance	
						Education	12		
	1.00	2.00	8.00	9. (00	12.00	13.00	14.00	
1.00	91.00	AGGREGATE-EMERGENCY	0		0		0 0	0	1.00
2.00	0.00		0		0		0 0	0	2.00
3.00	0.00		0		0		0 0	0	3.00
4.00	0.00		0		0		0 0	0	4.00
5.00	0.00		0		0		0 0	0	5.00
6.00	0.00		0		0		0 0	0	6.00
7.00	0.00		0		0		o 0	0	7.00
8.00	0.00		0		0		o 0	0	8.00
9.00	0.00		0		0		o 0	0	9.00
10.00	0.00		0		0		o 0	0	10.00
200.00			0		0		o 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjuste	ed RCE	RCE	Adj ustment		
		Identi fi er	Component	Lim	it	Di sal I owance			
			Share of col.						
			14						
	1.00	2.00	15.00	16.		17.00	18.00		
1.00		AGGREGATE-EMERGENCY	0		0		0 327, 655		1.00
2.00	0.00		0		0		0 0		2.00
3.00	0.00		0		0		0 0		3.00
4.00	0.00		0		0		0 0		4.00
5.00	0.00		0		0		0 0		5.00
6.00	0.00		0		0		0 0		6.00
7.00	0.00		0		0		0 0		7.00
8.00	0.00		0		0		0 0		8.00
9.00	0.00		0		0		0 0		9.00
10.00	0.00		0		0		o 0		10.00
200.00			0		0		0 327,655		200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	WESTVIEW F			Period: From 01/01/2014	u of Form CMS-: Worksheet B Part I	2002 10
					To 12/31/2014		
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1, 958, 230	1, 958, 230				1.00
2.00 4.00 5.00 7.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	2, 560, 169 3, 937, 653 5, 924, 768 1, 931, 833	0 635, 803 147, 882	2, 560, 16 831, 24	0 3, 937, 653 0 368, 043	7, 759, 854	2.00 4.00 5.00
8.00 9.00 10.00 11.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	4, 316 519, 435 125, 655 490, 069	2, 082 17, 892 6, 009 42, 277	23, 39 7, 85 55, 27	2 47, 185 7 13, 474 2 67, 431	152, 995 655, 049	9.00 10.00 11.00
13.00 14.00 15.00 16.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	128, 412 322, 642 531, 349 641, 058	12, 700 25, 760 14, 039 30, 481	33, 67 18, 35 39, 85	9 29, 103 4 65, 891 1 49, 967	411, 184 629, 633 761, 357	14.00 15.00 16.00
21. 00 22. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	1, 261, 669 96, 118	4, 411 0		7 172, 306 0 9, 269	1, 444, 153 105, 387	
30. 00 31. 00 32. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	2, 078, 479 370, 330 0	240, 155 32, 501 0	42, 49	1 59, 134 0 0	504, 456 0	31.00 32.00
33.00 34.00 40.00 41.00 42.00	03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0 0 260, 933 565, 819	0 0 14, 063 44, 743 0	18, 38		0 0 333, 230 749, 880 0	34.00 40.00 41.00
43.00 44.00 45.00 46.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE		0 0 0 0			0 0 0	43.00 44.00 45.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM				- I		
50.00 51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 600, 875 0 0	205, 895 0 0		5 282, 626 0 0 0 0	4, 358, 581 0 0	51.00 52.00
53.00 54.00 55.00 56.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 965, 141 0	0 184, 670 0	241, 43	0 0 6 137, 216 0 0	0 1, 528, 463 0 0	54.00 55.00
57.00	05700 CT SCAN 05700 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	132, 769 134, 926	0		0 18, 998 0 16, 667	151, 767 151, 593	57.00
59.00 60.00 60.01 61.00 62.00 63.00	06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	2, 082, 331 0 0 0	45, 102 0 0	58, 96	6 6, 187 0 0 0 0	2, 192, 586 0 0 0 0	60.00 60.01 61.00
64.00 65.00 66.00 67.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 441, 869 712, 826 124, 753	0 0 11, 003 87, 267 13, 531	14, 38 114, 09	2 125, 091	0	64.00 65.00 66.00
68.00 69.00 70.00 71.00 72.00 73.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	26, 931 26, 941 459, 448 144, 870 764, 353 1, 790, 118 2, 573, 122 90, 717	2, 825 4, 547 0 0 0	3, 69 5, 94	3 4, 104	36, 663	68.00 69.00 70.00 71.00 72.00 73.00
75.00	07500 ASC (NON-DI STINCT PART) 03020 ENDOSCOPY CENTER 03950 WOUND OSTOMY 03480 CRCC	0 0 828, 423 212, 972	0 0 63, 192 25, 029			0	75.00 76.00 76.01
88.00 89.00 90.00 90.23	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09023 CLINIC	000000000000000000000000000000000000000	000000000000000000000000000000000000000			0 0 0 0	89.00 90.00
90. 25 90. 27 91. 00	09025 CLINIC 09027 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	173, 490 0 2, 397, 266	0 0 0 44, 371	58, 01	0 24, 148 0 0 0 342, 628	197, 638 0 2, 842, 275	90. 25 90. 27

Health Financial Systems	WESTVIEW H	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150129	Period:	Worksheet B	
				From 01/01/2014	Part I	
				To 12/31/2014	Date/Time Pre	pared:
			ATED COSTS		5/27/2015 6:1	<u>3 pm</u>
		CAPITAL REL	LATED CUSIS			
Cast Contor Description	Not Exponence	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
Cost Center Description	Net Expenses for Cost	BLUG & FIXI	WVBLE EQUIP	BENEFITS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A			DEPARTMENT		
	•					
	<u>col.7)</u> 0	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS	0	1.00	2.00	4.00	4A	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	97.00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	-	
	0	0		0 0	0	
	0	0		0 0	-	99.00
99.10 09910 CORF	0	0		0 0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	1	0 0	0	105.00
	0	0		-		
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0	0 5 (0 1)	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	41, 365, 247	1, 958, 230	2, 560, 16	2, 667, 015	40, 094, 609	118.00
NONREI MBURSABLE COST CENTERS		0		0	0	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191.00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	9, 970, 949	0		0 1, 270, 638		
193.00 19300 NONPAI D WORKERS	0	0		0 0		193.00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.00
194.06 07956 CHN MOB	0	0		0 0		194.06
194.08 07958 FOUNDATION OPS	-743	0		0 0		194.08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	E4 005 155	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	51, 335, 453	1, 958, 230	2, 560, 16	3, 937, 653	51, 335, 453	202.00

	Financial Systems NLLOCATION - GENERAL SERVICE COSTS	WESTVIEW H		F	In Lie eriod: rom 01/01/2014 o 12/31/2014	u of Form CMS-: Worksheet B Part I Date/Time Pre	
	Cost Contor Deserintion			LAUNDRY &	HOUSEKEEPING	5/27/2015 6:1	3 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LINEN SERVICE		DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL	7 750 054					4.00
5.00 7.00	00700 OPERATION OF PLANT	7, 759, 854 420, 357	2, 780, 917				5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 624	4, 929				8.00
9.00	00900 HOUSEKEEPI NG	108, 253	42, 362				9.00
10.00	01000 DI ETARY	27, 245	14, 228			198, 457	10.00
11.00		116, 648	100, 097			99, 232	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	31,085	30, 070		-/	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	73, 222 112, 122	60, 991 33, 239		17, 098 9, 318	0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	135, 579	72, 168			0	16.00
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRVD	257, 168	10, 444			0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	18, 767	0	0	0	0	22.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	F 20, 007	F(0, (0)	1 740	150.40/	F/ 100	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	530, 097 89, 831	568, 603 76, 950			56, 122 9, 504	30.00
32.00	03200 CORONARY CARE UNI T	07,031	70, 950			9, 504 0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	0		0	34.00
40.00	04000 SUBPROVIDER - IPF	59, 340	33, 297			7, 811	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	133, 535	105, 935	669		25, 788 0	41.00
42.00	04300 NURSERY	0			0	0	42.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	C	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	C	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
F0 00		77/ 15/	407 400	2.004	124 444	0	50.00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	776, 154	487, 489 0			0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0	-	0	52.00
53.00	05300 ANESTHESI OLOGY	0	C	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	272, 181	437, 235	511		0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	27, 026	0	0	0	0	56.00 57.00
57.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	26, 995	0		0	0	57.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	Ő	0	0	0	59.00
60.00	06000 LABORATORY	390, 445	106, 786	0	29, 937	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C	0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	C	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	96, 387	26, 051	0	7, 303	0	65.00
66.00	06600 PHYSI CAL THERAPY	185, 069	206, 619		57, 924	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	31, 276	32, 036			0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 529 96, 818	6, 689 10, 767		.,	0	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	29, 942	10, 707	423		0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	136, 112	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	318, 775	C	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	458, 209	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	16, 154	0	63	0	0	74.00
75.00 76.00	07500 ASC (NON-DI STINCT PART) 03020 ENDOSCOPY CENTER		0		0	0	75.00 76.00
76.00	03950 WOUND OSTOMY	179, 426	149, 617	0	41, 944	0	76.00
76.05	03480 CRCC	54, 311	59, 260			0	76.05
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		0	0	89.00 90.00
90.00 90.23	09023 CLINIC	0			0	0	90.00
90.25	09025 CLINIC	35, 194	0	0	0	0	90.25
90. 27	09027 CLI NI C	0	0	0	0	0	90. 27
91.00	09100 EMERGENCY	506, 138	105, 055	1, 556	29, 451	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
95.00	COULDER NOL SERVICES						
95. 00 96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	C	0	0	0	96.00 97.00

Health Financial Systems	WESTVIEW H	HOSPI TAL		In Lie	u of Form CMS-2!	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prep 5/27/2015 6:13	
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVIC	HOUSEKEEPI NG	DI ETARY	pm
	5.00	7.00	8.00	9.00	10.00	
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0 1	00.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0 1	01.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0 1	05.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0 1	06.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0 1	07.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0 1	08.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0 1	09.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0 1	10.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0 1	11.00
113.00 11300 INTEREST EXPENSE					1	13.00
114.00 11400 UTILIZATION REVIEW-SNF					1	14.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0 1	15.00
116. 00 11600 HOSPI CE	0	0		0 0	0 1	16.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	5, 758, 014	2, 780, 917	15, 67	2 766, 355	198, 457 1	18.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		90.00
191. 00 19100 RESEARCH	0	0		0 0		91.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2,001,840	0		0 0		92.00
193.00 19300 NONPALD WORKERS	0	0		0 0		93.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		0 0		94.00
194.0607956CHN MOB	0	0		0 0		94.06
194.0807958 FOUNDATION OPS	0	0		0 0		94.08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	7, 759, 854	2, 780, 917	15, 67	2 766, 355	198, 457 2	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	WESTVIEW H		CCN: 150129	Peri od: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet B Part I Date/Time Pre	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	5/27/2015 6: 1 MEDI CAL RECORDS & LI BRARY	3 pm
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS	1					
. 00	00100 CAP REL COSTS-BLDG & FIXT						1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.0
. 00	00700 OPERATI ON OF PLANT						7.0
. 00	00800 LAUNDRY & LINEN SERVICE						8.0
. 00	00900 HOUSEKEEPI NG						9.0
0.00	01000 DI ETARY]					10.0
1.00	01100 CAFETERI A	999, 088					11.0
3.00	01300 NURSI NG ADMI NI STRATI ON	13, 233					13.0
4.00	01400 CENTRAL SERVICES & SUPPLY	26, 466					14.0
5.00 6.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	33, 082		298, 05 88		1 410 449	15.0
1.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	46, 315 0		55		1, 610, 668 0	
2.00	02200 I & SERVICES-OTHER PRGM COSTS APPRVD	0	-	37		0	
2.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	ŭ				0	22.0
0.00	03000 ADULTS & PEDI ATRI CS	191, 879	50, 093	2, 69	93 0	46, 327	30. 0
1.00	03100 INTENSIVE CARE UNIT	26, 466	6, 910	22		8, 084	
2.00	03200 CORONARY CARE UNI T	0	0		0 0	0	
3.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
4.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0		0 0	0	
0.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	13, 233		53	6 0	6, 720	
1.00	04100 SUBPROVIDER - TRF	52, 932	13, 819 0	50	0 0	16, 680 0	
3.00	04300 NURSERY	0	0		0 0	0	
4.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0	0	
5.00	04500 NURSING FACILITY	0	0		0 0	0	
6.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	46.0
	ANCI LLARY SERVI CE COST CENTERS	1					
0.00	05000 OPERATI NG ROOM	165, 412		51, 21		290, 070	
1.00	05100 RECOVERY ROOM	0	-		0 0	0	
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
3.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	79, 398	20, 729	2, 61	-	0 121, 295	
5.00	05500 RADI OLOGY-THERAPEUTI C	/ 9, 390	20, 729	2,0	0 0	121, 293	
6.00	05600 RADI OI SOTOPE	0	0		0 0	0	
7.00	05700 CT SCAN	6, 616	1, 727	1, 50		57, 741	
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	6, 616	1, 727	80	0 00	36, 857	58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0	-		0 0	0	
0.00	06000 LABORATORY	6, 616		4,43		217, 952	
0.01	06001 BLOOD LABORATORY	0	0		0 0	0	
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	61.0 62.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	
4.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	1
5.00	06500 RESPI RATORY THERAPY	46, 315	12, 092	72	29 0	19, 525	
6.00	06600 PHYSI CAL THERAPY	66, 165	17, 274	60	0 0	42, 757	66.0
7.00	06700 OCCUPATI ONAL THERAPY	13, 233		12		8, 496	
8.00	06800 SPEECH PATHOLOGY	0	0		26 0	2, 670	
9.00		59, 548	15, 547	1, 0		58, 677	
	07000 ELECTROENCEPHALOGRAPHY	0	0	57 12		29, 326	
1.00 2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			57, 1 ⁻ 133, 75		51, 569 120, 766	
3.00	07300 DRUGS CHARGED TO PATIENTS			133,71	0 562,044	144, 006	
4.00	07400 RENAL DIALYSIS	0	0		32 0	3, 443	
5.00	07500 ASC (NON-DI STINCT PART)	0	0		0 0	0,110	
6.00	03020 ENDOSCOPY CENTER	0	0		0 0	0	76.0
6. 01	03950 WOUND OSTOMY	26, 466	6, 910	6, 56		54, 659	76. C
6. 05	03480 CRCC	0	0	72	28 0	19, 719	76. C
0 00	OUTPATIENT SERVICE COST CENTERS				0		
8.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	
0.23	09023 CLINIC	0				0	
0.25	09025 CLI NI C	0	0	2, 17	75 0	8, 115	
0.27	09027 CLINIC	0	0		0 0	0,110	90.2
1.00	09100 EMERGENCY	119, 097	31, 093	6, 74	45 0	245, 214	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	OTHER REIMBURSABLE COST CENTERS	1					1.
	09400 HOME PROGRAM DIALYSIS	0	0	1	0 0	0	94. C
4.00			0		0 0	0	95.0

Health Financial Systems	WESTVIEW I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part I Date/Time Pre 5/27/2015 6:1	
Cost Center Description		NURSI NG ADMI NI STRATI ON	SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99.00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS			_			
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	999, 088	257, 382	574, 239	1, 124, 088	1, 610, 668	118.00
NONREI MBURSABLE COST CENTERS			_			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	21, 873	0	0	192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.0607956 CHN MOB	0	0	0	0	0	194.06
194.0807958 FOUNDATION OPS	0	0	0	0	0	194. 08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	999, 088	257, 382	596, 112	1, 124, 088	1, 610, 668	202.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Pre	nared.
					10 12/31/2014	5/27/2015 6:1	3 pm
		INTERNS &	RESIDENTS				
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		21.00	22.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION						1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00
14.00 15.00 16.00 21.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRVD	1, 715, 245	124 524				14.00 15.00 16.00 21.00
22.00	02200 I & SERVI CES-OTHER PRGM COSTS APPRVD I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	124, 526				22.00
30. 00 31. 00 32. 00 33. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T	143, 129 0 0 0	10, 391 0 0 0	4, 737, 29 743, 99		4, 583, 776 743, 994 0 0	31.00 32.00
34.00 40.00 41.00 42.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0 0 0 0	0 0 0 0	466, 61 1, 129, 47		0 466, 611 1, 129, 473 0	40. 00 41. 00
43.00 44.00 45.00 46.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE	0 0 0 0	0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	44. 00 45. 00
	ANCILLARY SERVICE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	42, 497	3, 085 0	6, 356, 35	5 -45, 582 0 0	6, 310, 773 0	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	33, 575	2, 437	36, 01		0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0	2, 585, 00		2, 585, 004 0	1
56.00	05600 RADI OLOGI - THERAPEOTIC	0	0		0 0	0	
57.00	05700 CT SCAN	0	0	246, 38		246, 383	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	224, 58	8 0	224, 588	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	2, 950, 48	0 0	0 2, 950, 482	
60. 01	06001 BLOOD LABORATORY	0	0	, ,	0 0	0	60.0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0	
62.00 63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	0	749, 67		749, 674	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	1, 615, 69 273, 23		1, 615, 690 273, 239	
58. 00	06800 SPEECH PATHOLOGY	0	0	54, 45		54, 452	
69.00	06900 ELECTROCARDI OLOGY	0	0	789, 50		789, 504	
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	228, 13 1, 009, 15		228, 130 1, 009, 152	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	2, 363, 42		2, 363, 429	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	3, 737, 38	0	3, 737, 381	73.0
74.00	07400 RENAL DIALYSIS	0	0	110, 40	0 0	110, 409	
75.00 76.00	07500 ASC (NON-DI STINCT PART) 03020 ENDOSCOPY CENTER	0	0			0	
76. 01	03950 WOUND OSTOMY	71, 288	5, 176	1, 549, 63		1, 473, 168	76.0
76. 05	03480 CRCC OUTPATIENT SERVICE COST CENTERS	0	0	456, 06	07 0	456, 067	76.0
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00 90.23	09000 CLINIC 09023 CLINIC	0	0		0 0	0	90.00 90.2
90.23 90.25	09023 CLINIC 09025 CLINIC	0	0	243, 12		0 243, 122	
90. 23 90. 27	09027 CLINIC 09100 EMERGENCY	55, 283	4, 014	59, 29 3, 886, 62	-59, 297	0 3, 886, 624	90. 2
91.00							

Health Financial Systems	WESTVIEW H	IOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 5/27/2015 6:13 pm
Cost Center Description	I NTERNS & SERVI CES-SALAR Y & FRI NGES		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
	21.00	22.00	24.00	25.00	26.00
OTHER REIMBURSABLE COST CENTERS	1				
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0 94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0 97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0 98.00
99. 00 09900 CMHC	0	0		0 0	0 99.00
99. 10 09910 CORF	0	0		0 0	0 99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0 100.00
101. 00 10100 HOME HEALTH AGENCY	0	0		0 0	0100.00
SPECIAL PURPOSE COST CENTERS	U U	0	l	0 0	0101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0 105.00
	0				
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0 106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0 107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0	0 108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0	0 109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0 110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0 111. 00
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0 115.00
116. 00 11600 H0SPI CE	0	0		0 0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	345, 772	25, 103	36, 602, 0	- 370, 875	<u>36, 231, 125</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	
191. 00 19100 RESEARCH	47, 188	3, 426			0 191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 322, 285	95, 997	14, 683, 5	82 -1, 418, 282	13, 265, 300 192. 00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0 193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0 194.00
194.0607956 CHN MOB	0	0		0 0	0 194.06
194.0807958 FOUNDATION OPS	0	0	-7	43 0	-743 194.08
200.00 Cross Foot Adjustments	0	0		0 0	0 200. 00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 TOTAL (sum lines 118-201)	1, 715, 245	124, 526	51, 335, 4	53 -1, 839, 771	49, 495, 682 202. 00

	I Financial Systems ATION OF CAPITAL RELATED COSTS	WESTVIEW H		1	Period: From 01/01/2014 To 12/31/2014	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/27/2015 6:1	pared:
			CAPI TAL REI	ATED COSTS		0/2//2010 0.1	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	635, 803			0	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	147, 882	193, 34		0	7.00
8.00 9.00	00900 HOUSEKEEPING	0	2, 082 17, 892			0	9.00
10.00	01000 DI ETARY	0	6, 009			0	10.00
11.00	01100 CAFETERIA	0	42, 277			0	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	12, 700 25, 760			0	13.00
15.00	01500 PHARMACY	0	14, 039			0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	30, 481	39, 85	1 70, 332	0	16.00
21.00	02100 I & SERVICES-SALARY & FRINGES APPRVD	0	4, 411	5, 76		0	21.00
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRVD I NPATI ENT ROUTI NE SERVICE COST CENTERS	0	0		0 0	0	22.00
30.00	03000 ADULTS & PEDI ATRI CS	0	240, 155	313, 97	7 554, 132	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	32, 501	42, 49		0	31.00
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	34.00
40.00	04000 SUBPROVI DER – I PF	0	14, 063	18, 38	6 32, 449	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	44, 743	58, 49	6 103, 239	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0	0			0	42.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0	0		0 0	0	44.00
45.00	04500 NURSING FACILITY	0	0		0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	46.00
50.00	05000 OPERATI NG ROOM	0	205, 895	269, 18	5 475, 080	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0			0	52.00 53.00
54.00	05400 RADI OLOGY – DI AGNOSTI C	0	184, 670			0	53.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	57.00 58.00
59.00		0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	45, 102	58, 96	6 104, 068	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	14.00		0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	11, 003 87, 267	14, 38 114, 09		0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	13, 531	17, 69		0	67.00
68.00	06800 SPEECH PATHOLOGY	0	2, 825			0	68.00
69.00		0	4, 547	5, 94	5 10, 492	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00		0	0		0 0	0	73.00
74.00 75.00		0	0			0	74.00
76.00	03020 ENDOSCOPY CENTER	0	0		0 0	0	76.00
76.01	03950 WOUND OSTOMY	0	63, 192			0	76.01
76.05	03480 CRCC OUTPATI ENT SERVI CE COST CENTERS	0	25, 029	32, 72	3 57, 752	0	76.05
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00 90.23	09000 CLINIC 09023 CLINIC	0	0		0 0	0	90.00 90.23
90. 23 90. 25	09023 CLINIC 09025 CLINIC	0	0			0	90.23
90. 27	09027 CLI NI C	0	0		0 0	0	90. 27
91.00	09100 EMERGENCY	0	44, 371	58, 01	0 102, 381	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00

Health Financial Systems	WESTVIEW H	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2014		
				Го 12/31/2014	Date/Time Pre 5/27/2015 6:1	area:
		CAPI TAL REI	ATED COSTS		1 37 217 2013 0.1	
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4.00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	(0 0	C	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	(0 0	C	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(0 0	C	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(0 0	C	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0	(0 0	C	98.00
99.00 09900 CMHC	0	0	(0 0	C	99.00
99. 10 09910 CORF	0	0	(0 0	C	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	(0 0	C	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	(0 0	C	101.00
SPECIAL PURPOSE COST CENTERS				_		
105.00 10500 KIDNEY ACQUISITION	0	0	(0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	(0 0	C	106.00
107.00 10700 LIVER ACQUISITION	0	0	(0 0	C	107.00
108.00 10800 LUNG ACQUISITION	0	0	(0 0	C	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	(0 0	C	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0 0	C	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(0 0	C	115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 958, 230	2, 560, 169	4, 518, 399	0	118.00
NONREI MBURSABLE COST CENTERS	1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0		190. 00
191. 00 19100 RESEARCH	0	0	(0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0	(0 0		193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0 0		194.00
194.0607956 CHN MOB	0	0	(0 0		194.06
194.0807958 FOUNDATION OPS	0	0	(0 0	0	194. 08
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	(0 0		201.00
202.00 TOTAL (sum lines 118-201)	0	1, 958, 230	2, 560, 169	4, 518, 399	0	202.00

				F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 6:1	pared: 3 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1, 467, 043					4.00 5.00
	00700 OPERATION OF PLANT	79, 471	420, 693				7.00
	00800 LAUNDRY & LINEN SERVICE	307	746				8.00
	00900 HOUSEKEEPI NG	20, 466	6, 408	2, 927	71, 085		9.00
	01000 DI ETARY	5, 151	2, 152		370	21, 539	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	22, 053 5, 877	15, 143 4, 549		2, 603 782	10, 770 0	11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	13, 843	9, 227	90	1, 586	0	13.00
	01500 PHARMACY	21, 197	5, 028		864	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	25, 632	10, 918		1, 877	0	16.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	48, 619	1, 580		272	0	21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	3, 548	0	0	0	0	22.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	100, 217	86, 016	650	14, 784	6, 091	30.00
	03100 I NTENSI VE CARE UNI T	16, 983	11, 641	0	2, 001	1, 031	31.00
32.00	03200 CORONARY CARE UNI T	0	0	0	0	0	32.00
	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0 5 027	0	0	0	34.00
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	25, 245	5, 037 16, 026		866 2. 755	848 2, 799	1
	04200 SUBPROVI DER	23, 243	10, 020	0	2, 735	2, 7,7	42.00
	04300 NURSERY	0	0	0	0	0	43.00
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
	04500 NURSING FACILITY	0	0	0	0	0	45.00
	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
	05000 OPERATING ROOM	146, 736	73, 747	749	12, 677	0	50.00
	05100 RECOVERY ROOM	0	0		0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY - DI AGNOSTI C	51, 457	66, 144		11, 370	0	54.00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0	0	0	55.00 56.00
	05700 CT SCAN	5, 109	0	0	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 104	0	0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
		73, 816	16, 154	0	2, 777	0	60.00
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01 61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
		18, 222	3, 941	0	677	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	34, 988 5, 913	31, 257 4, 846		5, 373 833	0	66.00 67.00
	06800 SPEECH PATHOLOGY	1, 234	1, 012		174	0	68.00
69.00	06900 ELECTROCARDI OLOGY	18, 304	1, 629		280	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	5, 661	0	0	0	0	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	25, 733	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	60, 266 86, 627	0		0	0	72.00 73.00
	07400 RENAL DI ALYSI S	3, 054	0	24	0	0	74.00
	07500 ASC (NON-DI STI NCT PART)	0	0	0	Ő	0	75.00
	03020 ENDOSCOPY CENTER	0	0	0	0	0	76.00
	03950 WOUND OSTOMY	33, 921	22, 634		3, 891	0	76.01
	03480 CRCC OUTPATI ENT SERVI CE COST CENTERS	10, 268	8, 965	166	1, 541	0	76.05
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	Ő	0	89.00
	09000 CLINIC	0	0	0	0	0	90.00
	09023 CLINIC	0	0	0	0	0	90.23
	09025 CLINIC 09027 CLINIC	6, 654	0	0	0	0	90.25 90.27
	09100 EMERGENCY	95, 688	15, 893	582	2, 732	0	90.27
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				2,		92.00
	OTHER REIMBURSABLE COST CENTERS	1		1	I		
01	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
	ANDULANCE CEDVILOEC						
95.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	95.00 96.00

Health Financial Systems	WESTVLEW F	WESTVI EW HOSPI TAL				2552-10
ALLOCATION OF CAPITAL RELATED COSTS				Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II	pared:
Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPING	DI ETARY	
	5.00	7.00	8.00	9.00	10.00	
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,088,583	420, 693	5, 85	6 71, 085	21, 539	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	378, 460	0		0 0		192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
194.0607956CHN MOB	0	0		0 0		194.06
194.0807958 FOUNDATION OPS	0	0		0 0	0	194. 08
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	1, 467, 043	420, 693	5, 85	6 71, 085	21, 539	202.00

	Financial Systems	WESTVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	1	Period: From 01/01/2014 Fo 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 6:1	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1 00	GENERAL SERVICE COST CENTERS	1	1				1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A	148, 118	3				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 962					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 924					14.00
15.00		4, 905				470.040	15.00
16.00 21.00	01600 MEDI CAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	6,866		132		172, 969 0	16.00 21.00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD					0	•
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	28, 446				4, 975	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	3, 924			3 O D O	868 0	31.00 32.00
33.00	03300 BURN I NTENSI VE CARE UNI T					0	32.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			0 0	0	34.00
40.00	04000 SUBPROVI DER – I PF	1, 962			1 0	722	•
41.00	04100 SUBPROVIDER - IRF	7,847		80		1, 791	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY					0	42.00 43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY				0	0	44.00
45.00	04500 NURSING FACILITY	C	0 0		0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0 0	(0 0	0	46.00
50.00	ANCI LLARY SERVICE COST CENTERS	24, 523	3 7, 127	7,668	3 0	31, 141	50.00
51.00	05100 RECOVERY ROOM	24, 525			0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0 0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	j v		0 0	0	53.00
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	11, 771		392	2 0	13, 027 0	54.00 55.00
56.00	05600 RADI OI SOTOPE				0	0	56.00
57.00	05700 CT SCAN	981		22!		6, 201	•
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	981				3, 958	•
59.00 60.00	06000 LABORATORY	981		664		0 23, 407	59.00 60.00
60.01	06001 BLOOD LABORATORY	C			0 0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.					0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY					0	64.00
65.00	06500 RESPI RATORY THERAPY	6, 866	5 1, 995	109	9 0	2, 097	1
66.00	06600 PHYSI CAL THERAPY	9,809		9	-	4, 592	•
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 962		19		912 287	•
69.00	06900 ELECTROCARDI OLOGY	8, 828	°	15:	2 0	6, 302	
70.00	07000 ELECTROENCEPHALOGRAPHY	C	0 0	108		3, 150	•
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	8, 552		5, 538	•
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0	20, 028	3 0 0 55, 217	12, 970 15, 466	
	07400 RENAL DIALYSIS				5 55,217	15, 466 370	
75.00	07500 ASC (NON-DISTINCT PART)	0	o o		o o	0	1
76.00	03020 ENDOSCOPY CENTER	0	°		0 0	0	
76. 01 76. 05	03950 WOUND OSTOMY 03480 CRCC	3, 924	1, 140	982		5, 870 2, 118	1
70.05	OUTPATIENT SERVICE COST CENTERS		<u> </u>	10		2,110	70.03
88.00	08800 RURAL HEALTH CLINIC	C	0 0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
90. 00 90. 23	09000 CLINIC 09023 CLINIC					0	90.00 90.23
90.25	09025 CLI NI C	0	0	320	J	872	•
90. 27	09027 CLI NI C	C	0 0	(0 0	0	90. 27
91.00	09100 EMERGENCY	17,656	5, 131	1, 010	0 0	26, 335	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	I		<u> </u>			92.00
94.00	09400 HOME PROGRAM DI ALYSI S	C	0 0	(0 0	0	94.00
95.00		0			0	0	
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0 0	(0 0	0	96.00

Health Financial Systems	WESTVI EW	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	_	Provi der		eriod: com 01/01/2014 o 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 6:1	
Cost Center Description		NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	771.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	148, 118	42, 474	85, 974	110, 434	172, 969	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	3, 275	0		192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.0607956CHN MOB	0	0	0	0		194.06
194.0807958 FOUNDATION OPS	0	0	0	0	0	194.08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	148, 118	42, 474	89, 249	110, 434	172, 969	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	WESTVIEW F		CCN: 150129	In Lie Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 6:1	pared:
		INTERNS &	RESI DENTS			572772015 8.1	
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHE PRGM COSTS	R Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		21.00	22.00	24.00	25.00	26.00	
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01000 CAFETERIA						1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00
11. 00 13. 00 14. 00 15. 00 16. 00 21. 00 22. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD I NPATI ENT ROUTI NE SERVI CE COST CENTERS	60, 732	3, 60	4			11.00 13.00 14.00 15.00 16.00 21.00 22.00
$\begin{array}{c} 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 33.\ 00\\ 34.\ 00\\ 40.\ 00\\ 41.\ 00\\ 42.\ 00\\ 43.\ 00\\ 44.\ 00\\ 45.\ 00\\ 46.\ 00\\ \end{array}$	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS			803, 98 112, 61 53, 74 162, 31	3 0 0 0 0 0 0 0 3 0	803, 982 112, 613 0 0 53, 743 162, 312 0 0 0 0 0 0 0 0 0	31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00
75.00 76.00 76.01 76.05	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03480 CRCC 0UTPATI ENT SERVI CE COST CENTERS			779, 44 583, 87 12, 80 10, 44 222, 15 290, 32 46, 27 9, 22 48, 71 8, 91 39, 82 93, 26 157, 31 3, 45 218, 17 80, 91	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1 0 9 0	0 222, 152 0 0 59, 295 290, 320 46, 276 9, 229 48, 711 8, 919 39, 823 93, 264 157, 310 3, 453 0 0 218, 171 80, 919	51.00 52.00 53.00 54.00 55.00 57.00 58.00 59.00 60.01 61.00 62.00 63.00 64.00 65.00 65.00 66.00 67.00 68.00 67.00 68.00 71.00 71.00 72.00 73.00 74.00 75.00 76.01 76.05
88.00 89.00 90.00 90.23 90.25 90.27 91.00 92.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09023 CLINIC 09025 CLINIC 09027 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)			7, 85 267, 40	0 0	0 0 0 7, 852 0 267, 408	89.00 90.00 90.23 90.25 90.27

Health Financial Systems	WESTVIEW H	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre 5/27/2015 6:1	pared: 3 pm
Cost Center Description	I NTERNS & SERVI CES-SALAR Y & FRI NGES	RESI DENTS SERVI CES-OTHER PRGM COSTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	21.00	22.00	24.00	25.00	26.00	
OTHER REIMBURSABLE COST CENTERS	21.00	22.00	24.00	23.00	20.00	
94. 00 94. 00 95. 00 95. 00 95. 00 95. 00 96. 00 97. 00 97. 00 97. 00 97. 00 97. 00 98. 00 98. 00 98. 00 98. 00 99. 00 90. 00				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		95.00 96.00 97.00 98.00 99.00
Intervention Intervention 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 100. 01 1000 INTESTI NAL ACQUI SI TI ON 111. 00 11000 INTERST EXPENSE 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 1117	0	0	4, 072, 3	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	105.00 106.00 107.00 108.00 109.00 110.00 111.00 113.00 114.00 115.00 116.00 118.00
190. 00 019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 193. 00 19300 NONPAID WORKERS 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 194. 06 07956 CHN MOB 194. 08 07958 FOUNDATION OPS 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 TOTAL (sum lines 118-201)	60, 732 0 60, 732	3, 604 0 3, 604		0 0 0 0 0 0 36 0 0 0	0 381, 735 0 0 0 0 64, 336	193.00 194.00 194.06 194.08 200.00 201.00

	Financial Systems LLOCATION - STATISTICAL BASIS	WESTVI EW		dor	CCN: 150129 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-10
CUST F	LEUCATION - STATISTICAL DASIS		PLOVE	uer	F	rom 01/01/2014		
						o 12/31/2014	Date/Time Pre 5/27/2015 6:1	
		CAPI TAL REI	LATED COSTS					
	Cost Center Description	BLDG & FIXT	MVBLE EQU	IΡ	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FE	ET)	BENEFITS		& GENERAL	
					DEPARTMENT (GROSS		(ACCUM. COST)	
		1.00	2.00		SALARI ES)	5A	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00		4.00	AC	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	158, 041						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	158,	041	21, 594, 707			2.00 4.00
5.00	00500 ADMINISTRATIVE & GENERAL	51, 313	51,	313	2, 018, 409		43, 576, 342	5.00
7.00	00700 OPERATION OF PLANT	11, 935		935	479, 893		2, 360, 560	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	168		168 444	C 258, 770		9, 119 607, 904	8.00 9.00
10.00	01000 DI ETARY	485		485	73, 892		152, 995	10.00
11.00		3, 412		412	369, 803		655, 049	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1,025		025 079	92, 398 159, 607	0	174, 564	13.00 14.00
15.00	01500 PHARMACY	1, 133		133	361, 360	-	629, 633	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2,460		460	274, 029		761, 357	16.00
21.00 22.00	02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM COSTS APPRVD	356		356 0	944, 958 50, 835		1, 444, 153 105, 387	21.00 22.00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS	~					100,007	22.00
30.00	03000 ADULTS & PEDIATRICS	19, 382		382	1, 887, 677			30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	2,623	Ζ,	623 0	324, 303 0		504, 456	31. 00 32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	C		0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	1	0	010 522	0	0	34.00
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	1, 135		135 611	218, 532 443, 240		333, 230 749, 880	40. 00 41. 00
42.00	04200 SUBPROVI DER	0		0	C		0	42.00
43.00	04300 NURSERY	0		0	C	-	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0		0	C	-	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0		0	C		-	46.00
50, 00	ANCI LLARY SERVICE COST CENTERS	16, 617	14	617	1, 549, 971	0	4, 358, 581	50.00
51.00	05100 RECOVERY ROOM	0	10,	0	1, 549, 971 C		4, 338, 381	50.00 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	C	-	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	14, 904	14	0 904	0 752, 516	0	0 1, 528, 463	53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	14,	0	752, 510 C		0	54.00 55.00
56.00	05600 RADI OI SOTOPE	0		0	0	0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	104, 187 91, 402		151, 767 151, 593	
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	0	59.00
60.00	06000 LABORATORY	3, 640	3,	640	33, 931	0	2, 192, 586	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	C	0	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	C	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	C	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	888		0 888	405, 911	0	0 541, 272	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	7,043		043	686, 020		1, 039, 276	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,092		092	107, 828		175, 636	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	228		228 367	22, 508 404, 473		36, 663 543, 693	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	127, 619		168, 140	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		0	C	0	764, 353	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0		0		0	1, 790, 118 2, 573, 122	
74.00	07400 RENAL DI ALYSI S	0		0	C	0	90, 717	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0		0	C	0	0	75.00
76. 00 76. 01	03020 ENDOSCOPY CENTER 03950 WOUND OSTOMY	5, 100	5	100	182, 910	0	0 1, 007, 584	76. 00 76. 01
76.05	03480 CRCC	2, 020		020	187, 925		304, 991	76.05
00.00	OUTPATIENT SERVICE COST CENTERS							00.00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER			0			0	88.00 89.00
90.00	09000 CLI NI C	0		0	C	0	0	90.00
90.23	09023 CLINIC	0		0	122 424	0	107 629	90.23
90. 25 90. 27	09025 CLINIC 09027 CLINIC			0	132, 434 C	0	197, 638 0	90. 25 90. 27
91.00	09100 EMERGENCY	3, 581	3,	581	1, 879, 032	0	2, 842, 275	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00

COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
		CAPI TAL REL	LATED COSTS			372772013 0. 1	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFI TS		& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	ER REIMBURSABLE COST CENTERS						
	00 HOME PROGRAM DI ALYSI S	0			0 0	0	
	00 AMBULANCE SERVI CES	0	(0 0	0	95.
	00 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	1
	00 DURABLE MEDICAL EQUIP-SOLD	0	0	D	0 0	0	
	51 OTHER REIMBURSABLE COST CENTERS	0	(0	0 0	0	
	OO CMHC	0	(0	0 0	0	1
	10 CORF	0	(0 0	0	
	00 I&R SERVICES-NOT APPRVD PRGM 00 HOME HEALTH AGENCY	0			0 0		100. 101.
	CIAL PURPOSE COST CENTERS	0	[(/	0 0	0	
	00 KIDNEY ACQUISITION	0	0		0 0	0	105
	00 HEART ACQUISITION	0			0 0		106
	00 LIVER ACQUISITION	0	(0 0		107
	OO LUNG ACQUISITION	0			0 0		108
	00 PANCREAS ACQUISITION	0			0 0		109
	00 INTESTINAL ACQUISITION	0	0		0 0	0	110.
11.00111	OO I SLET ACQUI SI TI ON	0	0	þ	0 0	0	111.
13.00 113	00 INTEREST EXPENSE						113.
14.00 114	OO UTILIZATION REVIEW-SNF						114.
	00 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.
	00 HOSPI CE	0	0	D	0 0		116.
18.00	SUBTOTALS (SUM OF LINES 1-117)	158, 041	158, 041	14, 626, 37	3 -7, 759, 854	32, 334, 755	118.
	REIMBURSABLE COST CENTERS	-	-	.1	-	-	
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0		190
		0			0 0		191.
	00 PHYSICIANS' PRIVATE OFFICES	0		6, 968, 33		11, 241, 587	192
	00 NONPAID WORKERS 50 OTHER NONREIMBURSABLE COST CENTERS	0			0 0		193
	56 CHN MOB	0			0 0		194
	58 FOUNDATION OPS	0			0 743		194
94.00077 00.00	Cross Foot Adjustments	0			0 743	0	200
01.00	Negative Cost Centers						200.
02.00	Cost to be allocated (per Wkst. B, Part I)	1, 958, 230	2, 560, 169	3, 937, 65	3	7, 759, 854	
03.00	Unit cost multiplier (Wkst. B, Part I)	12. 390645	16. 199398	0. 18234	3	0. 178075	203
04.00	Cost to be allocated (per Wkst. B,	12. 370043	10.177370	0.10234	0	1, 467, 043	
	Part II)						
05.00	Unit cost multiplier (Wkst. B, Part			0.00000	0	0. 033666	205

ST A	h Financial Systems ALLOCATION - STATISTICAL BASIS	WESTVI EW			Peri od:	u of Form CMS- Worksheet B-1	
					From 01/01/2014 To 12/31/2014		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	5/27/2015 6: 1 CAFETERI A	3 pm
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(FTES)	
		7.00	LAUNDRY)	0.00	10.00	11 00	
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
00	00100 CAP REL COSTS-BLDG & FIXT						1.
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.
00	00500 ADMINI STRATI VE & GENERAL						5.
00	00700 OPERATION OF PLANT	94, 793					7.
00	00800 LAUNDRY & LINEN SERVICE	168					8.
00 . 00	00900 HOUSEKEEPING 01000 DI ETARY	1, 444		93, 18 ⁻ 485			9. 10.
. 00		3, 412		3, 412		151	
. 00		1, 025		1, 025		2	
. 00		2,079				4	14.
. 00		1, 133				5	
. 00 . 00		2,460		_,		0	16. 21.
. 00		0				0	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		-		
. 00		19, 382				29	
. 00 . 00		2,623	0	2, 623		4	
. 00		0	c c		-	0	
. 00		0	C	0	0 0	0	34
. 00		1, 135				2	40
. 00		3, 611	14, 245	3, 61		8	
00						0	
. 00		0	0		0 0	0	
00		0	C			0	
. 00		0	C	(0 0	0	46
. 00	ANCI LLARY SERVICE COST CENTERS	16, 617	42, 692	16, 61	7 0	25	50
. 00		0	12, 0,2		0 0	0	
. 00		0	C		0 0	0	52
. 00		0	0	(0 0	0	
. 00 . 00		14, 904	10, 896	14, 904		12 0	
. 00						0	
. 00		0	C C	(0 0	1	57
. 00		0	C	(0 0	1	58
. 00		0	0		•	0	
. 00 . 01		3, 640		3, 640		1	60 60
. 00						0	61
00		0	C		0 0	0	
00		0	0	(0	0	
. 00 . 00		888		888		0	
00		7,043		7,043		10	
00		1, 092		1, 092		2	
00		228		228		0	
00		367	9,008	36		9	
00						0	
00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	i i	o o	0	
00		0	C	(0 0	0	
00		0	1, 349			0	
00						0	
01		5, 100	0	5, 100		4	76
05	03480 CRCC	2,020				0	76
00		^					0.0
00 00						0	
00		0	0			0	
23	09023 CLI NI C	0	0	(0 0	0	90
25		0	0	(0	0	
. 27 . 00		0 3, 581	0 33, 153	(3, 581		0 18	
00		3, 581	33, 153	3, 38	' ⁰	18	91
	OTHER REIMBURSABLE COST CENTERS						
. 00	09400 HOME PROGRAM DI ALYSI S	0	C	(0 0	0	94

Health Financial Systems	WESTVIEW F	IOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS				Period:	Worksheet B-1	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	CAFETERI A	
	PLANT	LINEN SERVICE		(MEALS SERVED)	(FTES)	
	(SQUARE FEET)	(POUNDS OF		, ,		
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	-	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	-	
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
99. 00 09900 CMHC 99. 10 09910 CORF	0	0			0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0			-	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
SPECIAL PURPOSE COST CENTERS	0	0	1	0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0)	0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	_	_		_		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0	00.10	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	94, 793	333, 870	93, 18	1 26, 373	151	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191, 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.00
194.0607956 CHN MOB	0	0		0 0	0	194.06
194.0807958 FOUNDATION OPS	0	0)	0 0	0	194.08
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	2, 780, 917	15, 672	766, 35	5 198, 457	999, 088	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	29. 336734	0. 046940				
204.00 Cost to be allocated (per Wkst. B,	420, 693	5, 856	71, 08	5 21, 539	148, 118	204.00
Part II)	4 420010	0 017540	0 74007	0 0 01/70/	000 010007	205 00
205.00 Unit cost multiplier (Wkst. B, Part	4. 438018	0. 017540	0. 76287	0 0. 816706	980. 913907	205.00
	1	1	I	1	I	I

	Financial Systems LLOCATION - STATISTICAL BASIS	WESTVIEW H		CCN: 150129 F	In Lie Period:	u of Form CMS-: Worksheet B-1	2552-10
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
						5/27/2015 6:1 I NTERNS &	3 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	RESI DENTS SERVI CES-SALAR Y & FRI NGES	
		(FTES)	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	(ASSIGNED TIME)	
		13.00	REQUIS.) 14.00	15.00	CHARGES) 16.00	21.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	21.00	
1.00 2.00 4.00 5.00 7.00 8.00 9.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						1.00 2.00 4.00 5.00 7.00 8.00 9.00
10.00 11.00 13.00 14.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	149	7, 977, 168				10.00 11.00 13.00 14.00
15.00 16.00 21.00 22.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	5 7 0 0	3, 988, 584 11, 784 7, 389 4, 974	200 100	131, 044, 816 0 0	18, 647	15.00 16.00 21.00 22.00
	INPATIENT ROUTINE SERVICE COST CENTERS		04,000		0.7/0.454		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	29 4	36, 038 2, 942			1, 556 0	30.00 31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	(0	0	32.00 33.00
33.00 34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0			0	34.00
40. 00 41. 00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	2	86 7, 188			0	40.00 41.00
42.00	04200 SUBPROVI DER	0	0	0	0 0	0	42.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0			0	43.00 44.00
45.00	04500 NURSING FACILITY	0	0	(-	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	(0 0	0	46.00
50.00	05000 OPERATI NG ROOM	25	685, 350			462	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0		-	0	51.00 52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 12	0 35, 001	(0 9, 868, 573	365 0	53.00 54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	35, 001 0		0 9,000,073	0	55.00
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	0 20, 147		0 4, 697, 860	0	56.00 57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1	10, 702	C	2, 998, 716	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 59, 325			0	59.00 60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61.00 62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	(0	0	63.00 64.00
65. 00	06500 RESPI RATORY THERAPY	7	9, 749		,	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	10	8, 116 1, 686		3, 478, 690 691, 272	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	352	0	217, 260	0	68.00
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	9	13, 559 9, 666		4, 773, 960 2, 386, 012	0	69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	764, 353	0	4, 195, 683	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	1, 790, 118 0	100	// 020/ 001	0	72.00 73.00
74.00	07400 RENAL DI ALYSI S	0	426		280, 095	0	74.00
	07500 ASC (NON-DI STINCT PART) 03020 ENDOSCOPY CENTER	0	0			0	75.00 76.00
76. 01 76. 05	03950 WOUND OSTOMY	4	87, 811 9, 745		4, 447, 113	775	76. 01 76. 05
	03480 CRCC OUTPATIENT SERVICE COST CENTERS	U	9, 745		1, 604, 370	0	10.05
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	88.00 89.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 23 90. 25	09023 CLI NI C 09025 CLI NI C	0	0 29, 105		0 0 660, 257	0	90. 23 90. 25
90. 27	09027 CLI NI C	0	0	(0 0	601	90. 27
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	18	90, 260		19, 950, 704	0	91.00 92.00

	ncial Systems	WESTVIEW H		001 450400		u of Form CMS-	
COST ALLOCA	TION - STATISTICAL BASIS		Provi der	CCN: 150129	Period: From 01/01/2014	Worksheet B-1	
					To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
						INTERNS &	
						RESI DENTS	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SERVI CES-SALAR	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	Y & FRINGES	
			SUPPLY	REQUIS.)	LIBRARY	(ASSI GNED	
		(FTES)	(COSTED REQUIS.)		(GROSS CHARGES)	TIME)	
		13.00	14.00	15.00	16.00	21.00	
OTHER	REIMBURSABLE COST CENTERS	13.00	14.00	13.00	10.00	21.00	
	HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95.00 09500	AMBULANCE SERVICES	0	0		0 0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700	DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 0985 ²	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99.00 09900	СМНС	0	0		0 0	0	99.00
99.10 09910	CORF	0	0		0 0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101.0010100	HOME HEALTH AGENCY	0	0		0 0	0	101.00
	AL PURPOSE COST CENTERS	r					
	KIDNEY ACQUISITION	0	0		0 0		105.00
	HEART ACQUISITION	0	0		0 0		106.00
	LIVER ACQUISITION	0	0		0 0		107.00
	LUNG ACQUISITION	0	0		0 0		108.00
	PANCREAS ACQUISITION	0	0		0 0		109.00
	INTESTINAL ACQUISITION	0	0		0 0		110.00
	I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
	INTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF						114.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00 116.00
116.0011600 118.00		0 149	7 (04 45)	20	0 0 00 131, 044, 816		
	SUBTOTALS (SUM OF LINES 1-117)	149	7, 684, 456	2(00 131, 044, 816	3, 759	118.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191.0019100		0	0		0 0		191.00
	PHYSICIANS' PRIVATE OFFICES	0	292, 712		0 0		192.00
	NONPAID WORKERS	0	0		0 0		193.00
	OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
194.0607956		0	0		0 0		194.06
	FOUNDATION OPS	0	0		0 0		194.08
200.00	Cross Foot Adjustments				-	-	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	257, 382	596, 112	1, 124, 08	1, 610, 668	1, 715, 245	
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1, 727. 395973	0.074727	5, 620. 44000	0. 012291	91. 985038	203.00
204.00	Cost to be allocated (per Wkst. B,	42, 474	89, 249	110, 43	34 172, 969	60, 732	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	285. 060403	0. 011188	552.17000	0. 001320	3. 256931	205.00
							1

	Financial Systems ALLOCATION - STATISTICAL BASIS	WESTVIEW HOS	Provider CCN: 150129	Period: From 01/01/2014	u of Form CMS-2552 Worksheet B-1
				To 12/31/2014	Date/Time Prepare 5/27/2015 6:13 pm
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS (ASSI GNED TI ME) 22.00			<u> </u>
	GENERAL SERVICE COST CENTERS				
. 00 2. 00 4. 00 5. 00 7. 00 3. 00 9. 00 1. 00 1. 00 1. 00 5. 00 6. 00 21. 00 22. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD INPATIENT ROUTINE SERVICE COST CENTERS	18, 647			1. 2. 4. 5. 7. 8. 9. 10. 11. 13. 14. 15. 16. 21. 22.
30.00	03000 ADULTS & PEDIATRICS	1, 556			30.
31.00 32.00 33.00 34.00 40.00 40.00 41.00 42.00 43.00 44.00 45.00 46.00 46.00 46.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03200 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE	0 0 0 0 0 0 0 0 0 0 0 0			31. 32. 33. 34. 40. 41. 42. 43. 44. 45. 46.
0 00	ANCI LLARY SERVICE COST CENTERS	440			F0
00.00 00.01 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 07.00 08.00 09.00 07.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	462 0 0 365 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 60. 61. 62. 63. 64. 65. 66. 67. 68. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 76. 76.
8.00 9.00 0.23 0.25 0.27 1.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09023 CLINIC 09025 CLINIC 09027 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0 0 601 0			88. 89. 90. 90. 90. 90. 91. 91. 92.

Health Financial Systems	WESTVIEW HOS	PITAL	In Lieu of Form CMS	-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 150129	Period: Worksheet B-	1
			From 01/01/2014	oporod
			To 12/31/2014 Date/Time Pr 5/27/2015 6:	
	INTERNS &		072772010 0.	
	RESI DENTS			
Cost Center Description	SERVI CES-OTHER			
·	PRGM COSTS			
	(ASSI GNED			
	TIME)			
	22.00			
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DI ALYSI S	0			94.00
95. 00 09500 AMBULANCE SERVICES	0			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0			98.00
99. 00 09900 CMHC	0			99.00
99. 10 09910 CORF	0			99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0			100.00
101.00 10100 HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0			105.00
106.00 10600 HEART ACQUI SI TI ON	0			106.00
107.00 10700 LIVER ACQUISITION	0			107.00
108.00 10800 LUNG ACQUISITION	0			108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0			110.00
111.00 11100 I SLET ACQUI SI TI ON	0			111.00
113.00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			115.00
116.00 11600 HOSPI CE	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 759			118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
191. 00 19100 RESEARCH	513			191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	14, 375			192.00
193. 00 19300 NONPALD WORKERS	0			193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0			194.00
194.0607956 CHN MOB	0			194.06
194.0807958 FOUNDATION OPS	0			194.08
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B,	124, 526			202.00
Part I)				
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 678072			203.00
204.00 Cost to be allocated (per Wkst. B,	3, 604			204.00
Part II)				
205.00 Unit cost multiplier (Wkst. B, Part	0. 193275			205.00
	•			

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	WESTVI EW			<u>In Lie</u> Period: From 01/01/2014 To 12/31/2014	u of Form CMS-: Worksheet C Part I Date/Time Pre 5/27/2015 6:1	epared:
			Titl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	4, 583, 776 743, 994		4, 583, 77 743, 99		4, 583, 776 743, 994	
	03200 CORONARY CARE UNIT	/43, 994		743, 99	0 0	143, 994	
	03300 BURN INTENSIVE CARE UNIT	C			0 0	0	
	03400 SURGI CAL INTENSI VE CARE UNI T	C			0 0	0	
	04000 SUBPROVIDER - IPF	466, 611		466, 61		466, 611	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	1, 129, 473		1, 129, 47	3 0	1, 129, 473 0	
43.00	04300 NURSERY				0 0	0	
44.00	04400 SKILLED NURSING FACILITY	C			0 0	0	44.00
45.00	04500 NURSING FACILITY	C)		0 0	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	C			0 0	0	46.00
50.00	05000 OPERATING ROOM	6, 310, 773		6, 310, 77	3 0	6, 310, 773	50.00
	05100 RECOVERY ROOM	C			0 0	0, 010, 7,0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	C			0 0	0	52.00
	05300 ANESTHESI OLOGY	0.505.004		0 505 00	0 0	0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 585, 004	-	2, 585, 00	4 0 0 0	2, 585, 004 0	
56.00	05600 RADI OI SOTOPE				0 0	0	
	05700 CT SCAN	246, 383		246, 38	3 0	246, 383	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	224, 588	6	224, 58		224, 588	
59.00	05900 CARDI AC CATHETERI ZATI ON	2 050 402			0 0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	2, 950, 482		2, 950, 48	2 0	2, 950, 482 0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C			0 0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	C			0 0	0	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	749, 674		749,67	0 0 4 0	0 749, 674	
66.00	06600 PHYSI CAL THERAPY	1, 615, 690		1, 615, 69		1, 615, 690	
67.00	06700 OCCUPATI ONAL THERAPY	273, 239		273, 23		273, 239	
	06800 SPEECH PATHOLOGY	54, 452		54,45		54, 452	
69.00		789, 504		789, 50		789, 504	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	228, 130 1, 009, 152		228, 13		228, 130 1, 009, 152	
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 363, 429		2, 363, 42		2, 363, 429	1
	07300 DRUGS CHARGED TO PATIENTS	3, 737, 381		3, 737, 38		3, 737, 381	
	07400 RENAL DIALYSIS	110, 409		110, 40		110, 409	
	07500 ASC (NON-DISTINCT PART) 03020 ENDOSCOPY CENTER				0 0 0 0	0	
	03950 WOUND OSTOMY	1, 473, 168		1, 473, 16		1, 473, 168	
	03480 CRCC	456, 067		456, 06		456, 067	
	OUTPATIENT SERVICE COST CENTERS		1				
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				0 0	0	
	09000 CLINIC				o n	0	
	09023 CLI NI C	C			0 0	0	
	09025 CLI NI C	243, 122		243, 12	2 0	243, 122	
				3, 886, 62	0 0 4 0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 886, 624 866, 769		3, 886, 62		3, 886, 624 866, 769	
72.00	OTHER REIMBURSABLE COST CENTERS	000,707		000,70	·	000,707	72.00
	09400 HOME PROGRAM DI ALYSI S	C			0 0	0	
	09500 AMBULANCE SERVICES	C			0 0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD					0	
	09851 OTHER REIMBURSABLE COST CENTERS				0 0	0	
	09900 CMHC	C			0	0	
	09910 CORF	C			0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	C			0		100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	I C	/		0	0	101.00
105.00	10500 KIDNEY ACQUISITION	C			0	0	105.00
106.00	10600 HEART ACQUI SI TI ON	C			0	0	106.00
	10700 LI VER ACQUI SI TI ON	C			0		107.00
100 00	10800 LUNG ACQUISITION	C			0		108.00
	10900 PANCREAS ACQUISITION	~			\cap	^	109.00

Health Financial Systems	WESTVIEW I	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014		
		Titl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
111.00 11100 I SLET ACQUI SITION 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	0 0 37, 097, 894 866, 769 36, 231, 125		37, 097, 8º 866, 70 36, 231, 12	59	0 0 37, 097, 894 866, 769	201.00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	WESTVIEW H		CCN: 150129	Peri od:	u of Form CMS- Worksheet C	2552-10
					From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	pared:
			Ti †I	e XVIII	Hospi tal	5/27/2015 6: 1 PPS	3 pm
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	L	6.00	7.00	8.00	9.00	10.00	
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2 424 779		2, 626, 7	79		30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 626, 778 657, 683		657,6			31.00
32.00	03200 CORONARY CARE UNI T	007,000		007,0	0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0			0		33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
40.00	04000 SUBPROVIDER - IPF	546, 740		546, 7			40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	1, 357, 124		1, 357, 1	24		41.00
42.00	04300 NURSERY	0			0		42.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0			0		44.00
45.00	04500 NURSING FACILITY	0			0		45.00
46.00	04600 OTHER LONG TERM CARE	0			0		46.00
	ANCI LLARY SERVICE COST CENTERS	4 594 979				0.000000	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	4, 526, 078	19, 074, 317	23, 600, 3	95 0. 267401 0 0. 000000	0. 000000 0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C C		0 0.000000	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	C		0 0. 000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	443, 432	9, 425, 141	9, 868, 5		0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0. 000000	0.00000	
56.00	05600 RADI OI SOTOPE	0	(1 210 202	4 (07 0	0 0.00000	0.00000	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	379, 557 128, 179	4, 318, 303 2, 870, 537			0. 000000 0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	120, 179	2, 870, 537	2, 990, 7	0 0.000000	0. 000000	
60.00	06000 LABORATORY	2, 232, 568	15, 500, 056	17, 732, 6		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	C		0 0. 000000	0. 000000	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0 0. 000000	0.00000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0. 000000	0.00000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0.000000	0.00000	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 107, 661	480, 907	1, 588, 5	0.000000	0. 000000 0. 000000	
66.00	06600 PHYSI CAL THERAPY	754, 260	2, 724, 430			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	450, 405	240, 867			0. 000000	
68.00	06800 SPEECH PATHOLOGY	134, 938	82, 322	217, 2	60 0. 250631	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	630, 865	4, 143, 095			0.00000	
70.00	07000 ELECTROENCEPHALOGRAPHY	14, 235	2, 371, 777			0.00000	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 620, 899 3, 136, 009	2, 574, 784 6, 689, 572			0. 000000 0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 690, 545	9, 025, 837			0. 000000	
74.00	07400 RENAL DIALYSIS	280, 095	C			0. 000000	74.00
	07500 ASC (NON-DISTINCT PART)	0	C		0 0. 000000	0. 000000	
	03020 ENDOSCOPY CENTER	0	0		0 0.000000	0.00000	
76. 01 76. 05	03950 WOUND OSTOMY 03480 CRCC	9, 935 1, 902	4, 437, 178 1, 602, 468			0. 000000 0. 000000	
70.05	OUTPATIENT SERVICE COST CENTERS	1, 702	1,002,400	1,004,3	0.204203	0.00000	/0.03
88.00	08800 RURAL HEALTH CLINIC	0	C)	0		88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
90.00	09000 CLINIC	0	C		0 0.000000	0.00000	
90.23 90.25	09023 CLI NI C 09025 CLI NI C	150 204	E01 971	440 D	0 0.000000 57 0.368223	0.00000	
90. 25 90. 27	09025 CLINIC 09027 CLINIC	158, 386	501, 871	660, 2	0 0.000000	0. 000000 0. 000000	
91.00	09100 EMERGENCY	1, 736, 759	18, 213, 945	19, 950, 7		0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	53, 678	1, 088, 698			0. 000000	
	OTHER REIMBURSABLE COST CENTERS		· · · · ·	1			
94.00	09400 HOME PROGRAM DI ALYSI S	0	C		0 0.00000	0.00000	
95.00	09500 AMBULANCE SERVICES	0	C		0 0.000000	0.00000	
96.00 97.00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0.000000 0 0.000000	0. 000000 0. 000000	
97.00	09851 OTHER REIMBURSABLE COST CENTERS	0	((0 0.000000	0. 000000	
99.00	09900 CMHC	0	C		0	0.00000	99.00
	09910 CORF	0	C		0		99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	C		0		100.00
101.00	10100 HOME HEALTH AGENCY	0	C		0		101.00
105 00	SPECIAL PURPOSE COST CENTERS	0	C		0		105.00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	C C		0		105.00
	10000 LIVER ACQUISITION	0	C.		0		107.00
	10800 LUNG ACQUISITION	0	C		0		108.00
109.00	10900 PANCREAS ACQUISITION	0	C		0		109.00
			C	1	0		110.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	C		0		111.00

Health Financial Systems	WESTVIEW H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
		·	+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116. 00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	25, 678, 711	105, 366, 105	131, 044, 81	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	25, 678, 711	105, 366, 105	131, 044, 81	6		202.00

Health Financial Systems	WESTVI EW HOSP	ITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150129	Period: From 01/01/2014	Worksheet C Part I
			To 12/31/2014	Date/Time Prepared:
		Title XVIII	Hospi tal	5/27/2015 6:13 pm PPS
Cost Center Description	PPS Inpatient Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T				30.00 31.00
32.00 03200 CORONARY CARE UNI T				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER – I PF				34.00 40.00
41. 00 04100 SUBPROVIDER - IRF				40.00
42. 00 04200 SUBPROVI DER				42.00
43.00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY				44.00 45.00
46. 00 04600 OTHER LONG TERM CARE				45.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 267401			50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			51.00 52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 261943			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000			55.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	0. 000000 0. 052446			56.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 074895			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
	0. 166387			60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			60. 01 61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0.000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0. 000000 0. 471918			64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 464454			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 395270			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 250631			68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 165377 0. 095611			69.00 70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 240522			70.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 240538			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 318988			73.00
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0. 394184 0. 000000			74.00 75.00
76. 00 03020 ENDOSCOPY CENTER	0. 000000			76.00
76.01 03950 WOUND OSTOMY	0. 331264			76.01
76. 05 03480 CRCC OUTPATI ENT SERVI CE COST CENTERS	0. 284265			76.05
88.00 08800 RURAL HEALTH CLINIC				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
90. 00 09000 CLINIC	0. 000000			90.00
90. 23 09023 CLINIC 90. 25 09025 CLINIC	0. 000000 0. 368223			90. 23 90. 25
90. 27 09027 CLINIC	0. 000000			90. 25
91. 00 09100 EMERGENCY	0. 194811			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 758742			92.00
0THER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000			94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0.000000			96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 98.00 09851 OTHER REIMBURSABLE COST CENTERS	0. 000000 0. 000000			97.00 98.00
98. 00 099031 0THER RELIMBURSABLE COST CENTERS 99. 00 09900 CMHC	0.000000			98.00
99. 10 09910 CORF				99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS				101.00
105. 00 10500 KIDNEY ACQUISITION				105.00
106.00 10600 HEART ACQUI SI TI ON				106.00
107.00 10700 LIVER ACQUISITION				107.00
108. 00 10800 LUNG ACQUISITION 109. 00 10900 PANCREAS ACQUISITION				108. 00 109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				110.00
111.00 11100 I SLET ACQUI SI TI ON				111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF				113. 00 114. 00
THE OUT THE ATTON REVIEW-SINF				114.00

Health Financial Systems	WESTVIEW H	HOSPI -	TAL	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150129	Peri od:	Worksheet C	
				From 01/01/2014	Part I	
				To 12/31/2014		pared:
					5/27/2015 6:1	<u>3 pm</u>
			Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)						115.00
116.00 11600 HOSPI CE						116.00
200.00 Subtotal (see instructions)						200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)						202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	WESTVI EW		F	<u>In Lie</u> Period: From 01/01/2014 Fo 12/31/2014	u of Form CMS-: Worksheet C Part I Date/Time Pre 5/27/2015 6:1	pared:
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	4, 583, 776	1	4, 583, 776	5 0	4, 583, 776	30.00
31. 00 03100 INTENSIVE CARE UNIT	743, 994		743, 994		4, 383, 778 743, 994	31.00
32. 00 03200 CORONARY CARE UNI T	0		(0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0	0 0	0	33.00
34.00 03400 SURGI CAL INTENSI VE CARE UNI T	0		0	0 0	0	34.00
40. 00 04000 SUBPROVI DER - I PF	466, 611		466, 61		466, 611	40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	1, 129, 473		1, 129, 473		1, 129, 473 0	41.00 42.00
43. 00 04300 NURSERY					0	43.00
44.00 04400 SKILLED NURSING FACILITY	0		0	0 0	0	44.00
45.00 04500 NURSING FACILITY	0		0	0 0	0	45.00
46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0		(0 0	0	46.00
50. 00 05000 OPERATING ROOM	6, 310, 773		6, 310, 773	3 0	6, 310, 773	50.00
51.00 05100 RECOVERY ROOM	0		(0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0		(0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 585, 004		2, 585, 004		2, 585, 004 0	54.00 55.00
56. 00 05600 RADI OLOGI - MERAPEUTI C					0	56.00
57. 00 05700 CT SCAN	246, 383		246, 383	-	246, 383	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	224, 588		224, 588	3 0	224, 588	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		(0 0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	2, 950, 482		2, 950, 482	2 0	2, 950, 482 0	60.00 60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		(0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0		740 (7	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	749, 674		749, 674 1, 615, 690		749, 674 1, 615, 690	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	273, 239		273, 239		273, 239	67.00
68.00 06800 SPEECH PATHOLOGY	54, 452		54, 452		54, 452	
69. 00 06900 ELECTROCARDI OLOGY	789, 504		789, 504		789, 504	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	228, 130 1, 009, 152		228, 130 1, 009, 152		228, 130 1, 009, 152	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	2, 363, 429		2, 363, 429		2, 363, 429	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 737, 381		3, 737, 381		3, 737, 381	73.00
74. 00 07400 RENAL DI ALYSI S	110, 409		110, 409	9 0	110, 409	
75.00 07500 ASC (NON-DISTINCT PART) 76.00 03020 ENDOSCOPY CENTER					0	75.00 76.00
76. 01 03950 WOUND OSTOMY	1, 473, 168		1, 473, 168	-	1, 473, 168	
76. 05 03480 CRCC	456, 067		456, 067		456, 067	76.05
OUTPATIENT SERVICE COST CENTERS		1	1		0	00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	88.00 89.00
90. 00 09000 CLINIC					0	90.00
90. 23 09023 CLI NI C	0			0 0	0	90. 23
90. 25 09025 CLINIC	243, 122		243, 122	2 0	243, 122	
90. 27 09027 CLI NI C 91. 00 09100 EMERGENCY	3, 886, 624		3, 886, 624	1 0	0 3, 886, 624	90.27 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	866, 769		866, 769		866, 769	
OTHER REIMBURSABLE COST CENTERS		1	1			
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0				0	94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED					0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0		(0 0	0	98.00
99. 00 09900 CMHC	0				0	99.00
99.10 09910 CORF 100.00 10000 I&R SERVICES-NOT APPRVD PRGM					0	99.10 100.00
101.00 10100 HOME HEALTH AGENCY	0					101.00
SPECIAL PURPOSE COST CENTERS		1	1			
105. 00 10500 KI DNEY ACQUI SI TI ON	0					105.00
106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON						106.00 107.00
108. 00 10800 LUNG ACQUI SI TI ON				D		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0		0			109.00
110.00 11000 INTESTINAL ACQUISITION	0		(ון	0	110.00

Health Financial Systems	WESTVI EW	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/27/2015 6:1	
		Ti ·	Ie XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
111.00 11100 I SLET ACQUI SITION 113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	0 0 37, 097, 894 866, 769 36, 231, 125) 37, 097, 8 866, 7 36, 231, 1	69	0	201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Cost Center Description Cost Center Description 30.00 O3000 ADULTS & PEDIATRICS 31.00 O3100 INTENSIVE CARE UNIT 32.00 O3200 CORONARY CARE UNIT 33.00 O3300 BURN INTENSIVE CARE UNIT 34.00 O3400 SURGICAL INTENSIVE CARE UNIT 40.00 O4000 SUBPROVIDER - IPF 41.00 O4100 SUBPROVIDER - IRF 42.00 O4200 SUBPROVIDER - IRF 43.00 O4400 SKILLED NURSING FACILITY 46.00 O4400 SKILLED NURSING FACILITY 46.00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS 50.00 O55000 OPERATING ROOM 51.00 O5500 DELIVERY ROOM & LABOR ROOM 53.00 O5300 ANESTHESIOLOGY 54.00 O5400 RADIOLOGY-DIAGNOSTIC	I npati ent 6. 00 2, 626, 778 657, 683 0 0 546, 740 1, 357, 124 0 0 0 0 4, 526, 078 0 0 0 0 0 0 0 0 0 0 0 0 0		I e XI X Total (col. 6 + col. 7) 8.00 2,626,77 657,68 546,74 1,357,12 23,600,39	3 0 0 0 0 4 4 0 0 0 0 0 0 0 0 0 0 0 0 0	Worksheet C Part I Date/Time Pre 5/27/2015 6:1 Cost TEFRA Inpati ent Rati o 10.00 0.00000 0.000000 0.000000 0.000000 0.000000	3 pm 3 pm 30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 45.00 45.00 50.00 51.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 I NTENSI VE CARE UNI T 32.00 03200 CORONARY CARE UNI T 33.00 03300 BURN I NTENSI VE CARE UNI T 34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 45.00 04500 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	6.00 2,626,778 657,683 0 0 546,740 1,357,124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Charges Outpati ent 7.00 19,074,317 0 0 0	Total (col. 6 + col. 7) 8.00 2, 626, 77 657, 68 546, 74 1, 357, 12 23, 600, 39	Cost or Other Rati o 9.00 8 3 0 0 0 0 0 4 4 0 0 0 0 0 0 0 0 0 0 0 0	Cost TEFRA Inpati ent Rati o 10.00 0.00000 0.00000 0.00000 0.00000	30.00 31.00 32.00 33.00 34.00 41.00 42.00 43.00 44.00 45.00 45.00 45.00 50.00 51.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 I NTENSI VE CARE UNI T 32.00 03200 CORONARY CARE UNI T 33.00 03300 BURN I NTENSI VE CARE UNI T 34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 45.00 04500 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	6.00 2,626,778 657,683 0 0 546,740 1,357,124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Charges Outpati ent 7.00 19,074,317 0 0 0	Total (col. 6 + col. 7) 8.00 2, 626, 77 657, 68 546, 74 1, 357, 12 23, 600, 39	Cost or Other Rati o 9.00 8 3 0 0 0 0 0 4 4 0 0 0 0 0 0 0 0 0 0 0 0	TEFRA Inpati ent Rati o 10.00 0.00000 0.00000 0.00000 0.00000	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 50. 00 51. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 31.00 03100 I NTENSI VE CARE UNI T 32.00 03200 CORONARY CARE UNI T 33.00 03300 BURN I NTENSI VE CARE UNI T 34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 45.00 04500 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	6.00 2,626,778 657,683 0 0 546,740 1,357,124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7.00 7.00 19,074,317 0 0 0	+ col. 7) 8.00 2,626,77 657,68 546,74 1,357,12 23,600,39	Ratio 9.00 8 3 0 0 0 0 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 000000 0. 000000 0. 000000	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 50. 00 51. 00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY 45.00 04600 OHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS 50.00 05000 51.00 05100 RECOVERY ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	2, 626, 778 657, 683 0 0 546, 740 1, 357, 124 0 0 0 0 4, 526, 078 0 0 443, 432 0 0	19, 074, 317 0 0 0	2, 626, 77 657, 68 546, 74 1, 357, 12 23, 600, 39	8 3 0 0 0 0 4 4 0 0 0 0 5 0. 267401 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000	10.00 0.000000 0.000000 0.000000	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 50. 00 51. 00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY 45.00 04600 OHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS 50.00 05000 51.00 05100 RECOVERY ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	657, 683 0 0 546, 740 1, 357, 124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	657, 68 546, 74 1, 357, 12 23, 600, 39	3 0 0 0 0 4 4 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 000000 0. 000000	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 50. 00 51. 00
31.00 03100 I NTENSI VE CARE UNI T 32.00 03200 CORONARY CARE UNI T 33.00 03300 BURN I NTENSI VE CARE UNI T 34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 46.00 04600 OHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS S000 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	657, 683 0 0 546, 740 1, 357, 124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	657, 68 546, 74 1, 357, 12 23, 600, 39	3 0 0 0 0 4 4 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 000000 0. 000000	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00 50. 00 51. 00
32.00 03200 CORONARY CARE UNI T 33.00 03300 BURN INTENSIVE CARE UNI T 34.00 03400 SURGI CAL INTENSI VE CARE UNI T 40.00 04000 SUBPROVI DER - IPF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 45.00 04600 OHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 50.00 05000 51.00 05100 RECOVERY ROOM 51.00 05200 DELI VERY ROOM & LABOR ROOM 51.00 05300 ANESTHESI OLOGY	0 0 546,740 1,357,124 0 0 0 0 0 4,526,078 0 0 0 443,432 0 0 0	0 0 0	546, 74 1, 357, 12 23, 600, 39	0 0 0 0 4 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 000000 0. 000000	32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 46.00 50.00 51.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 42.00 04200 SUBPROVIDER 43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY 45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS 05000 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	1, 357, 124 0 0 0 0 4, 526, 078 0 0 443, 432 0 0 0	0 0 0	546, 74 1, 357, 12 23, 600, 39	0 0 4 0 0 0 0 5 5 0.267401 0 0.00000 0 0.000000 0 0.000000	0. 000000 0. 000000	33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 46.00 550.00 51.00
40.00 04000 SUBPROVI DER - I PF 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 46.00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 50.00 50.00 05100 RECOVERY ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	1, 357, 124 0 0 0 0 4, 526, 078 0 0 443, 432 0 0 0	0 0 0	1, 357, 12	4 0 0 0 5 5 0.267401 0 0.00000 0 0.000000 0 0.000000	0. 000000 0. 000000	40.00 41.00 42.00 43.00 44.00 45.00 46.00 50.00 51.00
41.00 04100 SUBPROVI DER - IRF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 46.00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 50.00 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	1, 357, 124 0 0 0 0 4, 526, 078 0 0 443, 432 0 0 0	0 0 0	1, 357, 12	4 0 0 0 5 5 0.267401 0 0.00000 0 0.000000 0 0.000000	0. 000000 0. 000000	41.00 42.00 43.00 44.00 45.00 46.00 50.00 51.00
42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG 45.00 04500 NURSI NG FACI LI TY 45.00 04500 OHERI LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 50.00 05100 RECOVERY ROOM 51.00 05200 DELI VERY ROOM 52.00 05300 ANESTHESI OLOGY	0 0 0 0 4, 526, 078 0 0 443, 432 0 0 0	0 0 0	23, 600, 39	0 0 0 0 5 5 0.267401 0 0.00000 0 0.000000 0 0.000000	0. 000000 0. 000000	42.00 43.00 44.00 45.00 46.00 50.00 51.00
43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 46.00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 05000 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0 0 443, 432 0 0	0 0 0	23, 600, 39	0 5 0. 267401 0 0. 000000 0 0. 000000 0 0. 000000	0. 000000 0. 000000	43.00 44.00 45.00 46.00 50.00 51.00
44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 46.00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS 50.00 05000 05100 RECOVERY ROOM 51.00 05200 05100 RECOVERY ROOM 52.00 05200 05300 ANESTHESI OLOGY	0 0 443, 432 0 0	0 0 0	23, 600, 39	0 5 0. 267401 0 0. 000000 0 0. 000000 0 0. 000000	0. 000000 0. 000000	44.00 45.00 46.00 50.00 51.00
45.00 04500 NURSI NG FACILITY 46.00 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0 0 443, 432 0 0	0 0 0	23, 600, 39	0 5 0. 267401 0 0. 000000 0 0. 000000 0 0. 000000	0. 000000 0. 000000	45.00 46.00 50.00 51.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0 0 443, 432 0 0	0 0 0	23, 600, 39	5 0. 267401 0 0. 000000 0 0. 000000 0 0. 000000 0 0. 000000	0. 000000 0. 000000	50.00 51.00
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0 0 443, 432 0 0	0 0 0		0 0.000000 0 0.000000 0 0.000000	0. 000000 0. 000000	51.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0 0 443, 432 0 0	0 0 0		0 0.000000 0 0.000000 0 0.000000	0. 000000 0. 000000	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0 0	0 0 0 9, 425, 141 0 -		0 0.000000 0 0.000000	0.000000	
53. 00 05300 ANESTHESI OLOGY	0 0	0 0 9, 425, 141 0		0 0. 000000		1 02.00
	0 0	9, 425, 141 0			0. 00.000	
	0 0 379, 557	0	9, 868, 57	3 0. 261943	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0 379, 557	-		0 0. 000000	0.000000	55.00
56. 00 05600 RADI OI SOTOPE	379, 557	0		0 0.00000	0.00000	
57.00 05700 CT SCAN	100 170	4, 318, 303			0.000000	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	128, 179	2, 870, 537		6 0. 074895 0 0. 000000	0. 000000 0. 000000	
60. 00 06000 LABORATORY	2, 232, 568	15, 500, 056			0.000000	
60. 01 06001 BLOOD LABORATORY	0	0		0.000000	0.000000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0. 000000	0.000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0.00000	0.00000	
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0		0 0. 000000	0.000000	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	1, 107, 661	480, 907	1, 588, 56	0 0. 000000 8 0. 471918	0. 000000 0. 000000	
66. 00 06600 PHYSI CAL THERAPY	754, 260	2, 724, 430			0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	450, 405	240, 867			0.000000	
68.00 06800 SPEECH PATHOLOGY	134, 938	82, 322			0.000000	
69. 00 06900 ELECTROCARDI OLOGY	630, 865	4, 143, 095			0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	14, 235 1, 620, 899	2, 371, 777 2, 574, 784			0. 000000 0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 136, 009	6, 689, 572			0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 690, 545	9, 025, 837			0. 000000	
74. 00 07400 RENAL DIALYSIS	280, 095	0	280, 09		0.000000	
75.00 07500 ASC (NON-DI STI NCT PART)	0	0		0 0. 000000	0. 000000	
76. 00 03020 ENDOSCOPY CENTER 76. 01 03950 WOUND OSTOMY	0 9, 935	0 4, 437, 178		0 0. 000000 3 0. 331264	0.000000	
76. 05 03480 CRCC	9, 935 1, 902	1, 602, 468			0.000000	
OUTPATIENT SERVICE COST CENTERS	1,702	1,002,100	1,001,07	0.201200	0.00000	1 / 0. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0. 000000	0.000000	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0. 000000	0.000000	
90. 00 09000 CLINIC	0	0		0 0. 000000	0.000000	
90. 23 09023 CLI NI C 90. 25 09025 CLI NI C	158, 386	501, 871	660, 25	0 0. 000000 7 0. 368223	0. 000000 0. 000000	
90. 27 09027 CLINIC	0	0	000, 23	0.000000	0. 000000	
91.00 09100 EMERGENCY	1, 736, 759	18, 213, 945	19, 950, 70		0.000000	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	53, 678	1, 088, 698		6 0. 758742	0. 000000	92.00
OTHER REI MBURSABLE COST CENTERS		_		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.000053	
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	0		0 0. 000000 0 0. 000000	0. 000000 0. 000000	
95.00 09500 AMBULANCE SERVICES 96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0.000000	0.00000	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0.000000	0. 000000	
98. 00 09851 OTHER REI MBURSABLE COST CENTERS	Ő	0		0 0. 000000	0. 000000	
99. 00 09900 CMHC	0	0		0		99.00
99. 10 09910 CORF	0	0		0		99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0		0		100.00
SPECIAL PURPOSE COST CENTERS	0	0	I		<u> </u>	
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0		105.00
106. 00 10600 HEART ACQUI SI TI ON	Ő	0		o		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0		108.00
109. 00 10900 PANCREAS ACQUI SITION 110. 00 11000 INTESTINAL ACQUI SITION	0	0				109.00 110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00

Health Financial Systems	WESTVIEW H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014		
		Tit	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116. 00 11600 HOSPI CE	0	0		0		116.00
200.00 Subtotal (see instructions)	25, 678, 711	105, 366, 105	131, 044, 81	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	25, 678, 711	105, 366, 105	131, 044, 81	6		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150129 Period: From 01/01/2014 Worksheet 0 Part I To 12/31/2014 Date/Time 1 Cost Center Description PPS Inpatient Ratio 11 00 12 00 11 00	Prepared: 6:13 pm
To 12/31/2014 Date/Time Date/Time 5/27/2015 Cost Center Description PPS Inpatient Ratio	6:13 pm t
Title XIX Hospital Cost Cost Center Description PPS Inpatient Ratio For the XIX Hospital Cost	t
Ratio	30.00
	30.00
11.00	30.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	30.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T	31.00
32. 00 03200 CORONARY CARE UNI T	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	34.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	40.00 41.00
42. 00 04200 SUBPROVI DER	42.00
43. 00 04300 NURSERY	43.00
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	44.00
45. 00 04500 NURSI NG FACILI TY 46. 00 04600 OTHER LONG TERM CARE	45.00 46.00
ANCI LLARY SERVICE COST CENTERS	101.00
50. 00 05000 OPERATING ROOM 0. 000000	50.00
51.00 O5100 RECOVERY ROOM 0.000000 52.00 O5200 DELIVERY ROOM & LABOR 0.000000	51.00 52.00
53. 00 05300 ANESTHESI OLOGY 0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000	55.00
56. 00 05600 RADI 0I SOTOPE 0. 000000 57. 00 05700 CT SCAN 0. 000000	56.00 57.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGI NG (MRI) 0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000	59.00
60. 00 06000 LABORATORY 0. 000000	60.00
60. 01 06001 BLOOD LABORATORY 0. 000000 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM 0. 000000	60. 01 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY 0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY 0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000	70.00 71.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 000000 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000	73.00
74. 00 07400 RENAL DI ALYSI S 0. 000000	74.00
75. 00 07500 ASC (NON-DI STINCT PART) 0. 000000 76. 00 03020 ENDOSCOPY CENTER 0. 000000	75.00 76.00
76. 01 03950 WOUND_OSTOMY 0. 000000	76.00
76. 05 03480 CRCC 0. 000000	76.05
OUTPATI ENT SERVICE COST CENTERS	
88.00 08800 RURAL HEALTH CLINIC 0.000000 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000	88.00 89.00
90. 00 09000 CLINIC 0. 000000	90.00
90. 23 09023 CLINIC 0. 000000	90. 23
90. 25 09025 CLINIC 0. 000000	90.25
90. 27 09027 CLINIC 0.000000 91. 00 09100 EMERGENCY 0.000000	90. 27 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	
94. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000	94.00
95.00 09500 AMBULANCE SERVICES 0.000000 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000	95.00 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0. 000000	97.00
98. 00 09851 OTHER REI MBURSABLE COST CENTERS 0. 000000	98.00
99. 00 09900 CMHC 99. 10 09910 CORF	99.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	99. 10 100. 00
101.00 10100 HOME HEALTH AGENCY	100.00
SPECIAL PURPOSE COST CENTERS	4
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	105. 00 106. 00
106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION	106.00
108. 00 10800 LUNG ACQUI SI TI ON	108.00
109.00 10900 PANCREAS ACQUISITION	109.00
110. 00 11000 INTESTINAL_ACQUISITION 111. 00 11100 ISLET_ACQUISITION	110. 00 111. 00
113. 00 11300 I NTEREST EXPENSE	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	114.00

Health Financial Systems	WESTVIEW H	OSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150129	Peri od:	Worksheet C	
			From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	narod
			10 12/31/2014	5/27/2015 6:1	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					115.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	WESTVIEW F	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	AL COSTS		CCN: 150129	Period: From 01/01/2014 To 12/31/2014	5/27/2015 6:1	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	•	3 / col 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SUGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199) Cost Center Description	803,982 112,613 0 0 53,743 162,312 0 0 1,132,650 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	803, 98 112, 61 53, 74 162, 31 1, 132, 68	3 393 0 0 0 0 0 0 0 0 0 0 1,066 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		31.00 32.00 33.00 34.00 40.00 41.00 42.00
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00ADULTS & PEDIATRICS31. 00INTENSIVE CARE UNIT32. 00CORONARY CARE UNIT33. 00BURN INTENSIVE CARE UNIT34. 00SURGICAL INTENSIVE CARE UNIT40. 00SUBPROVIDER - IPF41. 00SUBPROVIDER - IRF42. 00SUBPROVIDER43. 00NURSERY	1,072 185 0 0 0 351 605 0 0	301, 243 53, 012 0 0 53, 742 92, 117 0 0				30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00
44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30-199)	0 0 2, 213	0 0 500, 114				44.00 45.00 200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	HOSPI TAL Provi der	CCN: 150129	Peri od:	u of Form CMS-: Worksheet D	
				From 01/01/2014 To 12/31/2014	Part II Date/Time Pre	
			e XVIII	Hospi tal	5/27/2015 6:1 PPS	<u>3 pm</u>
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	L. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	770 440	00 (00 005			F (000	1 50 00
50. 00 05000 OPERATI NG ROOM	779, 448					
51.00 05100 RECOVERY ROOM	0		0.0000			
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	-	-	0.0000		0	
	0 502.070		0.0000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	583, 879	9, 868, 573			24, 201	54.00
56. 00 05600 RADIOLOGI - THERAPEUTIC			0.0000		-	
57. 00 05700 CT SCAN	12, 801	-			-	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	10, 448					•
59. 00 05900 CARDIAC CATHETERIZATION	10, 448	2, 998, 716	0.00348			58.00
60. 00 06000 LABORATORY	222, 152	17, 732, 624			0 15, 103	•
60. 01 06001 BLOOD LABORATORY	222, 132		0.0000		0	•
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0.00000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0. 00000	0 0	0	•
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.					-	
64. 00 06400 I NTRAVENOUS THERAPY	0				-	•
65. 00 06500 RESPIRATORY THERAPY	59, 295				-	
66. 00 06600 PHYSI CAL THERAPY	290, 320					
67. 00 06700 OCCUPATIONAL THERAPY	46, 276					•
68. 00 06800 SPEECH PATHOLOGY	9, 229				853	•
69. 00 06900 ELECTROCARDI OLOGY	48, 711					•
70. 00 07000 ELECTROENCEPHALOGRAPHY	8, 919				21	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39, 823					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	93, 264				8, 838	
73.00 07300 DRUGS CHARGED TO PATIENTS	157, 310					•
74. 00 07400 RENAL DIALYSIS	3, 453					
75.00 07500 ASC (NON-DISTINCT PART)	0					•
76.00 03020 ENDOSCOPY CENTER	0	c c	0. 00000	0 00	0	76.00
76.01 03950 WOUND OSTOMY	218, 171	4, 447, 113	0. 0490	59 0	0	76.01
76. 05 03480 CRCC	80, 919	1, 604, 370	0. 05043	37 895	45	76.05
OUTPATIENT SERVICE COST CENTERS					•	1
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.0000	0 00	0	89.00
90. 00 09000 CLINIC	0	C	0.0000	0 00	0	90.00
90. 23 09023 CLI NI C	0	C	0.0000	0 00	0	90.23
90. 25 09025 CLI NI C	7,852	660, 257	0. 0118	92 0	0	90.25
90. 27 09027 CLINIC	0		0.0000	0 00	0	90.27
91.00 09100 EMERGENCY	267, 408	19, 950, 704	0. 01340	03 443, 542	5, 945	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	152, 029	1, 142, 376	0. 13308	81 19, 892	2, 647	92.00
OTHER REIMBURSABLE COST CENTERS		1				
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	-			-	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0				-	
98.00 09851 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50-199)	0 3, 091, 707		0.00000		0	
		125, 856, 491	1	8, 159, 808	172, 607	

Health Financial Systems	WESTVIEW H	HOSPI TAI		Inlie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		rs Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part III Date/Time Pre 5/27/2015 6:1	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	Medical Education Cos	instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0	41.00 42.00 43.00
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY 200. 00 Total (lines 30-199)				0 0 0	0 0	44.00 45.00 200.00
Cost Center Description	Total Patient Days 6.00	7.00	Inpatient Program Days 8.00	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
111 111 <td>2, 861 393 0 0 351 1, 066 0 0 0 0 0 0 0 0 4, 671</td> <td></td> <td>3!</td> <td>35 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td></td> <td>30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 200.00</td>	2, 861 393 0 0 351 1, 066 0 0 0 0 0 0 0 0 4, 671		3!	35 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 200.00

	Financial Systems	WESTVIEW HO				u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	VICE OTHER PASS	Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
-			Titl	e XVIII	Hospi tal	PPS	<u>5 piii</u>
	Cost Center Description	Non Physician N	ursing School	Allied Health		Total Cost	
		Anestheti st	-		Medi cal	(sum of col 1	
		Cost			Education Cost		
		1.00	2.00	3.00	4.00	4) 5.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	05000 OPERATING ROOM	0	0		0 0	0	50.00
	05100 RECOVERY ROOM	0	0		0 0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	•
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
	05600 RADI OI SOTOPE	0	0		0 0	0	•
	05700 CT SCAN	0	0		0 0	0	•
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	•
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	•
	06000 LABORATORY	0	0		0 0	0	
	06001 BLOOD LABORATORY	0	0		0 0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		o o	0	61.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
	06500 RESPIRATORY THERAPY	0	0		0 0	0	
	06600 PHYSI CAL THERAPY	0	0		0 0	0	
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
	06800 SPEECH PATHOLOGY	0	0		0 0	0	•
	06900 ELECTROCARDI OLOGY	0	0		o o	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	07400 RENAL DIALYSIS	0	0		0 0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	
	03020 ENDOSCOPY CENTER	0	0		0 0	0	
	03950 WOUND OSTOMY	0	0		0 0	0	
76.05	03480 CRCC	0	0		0 0	0	76.05
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	[0 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	•
	09000 CLINIC	0	0		0 0	0	•
	09023 CLI NI C	0	0		0 0	0	
	09025 CLI NI C	0	0		0 0	0	•
	09027 CLINIC	0	0		0 0	0	•
	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				1		
	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
	09500 AMBULANCE SERVI CES						95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
	09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
200.00	Total (lines 50-199)	0	0		0 0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY		HOSPI TAL	CCN: 150129	Peri od:	u of Form CMS-2 Worksheet D	2002 1
THROUGH COSTS	SERVICE UTHER PAS	S Provider		From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/27/2015 6:1	
		Ti tl	e XVIII	Hospi tal	PPS	o piii
Cost Center Description	Total	Total Charges			Inpati ent	
'	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	Ū	
	4)			7)		
L	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS					1 (0(050	-
50. 00 05000 OPERATING ROOM	0					
51.00 05100 RECOVERY ROOM	0				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				0	
53. 00 05300 ANESTHESI OLOGY	0	-	0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0				409, 046	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	-	0.00000		0	
56. 00 05600 RADI OI SOTOPE	0	-			0	
57.00 05700 CT SCAN	0	., ,			318, 674	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	_,			64, 829	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.00000		0	
50. 00 06000 LABORATORY	0	17, 732, 624	0.00000	0.00000	1, 205, 577	60.00
50. 01 06001 BLOOD LABORATORY	0	0 0	0.00000	0.00000	0	60.01
51.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0.00000	0	62.00
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	0. 000000	0	63.00
54.00 06400 INTRAVENOUS THERAPY	0	0	0. 00000	0. 000000	0	64.00
55. 00 06500 RESPI RATORY THERAPY	0	1, 588, 568	0. 00000	0. 000000	374, 320	65.00
56. 00 06600 PHYSI CAL THERAPY	0	3, 478, 690	0.00000	0. 000000	127, 586	66.00
57.00 06700 OCCUPATI ONAL THERAPY	0	691, 272	0.00000	0. 000000	61, 782	67.00
58.00 06800 SPEECH PATHOLOGY	0	217, 260	0.00000	0. 000000	20, 077	68.00
59. 00 06900 ELECTROCARDI OLOGY	0	4, 773, 960	0. 00000	0.000000	348, 026	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	2, 386, 012	0. 00000	0. 000000	5, 694	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o 0	4, 195, 683	0.00000	0. 000000	754, 520	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				931, 104	
73.00 07300 DRUGS CHARGED TO PATIENTS	0				1, 259, 059	
74.00 07400 RENAL DIALYSIS	0				118, 932	
75.00 07500 ASC (NON-DISTINCT PART)	0		0. 00000	0. 000000	0	75.00
76.00 03020 ENDOSCOPY CENTER	0				0	
76.01 03950 WOUND OSTOMY	0	4, 447, 113			0	76.01
76. 05 03480 CRCC	0				895	
OUTPATIENT SERVICE COST CENTERS						
38. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0.000000	0	88. 00
39. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0.00000	0.00000	0	89.00
90. 00 09000 CLINIC	0	c c	0.00000	0. 000000	0	90.00
70. 23 09023 CLINIC	0	o c	0. 00000	0. 000000	0	90.23
90. 25 09025 CLINIC	0	660, 257	0. 00000	0. 000000	0	90.25
70. 27 09027 CLINIC	0		0. 00000	0. 000000	0	90.27
91.00 09100 EMERGENCY	0	19, 950, 704	0.00000	0. 000000	443, 542	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-				19, 892	
OTHER REIMBURSABLE COST CENTERS						1 1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	0.00000	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0. 00000	0.00000	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		1		0	
	0		1		0	
78.00 10985110THER REIMBURSABLE COST CENTERS						
98.00 09851 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50-199)	0			-	8, 159, 808	

Health Financial Systems	WESTVIEW H	OSPI TAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/27/2015 6:	epared: 13 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12)	h		
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS	•			L		
50.00 05000 OPERATING ROOM	0	4, 933, 713		0		50.00
51.00 05100 RECOVERY ROOM	0	0		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 262, 330		0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0		56.00
57.00 05700 CT SCAN	0	1, 001, 070		0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	684, 682		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 06000 LABORATORY	0	1, 616, 480		0		60.00
60. 01 06001 BLOOD LABORATORY	0	0		0		60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	82, 424		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	6, 085		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 641, 486		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	1, 501, 222		0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	514, 147		0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	4, 290, 276		0		73.00
74. 00 07400 RENAL DI ALYSI S	0	1, 749		0		74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0		0		75.00
76. 00 03020 ENDOSCOPY CENTER 76. 01 03950 WOUND OSTOMY	0	2, 417, 589		0		76.00
76. 05 03480 CRCC	0	2, 417, 589 495, 640		0		76.01
OUTPATIENT SERVICE COST CENTERS	0	495, 640	1	0		70.05
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLINIC	0	0		0		90.00
90. 00 109000 CETNIC 90. 23 09023 CLINIC	0	0		0		90.00
90. 25 09025 CLINIC	0	0		0		90.23
90. 27 09023 CLINIC	0	0		0		90.25
90. 27 09027 CETNIC 91. 00 09100 EMERGENCY	0	1, 677, 207		0		90.27
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	143, 562		0		92.00
OTHER REIMBURSABLE COST CENTERS	0	145, 502		V		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	Ω		0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-KENTED	0	0		0		97.00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0		98.00
200.00 Total (lines 50-199)	0	23, 269, 662		0		200.00
200.00 [10tul (11103 00-177)	ı V	20,207,002	I	Ч Ч		1200.00

PPORTI ON	nancial Systems MENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCI NE COST		CCN: 150129	Period: From 01/01/2014 To 12/31/2014		pared:
			Titl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.)		F 00	
		1.00	2.00	3.00	4.00	5.00	
	CI LLARY SERVI CE COST CENTERS	0. 267401	4, 933, 713		0 0	1, 319, 280	50.00
	100 RECOVERY ROOM	0. 207401			0 0	1, 319, 200	51.00
					0 0	-	
	200 DELIVERY ROOM & LABOR ROOM	0.000000			0 0	0	52.00
	300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C	0. 261943			0 0	592, 602	
	500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	55.00
	600 RADI OI SOTOPE	0. 000000			0 0	0	56.00
	700 CT SCAN	0. 052446			0 0	52, 502	
	BOO MAGNETIC RESONANCE IMAGING (MRI)	0. 074895			0 0	51, 279	
	900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	59.00
0.00 060	DOO LABORATORY	0. 166387	1, 616, 480		0 0	268, 961	60.00
0. 01 060	DO1 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
1.00 06 ⁻	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
2.00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
3.00 063	300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
4.00 064	400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
5.00 065	500 RESPI RATORY THERAPY	0. 471918			0 0	38, 897	65.00
	500 PHYSI CAL THERAPY	0. 464454			0 0	0	66.00
	700 OCCUPATIONAL THERAPY	0. 395270			0 0	0	67.00
	BOO SPEECH PATHOLOGY	0. 250631			0 0	1, 525	•
	900 ELECTROCARDI OLOGY	0. 165377			0 0	271, 464	1
	DOO ELECTROENCEPHALOGRAPHY	0. 095611			0 0	0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 240522			64 0	361, 077	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 240522			0 0	123, 672	72.00
	300 DRUGS CHARGED TO PATIENTS	0. 318988			0 987	1, 368, 547	73.00
	400 RENAL DI ALYSI S	0. 394184			0 0	1, 308, 347	
	500 ASC (NON-DISTINCT PART)	0. 000000			0 0	009	75.00
	,				-		
	D20 ENDOSCOPY CENTER	0. 000000			0 0	0	76.00
	950 WOUND OSTOMY	0. 331264			0 0		
	480 CRCC	0. 284265	495, 640		0 0	140, 893	76.05
	TPATIENT SERVICE COST CENTERS	0.000000	1	1		0	
	BOO RURAL HEALTH CLINIC	0. 000000				0	88.00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
		0. 000000			0 0	0	90.00
	D23 CLINIC	0. 000000			0 0	0	90.23
	D25 CLINIC	0. 368223			0 0	0	90.25
	D27 CLINIC	0. 000000			0 0	-	
	100 EMERGENCY	0. 194811			0 0		
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 758742	143, 562		0 0	108, 927	92.00
	HER REIMBURSABLE COST CENTERS	1	1				
	400 HOME PROGRAM DI ALYSI S	0. 000000			0		94.00
	500 AMBULANCE SERVI CES	0. 000000			0		95.00
6.00 096	500 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0		0 0	0	96.00
7.00 097	700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000	0		0 0	0	97.00
	B51 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
00.00	Subtotal (see instructions)		23, 269, 662	20	64 987	5, 827, 913	
01.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
02.00	Net Charges (line 200 +/- line 201)	1	23, 269, 662		64 987	5, 827, 913	laga a

	Financial Systems	WESTVIEW H			Lieu of Form CMS-2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 1	50129 Peri od: From 01/01/20 To 12/31/20	
			Title XVII	I Hospital	PPS
	·	Cos	ts		
	Cost Center Description	Cost	Cost		
		Reimbursed	Reimbursed		
		Servi ces	Services Not		
		Subject To Ded. & Coins.	Subject To Ded. & Coins.		
		(see inst.)	(see inst.)		
		6.00	7.00		
A	NCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0	0		50.00
51.00 C	05100 RECOVERY ROOM	0	0		51.00
52.00 0	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 C	05300 ANESTHESI OLOGY	0	0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
	05600 RADI OI SOTOPE	0	0		56.00
	05700 CT SCAN	0	0		57.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		59.00
1	06000 LABORATORY	0	0		60.00
1	06001 BLOOD LABORATORY	0	0		60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		61.00 62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
	06400 I NTRAVENOUS THERAPY	0	0		64.00
	06500 RESPI RATORY THERAPY	0	0		65.00
	06600 PHYSI CAL THERAPY	0	0		66.00
	06700 OCCUPATI ONAL THERAPY	0	0		67.00
	06800 SPEECH PATHOLOGY	0	o		68.00
	06900 ELECTROCARDI OLOGY	0	0		69.00
1	7000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	63	o		71.00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	0	315		73.00
	07400 RENAL DIALYSIS	0	0		74.00
	07500 ASC (NON-DI STINCT PART)	0	0		75.00
	03020 ENDOSCOPY CENTER	0	0		76.00
	03950 WOUND OSTOMY	0	0		76.01
		0	0		76. 05
	DUTPATIENT SERVICE COST CENTERS	0	0		
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		88. 00 89. 00
	09000 CLINIC	0	0		90.00
	09023 CLINIC	0	0		90. 23
	09025 CLINIC	0	0		90. 25
	09027 CLINIC	0	0		90.23
	09100 EMERGENCY	0	o		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
	THER REIMBURSABLE COST CENTERS	-1			
	09400 HOME PROGRAM DI ALYSI S	0	0		94.00
	09500 AMBULANCE SERVICES	0			95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00 C	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98. 00 C	09851 OTHER REIMBURSABLE COST CENTERS	0	o		98.00
200.00	Subtotal (see instructions)	63	315		200.00
201.00	Less PBP Clinic Lab. Services-Program	0			201.00
	Only Charges				
202.00	Net Charges (line 200 +/- line 201)	63	315		202.00

alth Financial Systems	WESTVIEW I		CON 150100		u of Form CMS-2	2552-10
PORTIONMENT OF INPATIENT ANCILLARY SERVICE CA	PITAL COSTS		CCN: 150129 t CCN: 15S129	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/27/2015 6:1	
		Ti tl	e XVIII	Subprovider -	PPS	5 pill
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	779, 448	23, 600, 395	0. 03302	27 0	0	50.00
					0	
	0					
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-			0	
. 00 05300 ANESTHESI OLOGY	0					
. 00 05400 RADI OLOGY-DI AGNOSTI C	583, 879				298	
. 00 05500 RADI OLOGY-THERAPEUTI C	0				0	
. 00 05600 RADI 0I SOTOPE	0	-			0	
. 00 05700 CT SCAN	12, 801				16	
00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	10, 448				0	
. 00 05900 CARDI AC CATHETERI ZATI ON	0	-			0	
00 06000 LABORATORY	222, 152	17, 732, 624			588	
01 06001 BLOOD LABORATORY	0	C	0.0000	0 00	0	
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61.0
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		C			0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-			0	
. 00 06400 I NTRAVENOUS THERAPY	0	-			0	
. 00 06500 RESPI RATORY THERAPY	59, 295				130	
. 00 06600 PHYSI CAL THERAPY	290, 320				79	
. 00 06700 OCCUPATI ONAL THERAPY	46, 276				0	
. 00 06800 SPEECH PATHOLOGY	9, 229				0	
. 00 06900 ELECTROCARDI OLOGY	48, 711				9	
. 00 07000 ELECTROENCEPHALOGRAPHY	8, 919				0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT					50	•
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	93, 264	9, 825, 581			0	72.0
. 00 07300 DRUGS CHARGED TO PATIENTS	157, 310	11, 716, 382	0. 01342	26 116, 320	1, 562	73.0
. 00 07400 RENAL DIALYSIS	3, 453	280, 095	0. 01232	28 0	0	74.0
. 00 07500 ASC (NON-DISTINCT PART)	0	C	0.0000	0 00	0	
. 00 03020 ENDOSCOPY CENTER	0	C	0.0000	0 00	0	76.0
. 01 03950 WOUND OSTOMY	218, 171	4, 447, 113	0. 04905	59 0	0	76.0
. 05 03480 CRCC	80, 919	1, 604, 370	0. 05043	37 0	0	76.0
OUTPATIENT SERVICE COST CENTERS						
. 00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 00	0	88.0
. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.0000	0 00	0	89.0
. 00 09000 CLINIC	0	C	0.0000	0 00	0	90.0
. 23 09023 CLI NI C	0	C			0	90.2
. 25 09025 CLINIC	7, 852	660, 257	0. 01189	92 0	0	90. 2
. 27 09027 CLINIC	0	C	0.0000	0 00	0	90.2
. 00 09100 EMERGENCY	267, 408				24	91.00
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0 00	0	92.00
OTHER REIMBURSABLE COST CENTERS						
. 00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	94.0
. 00 09500 AMBULANCE SERVICES						95.0
. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	c c	0. 00000	0 00	0	
. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	c c	0. 00000	0 00	0	97.0
. OU UUFTOU DURABLE MEDICAL EQUIF-SOLD						
00 09851 OTHER REIMBURSABLE COST CENTERS	0	c c	0.0000	0 00	0	98.00 200.00

Health Financial Systems	WESTVIEW H				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PASS		CCN: 150129 t CCN: 15S129	Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Subprovider - IPF	PPS	<u>o p</u>
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st			Medical	(sum of col 1	
	Cost			Education Cost	through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		2100	0.00		0.00	
50. 00 05000 OPERATI NG ROOM	0	C)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C)	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0		
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	
56. 00 05600 RADI OI SOTOPE	0	C		0 0		
57. 00 05700 CT SCAN	0	C		0 0	-	
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	C		0 0	-	
59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY	0	C		0 0	-	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	C		0 0	-	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	1	0 0	-	
64. 00 06400 I NTRAVENOUS THERAPY	0	C		0 0	-	
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0		
66.00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C)	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	-	
74. 00 07400 RENAL DI ALYSI S	0	C		0 0	-	
75. 00 07500 ASC (NON-DI STINCT PART) 76. 00 03020 ENDOSCOPY CENTER	0	C		0 0	0	1
76. 01 03950 WOUND OSTOMY	0	0		0 0		1
76. 05 03480 CRCC	0	C		0 0		1
OUTPATIENT SERVICE COST CENTERS			1		<u> </u>	/0.00
88. 00 08800 RURAL HEALTH CLINIC	0	C)	0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0		1
90. 00 09000 CLINIC	0	C		0 0	0	90.00
90. 23 09023 CLI NI C	0	C		0 0	0	90.23
90. 25 09025 CLI NI C	0	C		0 0	0	90.25
90. 27 09027 CLINIC	0	C)	0 0	0	90.27
91. 00 09100 EMERGENCY	0	C		0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	C		0 0	0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C)	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0	-	1
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	C		0 0		1
200.00 Total (lines 50-199)	0	C		0 0	0	200.00

Health Financial Systems	WESTVI EW	HOSPI TAL			u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 150129	Peri od:	Worksheet D	
THROUGH COSTS		Componer	t CCN: 15S129	From 01/01/2014 To 12/31/2014		
		Tit	le XVIII	Subprovider - IPF	PPS	
Cost Center Description	Total		Ratio of Cos		Inpati ent	
	Outpatient	(from Wkst. C	U U	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	8.00	7)	10.00	
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
50.00 05000 OPERATING ROOM	0	23, 600, 39	5 0. 00000	0.00000	0	50.00
51.00 05100 RECOVERY ROOM	0		0. 00000	0. 000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0. 00000	0. 000000	0	52.00
53. 00 05300 ANESTHESI OLOGY	0		0. 00000	0. 000000	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 868, 57	0. 00000	0. 000000	5, 031	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0. 00000	0. 000000	0	55.00
56. 00 05600 RADI 0I SOTOPE	0		0. 00000		0	56.00
57.00 05700 CT SCAN	0	4, 697, 86	0. 00000			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0. 00000		l o	59.00
60. 00 06000 LABORATORY	0	17, 732, 62			46, 901	60.00
60. 01 06001 BLOOD LABORATORY	0		0. 00000	0. 000000	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0. 00000	0.00000	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0.0000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	0				3, 480	•
66. 00 06600 PHYSI CAL THERAPY	0				945	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0				0	67.00
68.00 06800 SPEECH PATHOLOGY	0				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0				930	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				116, 320	73.00
74. 00 07400 RENAL DI ALYSI S	0				0	74.00
75.00 07500 ASC (NON-DI STINCT PART)	0		0.0000		0	75.00
76. 00 03020 ENDOSCOPY CENTER	0		0.0000		0	76.00
76. 01 03950 WOUND OSTOMY	0				0	76.01
76. 05 03480 CRCC	0				0	76.05
OUTPATIENT SERVICE COST CENTERS	-1	, , , , , ,				
88.00 08800 RURAL HEALTH CLINIC	0		0.0000	0.00000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 00000	0. 000000	0	89.00
90. 00 09000 CLINIC	0		0. 00000		0	90.00
90. 23 09023 CLINIC	0		0. 00000		0	90.23
90. 25 09025 CLINIC	0	660, 25			0	90.25
90. 27 09027 CLINIC	0		0. 00000		0	90.27
91. 00 09100 EMERGENCY	0	19, 950, 70	4 0. 00000	0. 000000	1, 784	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS			-1	-		
94. 00 09400 HOME PROGRAM DI ALYSI S	0		0.0000	0.00000	0	
95. 00 09500 AMBULANCE SERVICES	_				_	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0.0000		0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0		0.0000		0	•
98.00 09851 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50-199)	0		0.0000	0. 00000	0	98.00
200.00 Total (lines 50-199)	0	125, 856, 49	11	1	186, 398	1200-00

Health Financial Systems	WESTVIEW H				u of Form CMS	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI THROUGH COSTS	ERVICE OTHER PASS		CCN: 150129	Period: From 01/01/2014 To 12/31/2014		epared.
					5/27/2015 6:	
		lit	le XVIII	Subprovider - IPF	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent		.4	
	Program	Program	Program			
	Pass-Through Costs (col. 8	Charges	Pass-Throug Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS					-	
50.00 05000 OPERATING ROOM	0		0	0		50.00
51.00 05100 RECOVERY ROOM	0		0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		D	0		52.00
53.00 05300 ANESTHESI OLOGY	0		0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		0	0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0		55.00
56. 00 05600 RADI OI SOTOPE	0		0	0		56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0		57.00 58.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0			0		59.00
60. 00 06000 LABORATORY	0		0	0		60.00
60. 01 06001 BLOOD LABORATORY	0		0	0		60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0		61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0		62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		o	0		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0		o	0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	(0	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0		o	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0		0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	(0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0		0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	0		73.00
74.00 07400 RENAL DI ALYSI S	0		0	0		74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0		0	0		75.00
76. 00 03020 ENDOSCOPY CENTER	0		0	0		76.00
76. 01 03950 WOUND OSTOMY 76. 05 03480 CRCC	0		0	0		76.01
OUTPATIENT SERVICE COST CENTERS	<u> </u>		<u>ч</u>	0		/0.05
88. 00 08800 RURAL HEALTH CLINIC	0		0	0		88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0		89.00
90. 00 09000 CLINIC	0		o	0		90.00
90. 23 09023 CLINIC	0	(0	0		90.23
90. 25 09025 CLINIC	0		o	0		90.25
90. 27 09027 CLINIC	0		o	0		90.27
91.00 09100 EMERGENCY	0	(0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0		92.00
OTHER REIMBURSABLE COST CENTERS			-1	_		_
94. 00 09400 HOME PROGRAM DI ALYSI S	0		0	0		94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0	0		96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0		0	0		97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0		0	0		98.00
200.00 Total (lines 50-199)	0		0	0		200.00

ealth Financial Systems PPORTIONMENT OF INPATIENT AN	CILLARY SERVICE CARLEA		IOSPI TAL	CCN: 150129	Peri od:	u of Form CMS-2 Worksheet D	2002-10
FFORTIONMENT OF TNEATTENT AN	GILLARI SERVICE CAFITA	L 00313			From 01/01/2014 To 12/31/2014	Part II Date/Time Pre 5/27/2015 6:1	
			Ti tl	e XVIII	Subprovider - IRF	PPS	
Cost Center Descr	ription	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00	1.00	F 00	
		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST	CENTERS	770 440	22 (00 205	0.0000		170	
0.00 05000 OPERATING ROOM		779, 448	23, 600, 395			172	
1.00 05100 RECOVERY ROOM		0	C			0	51.00
2.00 05200 DELIVERY ROOM & L	ABOR ROOM	0	C			0	52.00
3. 00 05300 ANESTHESI OLOGY		0	0			0	53.00
4. 00 05400 RADI OLOGY-DI AGNOS		583, 879	9, 868, 573			1, 059	
5. 00 05500 RADI OLOGY-THERAPE	UTIC	0	C			0	55.00
6. 00 05600 RADI 0I SOTOPE		0	C			0	56.00
7.00 05700 CT SCAN		12, 801	4, 697, 860			35	57.00
B. 00 05800 MAGNETIC RESONANC		10, 448	2, 998, 716			0	58.00
9.00 05900 CARDI AC CATHETERI	ZATION	0	C			0	59.00
D. 00 06000 LABORATORY		222, 152	17, 732, 624			2, 267	60.00
D. 01 06001 BLOOD LABORATORY		0	C	0.00000	0 0	0	60. O
1.00 06100 PBP CLINICAL LAB							61.00
2.00 06200 WHOLE BLOOD & PAC		0	C			0	62.00
3.00 06300 BLOOD STORING, PR		0	C			0	63.00
4.00 06400 INTRAVENOUS THERA		0	C			0	64.00
5. 00 06500 RESPI RATORY THERA	λPY	59, 295	1, 588, 568			2, 146	65.00
6. 00 06600 PHYSI CAL THERAPY		290, 320	3, 478, 690	0. 08345	57 311, 473	25, 995	66.00
7.00 06700 OCCUPATIONAL THER	APY	46, 276	691, 272	0. 06694	3 292, 150	19, 557	67.00
8.00 06800 SPEECH PATHOLOGY		9, 229	217, 260	0. 04247	77, 614	3, 297	68.00
9. 00 06900 ELECTROCARDI OLOGY	, ,	48, 711	4, 773, 960	0. 01020	6, 211	63	69.00
D. 00 07000 ELECTROENCEPHALOG		8, 919	2, 386, 012	0.00373	88 0	0	70.00
1.00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENTS	39, 823	4, 195, 683	0.00949	65, 123	618	71.00
2.00 07200 IMPL. DEV. CHARGE	D TO PATIENTS	93, 264	9, 825, 581	0.00949	02 0	0	72.0
3.00 07300 DRUGS CHARGED TO	PATIENTS	157, 310	11, 716, 382	0. 01342	315, 966	4, 242	73.00
4.00 07400 RENAL DIALYSIS		3, 453	280, 095	0. 01232	28 0	0	74.00
5.00 07500 ASC (NON-DISTINCT	PART)	0	C	0. 00000	0 0	0	75.00
6.00 03020 ENDOSCOPY CENTER		0	C	0.00000	0 0	0	76.00
6.01 03950 WOUND OSTOMY		218, 171	4, 447, 113	0. 04905	59 0	0	76.0 ⁴
6. 05 03480 CRCC		80, 919	1, 604, 370	0. 05043	37 0	0	76.05
OUTPATIENT SERVICE COST	r centers						
8.00 08800 RURAL HEALTH CLIN	II C	0	C	0.00000	0 0	0	88.00
9. 00 08900 FEDERALLY QUALIFI	ED HEALTH CENTER	0	C	0.00000	0 0	0	89.00
D. 00 09000 CLINIC		0	C	0.00000	0 0	0	90.00
D. 23 09023 CLINIC		0	C	0.00000	0 0	0	90. 23
0. 25 09025 CLINIC		7, 852	660, 257	0. 01189	02 0	0	90.25
D. 27 09027 CLINIC		0	C			0	90.27
1.00 09100 EMERGENCY		267, 408	19, 950, 704	0. 01340	03 0	0	91.00
2.00 09200 OBSERVATION BEDS	(NON-DISTINCT PART)	0			0 0	0	92.00
OTHER REIMBURSABLE COST							1
4. 00 09400 HOME PROGRAM DI AL		0	C	0.0000	0 00	0	94.0
5. 00 09500 AMBULANCE SERVI CE							95.0
6.00 09600 DURABLE MEDICAL E		0	C	0.00000	0 0	0	
7.00 09700 DURABLE MEDICAL E		0	C			0	
7.00 109700 DURABLE WEDTCAL E						-	
8. 00 09851 OTHER REI MBURSABL	E COST CENTERS	0	C	0.00000	0	0	98.00

Health Financial Systems	WESTVI EW HOSI	PITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/27/2015 6:1	pared: 3 pm
		Ti tl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Non Physician Nur Anesthetist Cost	sing School	Allied Health		Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS					0	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0	0			0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 C	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00 05700 CT SCAN	0	0		0 C	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
	0	0		0 0	0	
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	60.01 61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		o o	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		o o	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 C	0	•
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	•
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	•
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76.00 03020 ENDOSCOPY CENTER	0	0		0 C	0	
76. 01 03950 WOUND OSTOMY	0	0		0 0	0	
76. 05 03480 CRCC	0	0		0 0	0	76.05
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 10	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90. 00 09000 CLINIC	0	0		0 0	0	
90. 23 09023 CLINIC	0	0		0 0	0	
90. 25 09025 CLI NI C	0	0		0 0	0	90.25
90. 27 09027 CLINIC	0	0		0 0	0	90. 27
91. 00 09100 EMERGENCY	0	0		0 C	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		0			0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	0	94.00 95.00
95. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		o o	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
200.00 Total (lines 50-199)	0	0		0 0	0	200.00

	Financial Systems	WESTVI EW					eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S I	Provi der	CCN: 150129	Period: From 01/01/201	Worksheet D 4 Part IV	
THROUG	H COSTS		(Component	CCN: 15T129	To 12/31/201		
				Ti tl	e XVIII	Subprovider - IRF		
	Cost Center Description	Total			Ratio of Cos		Inpati ent	
		Outpati ent		Wkst. C,		Ratio of Cost	U U	
		Cost (sum of			(col. 5 ÷ col		Charges	
		col. 2, 3 and		8)	7)	(col. 6 ÷ col		
		4)	7	. 00	8.00	7)	10.00	
	ANCI LLARY SERVICE COST CENTERS	0.00	, ,	. 00	0.00	7.00	10.00	
50.00	05000 OPERATING ROOM	0	23	, 600, 395	0.0000	0.0000	0 5, 200	50.00
51.00	05100 RECOVERY ROOM	0		0				1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0			0 0	1
53.00	05300 ANESTHESI OLOGY	0		Ū	0.0000	0. 00000	o o	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9	, 868, 573	0.0000	0. 00000	0 17,906	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0.0000	0. 00000	o o	55.00
56.00	05600 RADI OI SOTOPE	0		0	0.0000	0. 00000	o o	56.00
57.00	05700 CT SCAN	0	4	, 697, 860	0.0000	0. 00000	0 12, 746	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2	, 998, 716	0.0000	0. 00000	o 0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		C	0.0000	0. 00000	0 0	59.00
60.00	06000 LABORATORY	0	17	, 732, 624	0.0000	0. 00000	0 180, 956	60.00
60.01	06001 BLOOD LABORATORY	0		0	0.0000	0. 00000	o o	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0.0000	0. 00000	0 0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0.0000	0. 00000	0 0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0		0	0.0000			
65.00	06500 RESPI RATORY THERAPY	0	1	, 588, 568				65.00
66.00	06600 PHYSI CAL THERAPY	0) 3	, 478, 690				
67.00	06700 OCCUPATIONAL THERAPY	0		691, 272				
68.00	06800 SPEECH PATHOLOGY	0		217, 260				
69.00	06900 ELECTROCARDI OLOGY	0		, 773, 960				
70.00	07000 ELECTROENCEPHALOGRAPHY	0		, 386, 012				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		, 195, 683				
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		, 825, 581				
73.00	07300 DRUGS CHARGED TO PATIENTS	0		, 716, 382				
74.00	07400 RENAL DI ALYSI S	0	0	280, 095				
75.00	07500 ASC (NON-DI STI NCT PART)	0	2	0				
76.00	03020 ENDOSCOPY CENTER	0		0				
76.01	03950 WOUND OSTOMY	0		, 447, 113				
76.05	03480 CRCC	0	ו ון	, 604, 370	0.0000	0. 00000	0 0	76.05
88.00	OUTPATIENT SERVICE COST CENTERS	0	1	0	0.0000	0. 00000	0 0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0				
90.00	09000 CLINIC	0		0				
90.00 90.23	09023 CLINIC	0		0				90.23
90.23 90.25	09025 CLINIC	0		660, 257				90.23
90.23 90.27	09027 CLINIC	0	Ś	000, 237				1
	09100 EMERGENCY	0	1	, 950, 704				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1	, 142, 376				92.00
/2.00	OTHER REIMBURSABLE COST CENTERS	. 0	<u>' '</u>	, 172, 370	0.0000	0.0000	<u> </u>	/2.00
94.00	09400 HOME PROGRAM DI ALYSI S	0		0	0.0000	0. 00000	0 0	94.00
95.00	09500 AMBULANCE SERVICES			0		0.00000	-	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0. 00000	0. 00000	o o	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0				
98.00	09851 OTHER REI MBURSABLE COST CENTERS	0		0				1
200.00		0		, 856, 491			1, 342, 848	
			1 120	, 000, 171	I	I.	1 ., 512, 540	

	n Financial Systems	WESTVIEW H					eu of Form CM	
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE GH COSTS	RVICE OTHER PASS		er CCN: 150 ent CCN: 151	From C	l:)1/01/2014 2/31/2014	Date/Time P	repared:
			т	itle XVIII	Subpr	rovider -	5/27/2015 6 PPS	
	Cost Center Description	Inpatient	Outpati en	t Outpat	ient	IRF		
		Program	Program	Progr				
		Pass-Through Costs (col. 8	Charges	Pass-Th Costs (d				
		x col. 10)		x col.				
		11.00	12.00	13. (
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0		0	0			50.00
51.00	05100 RECOVERY ROOM	0		0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0			52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		0	0			53.00 54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0			55.00
56.00	05600 RADI OLSOTOPE	0		0	0			56.00
57.00	05700 CT SCAN	0		o	Ö			57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0			59.00
60.00	06000 LABORATORY	0		0	0			60.00
60. 01	06001 BLOOD LABORATORY	0		0	0			60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0			62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0		0	0			63.00 64.00
65.00	06500 RESPIRATORY THERAPY	0		0	0			65.00
66.00	06600 PHYSI CAL THERAPY	0		0	0			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		0	Ö			67.00
68.00	06800 SPEECH PATHOLOGY	0		0	0			68.00
69.00	06900 ELECTROCARDI OLOGY	0		0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0			73.00
74.00		0		0	0			74.00
75.00 76.00	07500 ASC (NON-DI STINCT PART) 03020 ENDOSCOPY CENTER	0		0	0			75.00
76.00	03950 WOUND OSTOMY	0		0	0			76.01
76.05		0		Ö	õ			76.05
	OUTPATIENT SERVICE COST CENTERS	1						
88.00	08800 RURAL HEALTH CLINIC	0		0	0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0			89.00
90.00	09000 CLI NI C	0		0	0			90.00
90.23	09023 CLINIC	0		0	0			90.23
90.25	09025 CLINIC	0		0	0			90.25
90.27	09027 CLINIC 09100 EMERGENCY	0		0	0			90.27
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0			91.00
, <u>,</u> , 00	OTHER REIMBURSABLE COST CENTERS	0		<u> </u>	5			,2.00
94.00		0		0	0			94.00
95.00					-			95.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0		0	0			96.00
97.00		0		0	0			97.00
98.00		0		0	0			98.00
200.00	D Total (lines 50-199)	0		0	0			200.00

	Financial Systems WESTVIEW HOSP FATION OF INPATIENT OPERATING COST	Provider CCN: 150129	Period: From 01/01/2014	u of Form CMS-2 Worksheet D-1			
			To 12/31/2014	Date/Time Pre 5/27/2015 6:1			
	Cost Center Description	Title XVIII	Hospi tal	PPS			
	PART I - ALL PROVIDER COMPONENTS			1.00			
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	oveluding nowborn)		2, 861	1 1.		
00	Inpatient days (including private room days, excluding swing-be	ed and newborn days)		2, 861	2.		
00	Private room days (excluding swing-bed and observation bed days do not complete this line.	s). If you have only pr	ivate room days,	0	3.		
00 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room reporting period		er 31 of the cost	2, 320 0			
00	Total swing-bed SNF type inpatient days (including private roor	m days) after December	31 of the cost	0	6		
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7		
00	reporting period Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	31 of the cost	0	8		
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)						
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructi	0	10				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	ly (including private r	room days) after	0	11		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year			0	13		
. 00	Medically necessary private room days applicable to the Program			0			
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0			
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	of the cost	0.00	17		
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	s after December 31 of	the cost	0.00	18		
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	f the cost	0.00	19		
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20		
. 00 . 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	4, 583, 776 0			
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3		0.1	0			
. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24		
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3		5 · · ·	0	25		
. 00	Total swing-bed cost (see instructions)		,	0			
. 00	General inpatient routine service cost net of swing-bed cost (I	line 21 minus line 26)		4, 583, 776			
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28		
. 00	Private room charges (excluding swing-bed charges)			0			
. 00	Semi-private room charges (excluding swing-bed charges)	lino 29)		0.000000			
00	General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	1110 20)		0.000000			
	Average semi-private room per diem charge (The 29 - The 3) Average semi-private room per diem charge (Line 30 ÷ Line 4)			0.00			
00	priverage semi private room per arem charge (rine so ÷ fille 4)	us line 33)(see instruc	tions)	0.00			
00 00	Average per diem private room charge differential (line 32 min						
00 00 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line				1 25		
00 00 00 00	Average per diem private room cost differential (line 34 x line			0.00			
. 00 . 00 . 00 . 00 . 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar	e 31)	fferential (line		36		
. 00 . 00 . 00 . 00 . 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	e 31)	fferential (line	0. 00 0	36		
. 00 . 00 . 00 . 00 . 00 . 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	e 31) nd private room cost di STMENTS	fferential (line	0. 00 0 4, 583, 776	36 37		
2. 00 3. 00 5. 00 5. 00 5. 00 7. 00 8. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i	e 31) nd private room cost di STMENTS instructions)	fferential (line	0.00 0 4, 583, 776	36 37 38		
2. 00 2. 00 3. 00 4. 00 5. 00 5. 00 5. 00 7. 00 3. 00 9. 00 0. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	e 31) nd private room cost di STMENTS i nstructions) 38)	fferential (line	0. 00 0 4, 583, 776	36 37 38 39		

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 150129	Period: From 01/01/2014	Worksheet D-1	1
					To 12/31/2014		
	Cost Center Description	Total		e XVIII Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient Costlr				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	00 0	C	9 42.
00	INTENSI VE CARE UNI T	743, 994	393	1, 893. 1	1 185	350, 225	5 43
. 00	CORONARY CARE UNI T	0	0				
. 00	BURN INTENSIVE CARE UNIT	0	0			-	
	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	0	0	0.0	0 0	C	46
. 00	Cost Center Description	I					47
00	Program inpatient ancillary service cost (Wks	t D 2 col 2	Lino 200)			1.00 2,062,050) 48
00	Total Program inpatient costs (sum of lines 4			ns)		4, 129, 791	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	itient routine se	ervices (from	Wkst. D, sum	of Parts I and	354, 255	50
. 00	Pass through costs applicable to Program inpa	tient ancillary	services (fr	om Wkst. D, s	um of Parts II	172, 607	51
<u> </u>	and IV)		-				
. 00 . 00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		ated non new	sician anosth	bre tist	526, 862 3, 602, 929	
. 00	medical education costs (line 49 minus line 5		ateu, non-pny	Si ci all'allesti	letist, and	3,002,929	0.00
_	TARGET AMOUNT AND LIMIT COMPUTATION					1	
	Program di scharges					0.00	
. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ng cost and targ	get amount (I	ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period e	nding 1996, u	pdated and co	ompounded by the	0.00) 59
. 00	Lesser of lines 53/54 or 55 from prior year of	ost report, upda	ated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines					C	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		(lines 54 x	60), or 1% of	the target		
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	s through Decem	per 31 of the	cost reporti	ng period (See	0	64
. 00	instructions)(title XVIII only)	0			0.1		
. 00	Medicare swing-bed SNF inpatient routine cost	s after December	- 31 of the c	ost reporting	period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	e costs (line 64	1 plus line 6	5)(title XVII	lonly) For	0	66
. 00	CAH (see instructions)				r onry). For		
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through I	December 31 o	f the cost re	porting period	0	67
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after Dec	cember 31 of	the cost repo	orting period	c	68
	(line 13 x line 20)				0.1		
. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU			,		0) 69
. 00	Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line 7		(line 14 v li	no 25)			72
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi			ne 33)			73
. 00	Capital-related cost allocated to inpatient r	•		orksheet B, F	Part II, column		75
00	26, line 45)						-,
. 00 . 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
	Inpatient routine service cost (line 74 minus	,					78
. 00	Aggregate charges to beneficiaries for excess	• •		· · · ·			79
. 00 . 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		st limitation	(line 78 mir	ius Line 79)		80
. 00	Inpatient routine service cost per drem find (81
. 00	Reasonable inpatient routine service costs (s	· · · · · · · · · · · · · · · · · · ·)				83
. 00	Program inpatient ancillary services (see ins						84
. 00 . 00	Utilization review - physician compensation (85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		Jagn 007			l	- 00
. 00	Total observation bed days (see instructions)					541	
3. 00	Adjusted general inpatient routine cost per d		ine 2)			1, 602. 16 866, 769	
	Observation bed cost (line 87 x line 88) (see						

Health Financial Systems	WESTVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	803, 982	4, 583, 776	0. 17539	7 866, 769	152, 029	90.00
91.00 Nursing School cost	0	4, 583, 776	0.00000	0 866, 769	0	91.00
92.00 Allied health cost	0	4, 583, 776	0.00000	0 866, 769	0	92.00
93.00 All other Medical Education	0	4, 583, 776	0.00000	866, 769	0	93.00

		ponent CCN: 15S129	From 01/01/2014 To 12/31/2014	Date/Time Prep 5/27/2015 6:13	pare
				1.00	
	Inpatient days (including private room days and swing-bed days, exc			351	1
00		f you have only pri	vate room days,	0	3
00		s)		351	4
			31 of the cost		
00		s) after December 3	31 of the cost	0	6
00) through December	31 of the cost	0	7
		,			
00) after December 31	of the cost	0	8
\sim		Program (excluding	swing_bed_and	351	
50	5 51 5 11	riogram (excruding	swing-bed and	331	'
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (i		oom days)	0	10
~ ~					
. 00			oom days) after	0	11
. 00			e room davs)	0	12
	through December 31 of the cost reporting period	х <u>э</u> т	5,7		
. 00				0	13
00				0	1/
		cruding swing-bed t	lays)		
				0	
~~			<u></u>		
00		ough December 31 of	the cost	0.00	
00		er December 31 of 1	the cost	0.00	18
	1 51				
. 00		ugh December 31 of	the cost	0.00	19
. 00		r December 31 of th	ne cost	0.00	20
		<u>.</u>			
. 00		of the cost reporti	ng period (line	0	22
. 00	,	the cost reporting	period (line 6	0	23
	x line 18)				
. 00		f the cost reportin	ng period (line	0	24
00		the cost reporting	period (line 8	0	25
. 00		the cost reporting		0	20
	a				
. 00	General inpatient routine service cost net of swing-bed cost (line .	21 minus line 26)		466, 611	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and	observation bed cha	arges)	0	28
	Private room charges (excluding swing-bed charges)		ii goo)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ line	28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 minus li	ne 33)(see instruct	tions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)		- /	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost and pr	ivate room cost dif	Terential (line	466, 611	37
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN	TS			1
	Adjusted general inpatient routine service cost per diem (see instr			1, 329. 38	
00	Program general inpatient routine service cost (line 9 x line 38)			466, 612	39
	Medically necessary private room cost applicable to the Program (li	no 14 y 11 05	1	0	40

	Financial Systems ATION OF INPATIENT OPERATING COST	WESTVIEW HO		CCN: 150129	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15S129	From 01/01/2014 To 12/31/2014	Date/Time Pre	
			Ti tl	e XVIII	Subprovider -	5/27/2015 6: 1 PPS	13 p
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		Inpatient Costl	npatient Days	Diem (col. 1		(col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	+
. 00	NURSERY (title V & XIX only)	0	C	0.0	0 00	C) 4:
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.0			2 43
. 00	CORONARY CARE UNI T	0	0	0. (0 00	C	44
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0				
	OTHER SPECIAL CARE (SPECIFY)						4
	Cost Center Description					1.00	-
	Program inpatient ancillary service cost (Wks					50, 369	
. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)(s	ee instructio	ns)		516, 981	4
00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	53, 742	2 50
. 00	III) Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst D /	sum of Darte IJ	2, 756	5 5
	and IV)	5	351 VI 65 (11	UNI WINSL. D, S	Sum OF FAILS II		
. 00	Total Program excludable cost (sum of lines !	,	atad non nh	cicion anosti	actict and	56, 498	
. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		ateu, non-phy		ietist, dilu	460, 483	3 5
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					c	5
. 00	Target amount per discharge					0.00	5
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and tar	met amount (1	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	ng cost and tai	get amount (i			0	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period e	nding 1996, ι	pdated and co	ompounded by the	0.00) 5
. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, upd	lated by the m	arket basket		0.00	6
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C) 6
	amount (line 56), otherwise enter zero (see i		(1111es 54 x	60), 01 1% 01	the target		
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ont (coo instruc	tionc)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Decem	ber 31 of the	cost reporti	ng period (See	C) 6
. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decembe	er 31 of the c	ost reporting	g period (See	C	6!
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 nlus line A	5)(title XVII	lonly) For		6
	CAH (see instructions)			, ,	5.		
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	f the cost re	eporting period	C	6
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	orting period	C	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutine costs (l	ine 67 + line	68)		c c	6
	PART III - SKILLED NURSING FACILITY, OTHER NU	IRSING FACILITY,	AND ICF/MR C	NLY		1	
. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co						70
. 00	Program routine service cost (line 9 x line 1	71)					7
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi						7:
. 00	Capital-related cost allocated to inpatient i	•			Part II, column		7!
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					7
. 00	Program capital-related costs (line 9 x line	76)					7
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	s)			7
00	Total Program routine service costs for compa				nus line 79)		8
00	Inpatient routine service cost per diem limit						8
. 00 . 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						8
. 00	Program inpatient ancillary services (see ins	structions)					8
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						8
	PART IV - COMPUTATION OF OBSERVATION BED PASS	5 THROUGH COST				1	
. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (see	•					8

Health Financial Systems	WESTVI EW	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
		Component		To 12/31/2014	Date/Time Prep 5/27/2015 6:13	
		Titl	e XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	53, 743	466, 611	0. 11517	7 0	0	90.00
91.00 Nursing School cost	0	466, 611	0.00000	0 0	0	91.00
92.00 Allied health cost	0	466, 611	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	466, 611	0.00000	0 0	0	93.00

MPUL	ATION OF INPATIENT OPERATING COST	Provider CCN: 150129 Component CCN: 15T129 Title XVIII	Peri od: From 01/01/2014 To 12/31/2014 Subprovi der -	Worksheet D-1 Date/Time Pre 5/27/2015 6:13 PPS	
	Cost Center Description		IRF	110	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days,			1, 066	1.
00	Inpatient days (including private room days, excluding swing-bed		ivata naam dava	1, 066	2.
00	Private room days (excluding swing-bed and observation bed days) do not complete this line.	. If you have only pr	ivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation bed	days)		1, 066	4.
00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5.
00	reporting period Total swing-bed SNF type inpatient days (including private room	dave) after December	21 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)	uays) arter becember	ST OF THE COST	0	0.
00	Total swing-bed NF type inpatient days (including private room d	lays) through December	31 of the cost	0	7.
00	reporting period				
00	Total swing-bed NF type inpatient days (including private room d reporting period (if calendar year, enter 0 on this line)	ays) after December 3	I OF THE COST	0	8.
00	Total inpatient days including private room days applicable to t	the Program (excluding	swing-bed and	605	9
	newborn days)			_	
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	0	10.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, ente	er 0 on this line)			
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX of the cost reporting period	only (including privat	e room days)	0	12
3. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX o	only (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar year			-	
	Medically necessary private room days applicable to the Program	(excl udi ng swi ng-bed	days)	0	14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 16.
. 00	SWING BED ADJUSTMENT			0	10
. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of	the cost	0.00	10
5. 00	reporting period	arter beceniber 31 01	the cost	0.00	10
9.00	Medicaid rate for swing-bed NF services applicable to services t	through December 31 of	the cost	0.00	19
). 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	ftor Docombor 21 of t	ha aast	0.00	20
. 00	reporting period	arter December 31 01 t	ne cost	0.00	20
	Total general inpatient routine service cost (see instructions)			1, 129, 473	21
2.00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31	of the cost reportin	a period (line 6	0	23
	x line 18)		g poir ou (iriio o	0	20
1.00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reporti	ng period (line	0	24
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25
	x line 20)	or the cost reporting		c c	
	Total swing-bed cost (see instructions)			0	26
7.00	General inpatient routine service cost net of swing-bed cost (li PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne 21 minus line 26)	I	1, 129, 473	27
8. 00	General inpatient routine service charges (excluding swing-bed a	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		0	0	29
	Semi-private room charges (excluding swing-bed charges)	ing 20)		0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ l Average private room per diem charge (line 29 ÷ line 3)	rne 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 20 ÷ line 4)			0.00	
. 00	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)				
o. 00 7. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and	h nrivate room cost di	fferential (line	0 1, 129, 473	36
	27 minus line 36)			1, 127, 473	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST			1 050 54	20
	Adjusted general inpatient routine service cost per diem (see in Program general inpatient routine service cost (line 9 x line 38			1, 059. 54 641, 022	
	Medically necessary private room cost applicable to the Program			041,022	40
	Total Program general inpatient routine service cost (line 39 +	. ,		641, 022	

	Financial Systems ATION OF INPATIENT OPERATING COST	WESTVIEW HO		CCN: 150129	Peri od:	eu of Form CMS- Worksheet D-1	
			Componen	t CCN: 15T129	From 01/01/2014 To 12/31/2014	Date/Time Pre	
			Ti tl	e XVIII	Subprovider -	5/27/2015 6: * PPS	13 p
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
		Inpatient Costl		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 C	0 0) 4
. 00	INTENSIVE CARE UNIT	0	C	0.	00 0		0 4
. 00	CORONARY CARE UNI T	0	C				
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	C			-	
	OTHER SPECIAL CARE (SPECIFY)	0	C	0.1			4
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			461, 069	9 48
. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	ee instructio	ons)		1, 102, 091	4
00	Pass through costs applicable to Program inp.	atient routine s	ervices (from	n Wkst. D, su	n of Parts I and	92, 117	7 50
. 00) Pass through costs applicable to Program inp	ationt ancillar	convicos (fr	om Wkst D	cum of Parts II	59, 451	1 5
. 00	Pass through costs applicable to Program inp. and IV)	5	SELVICES (T	UNI WKSL. D, S	Sum OF PAILS II	39,451	' ⁵
. 00	Total Program excludable cost (sum of lines	,	ated are at	alalan U	action and	151, 568	
. 00	Total Program inpatient operating cost exclu- medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	sician anesti	netist, and	950, 523	
	Program di scharges					0.00	
. 00 . 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	C	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1006 i	indated and c	ompounded by the	0.00	
. 00	market basket	portring period e	and ng 1990, c		shipourided by the	0.00	
. 00	Lesser of lines 53/54 or 55 from prior year				* b · · · · · · · · · ·	0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					C) 6
	amount (line 56), otherwise enter zero (see		(
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)				
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost report	ng period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reportin	g period (See	0) 6!
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line 6	5)(title XVI	ll only). For	C) 6
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost r	eporting period	C	6
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of	the cost rep	orting period) 6
	(line 13 x line 20)				si ting por ou		
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					C) 6
. 00	Skilled nursing facility/other nursing facil	ity/ICF/MR routi	ne service co	ost (line 37)			70
. 00 . 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne 70 ÷ line	2)			7
. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			7
. 00	Total Program general inpatient routine serv	•			Domt II!		7
. 00	Capital-related cost allocated to inpatient 26, line 45)	ioutine service	COSTS (TROM V	iorksneet B, I	Part II, Column		7
. 00	Per diem capital-related costs (line 75 ÷ li						7
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						7
00	Aggregate charges to beneficiaries for exces	s costs (from pr					7
00	Total Program routine service costs for comp		ost limitation	n (line 78 min	nus line 79)		8
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						8
. 00	Reasonable inpatient routine service costs (see instructions					8
	Program inpatient ancillary services (see in						8
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						8
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	3 /				
. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			0.00	
	Observation bed cost (line 87 x line 88) (se		1116 2/			0.00	1 0

Health Financial Systems	WESTVIEW I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
		Component		To 12/31/2014	Date/Time Prep 5/27/2015 6:13	pared: 3 pm
		Titl	e XVIII	Subprovider -	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	162, 312	1, 129, 473	0. 14370	6 0	0	90.00
91.00 Nursing School cost	0	1, 129, 473	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 129, 473	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 129, 473	0. 00000	0 0	0	93.00

	Financial Systems WESTVIEW HOSPIT		001 450100		eu of Form CMS-2	
I NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014		pared:
		Ti tl	e XVIII	Hospi tal	PPS	<u>5 piii</u>
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT			1, 150, 805		30.00
31.00 32.00	03200 CORONARY CARE UNIT			239, 637		31.00 32.00
	03300 BURN I NTENSI VE CARE UNI T			0		33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
	04000 SUBPROVIDER - IPF			0		40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER			0		41.00
	04300 NURSERY			0		43.00
	ANCI LLARY SERVI CE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 2674			50.00
51.00	05100 RECOVERY ROOM		0.0000			51.00 52.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		0.0000		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 2619			54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		0.0000	00 00	0	55.00
56.00	05600 RADI OI SOTOPE		0.0000		-	56.00
57.00	05700 CT SCAN		0.0524			
58.00 59.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON		0. 0748 0. 0000		4, 855 0	58.00 59.00
60.00	06000 LABORATORY		0. 1663			60.00
60. 01	06001 BLOOD LABORATORY		0.0000		0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		-	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	62.00
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY		0.0000		-	63.00 64.00
65.00	06500 RESPI RATORY THERAPY		0. 4719		-	
66.00	06600 PHYSI CAL THERAPY		0.4644		59, 258	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 3952			67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0.2506			
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1653			69.00 70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2405			1
	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2405			
	07300 DRUGS CHARGED TO PATIENTS		0. 3189			
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)		0. 3941			74.00
	03020 ENDOSCOPY CENTER		0.0000		0	76.00
	03950 WOUND OSTOMY		0. 3312			
76.05	03480 CRCC		0. 2842	65 895	254	76.05
88.00	OUTPATIENT SERVICE COST CENTERS		0.0000	00	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89.00
90.00	09000 CLINIC		0.0000		0	90.00
	09023 CLI NI C		0.0000		0	90. 23
90.25	09025 CLINIC		0. 3682		0	90.25
90. 27 91. 00	09027 CLINIC 09100 EMERGENCY		0.0000		0	90.27 91.00
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1948 0. 7587			
	OTHER REIMBURSABLE COST CENTERS					
	09400 HOME PROGRAM DI ALYSI S		0.0000	00 00	0	94.00
	09500 AMBULANCE SERVICES		0.0000	~	_	95.00
	09600 DURABLE MEDI CAL EQUI P-RENTED 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000		0	
	09851 OTHER REIMBURSABLE COST CENTERS		0.0000		0	
200.00	Total (sum of lines 50-94 and 96-98)			8, 159, 808	-	
201.00		ine 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1	8, 159, 808	1	202.00

Health Financial Systems WESTVIEW HOSE				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 150129	Period: From 01/01/2014	Worksheet D-3	
	Component	CCN: 15S129	To 12/31/2014	Date/Time Pre	
	Title	XVIII	Subprovider -	5/27/2015 6:1 PPS	<u>3 pm</u>
			I PF		
Cost Center Description	H	Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs	
		To charges	Charges	$(col \cdot 1 \times col \cdot)$	
	_			2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT			0		32.00 33.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
40.00 04000 SUBPROVIDER - IPF			543, 217		40.00
41.00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY			0		42.00
ANCI LLARY SERVI CE COST CENTERS				1	
50. 00 05000 OPERATI NG ROOM		0.2674		-	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2619			
55. 00 05500 RADI 0L0GY-THERAPEUTI C 56. 00 05600 RADI 0I SOTOPE		0.0000		0	
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT_SCAN		0.0000 0.0524		0 304	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0748			
59. 00 05900 CARDIAC CATHETERIZATION		0.0000		0	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 1663		7, 804 0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY		0. 0000 0. 4719		0 1,642	
66. 00 06600 PHYSI CAL THERAPY		0. 4644			
67.00 06700 OCCUPATI ONAL THERAPY		0.3952			
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0. 2506 0. 1653		-	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1053		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2405		1, 255	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2405		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		0. 31898 0. 39418		37, 105 0	
75. 00 07500 ASC (NON-DI STINCT PART)		0.0000		0	
76.00 03020 ENDOSCOPY CENTER		0.0000		-	
76. 01 03950 WOUND_OSTOMY 76. 05 03480 CRCC		0. 3312 0. 2842		0	1 / 01 01
OUTPATI ENT SERVICE COST CENTERS		0.20420	55 0	0	1 70.05
88. 00 08800 RURAL HEALTH CLINIC		0.0000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLI NI C 90. 23 09023 CLI NI C		0.0000		0	
90. 25 09025 CLINIC		0. 36822		0	
90. 27 09027 CLINIC		0.0000	0 00	0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 1948 ⁻ 0. 7587-		348 0	
OTHER REIMBURSABLE COST CENTERS		0.7567	T2 U	0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.0000	0 00	0	
95.00 09500 AMBULANCE SERVICES		0.0000		_	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000		0	
98.00 09851 OTHER REIMBURSABLE COST CENTERS		0.0000		0	98.00
200.00 Total (sum of lines 50-94 and 96-98)			186, 398	50, 369	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		104 200		201.00
202.00 Net Charges (line 200 minus line 201)	I		186, 398	1	202.00

Health Financial Systems WESTVIEW H				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 150129	Period: From 01/01/2014	Worksheet D-3	3
	Component	CCN: 15T129	To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
	Ti tl e	XVIII	Subprovider -	PPS	5 pm
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
32. 00 03200 CORONARY CARE UNIT			0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		33.00 34.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 O4100 SUBPROVI DER – I RF			692, 154		41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY			0		42.00
ANCI LLARY SERVI CE COST CENTERS					10.00
50. 00 05000 OPERATING ROOM		0.26740			
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000 0.00000			
53. 00 05300 ANESTHESI OLOGY		0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 26194			
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE		0.00000 0.00000		0	
57. 00 05700 CT SCAN		0. 05244			
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.07489		-	
59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY		0. 00000 0. 16638		0 30, 109	
60. 01 06001 BLOOD LABORATORY		0. 00000		0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000 0.00000		0	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000			
65. 00 06500 RESPI RATORY THERAPY		0. 47191			
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY		0. 46445 0. 39527			
68. 00 06800 SPEECH PATHOLOGY		0. 25063			
69. 00 06900 ELECTROCARDI OLOGY		0. 16537		1, 027	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 09561 0. 24052		-	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24052		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 31898			
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART)		0. 39418 0. 00000		0	
76. 00 03020 ENDOSCOPY CENTER		0.00000			
76. 01 03950 WOUND OSTOMY		0. 33126		-	
76. 05 03480 CRCC OUTPATI ENT SERVI CE COST CENTERS		0. 28426	05 0	0	76.05
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC 90. 23 09023 CLINIC		0.00000 0.00000		0	
90. 25 09025 CLI NI C		0. 36822		0	
90. 27 09027 CLINIC		0.00000	0 0	0	90. 27
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 19481 0. 75874		-	
OTHER REIMBURSABLE COST CENTERS		0.73074	0		12.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0 0	0	
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000	0 0	0	95.00 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000			
98.00 09851 OTHER REIMBURSABLE COST CENTERS		0.00000	0 0	0	98.00
	1				0.0-
200.00 Total (sum of lines 50-94 and 96-98) 201.00 Less PBP Clinic Laboratory Services-Program only charg	res (line 61)		1, 342, 848	461, 069	200.00

	Financial Systems WESTVIEW HOSPI		001 450105		eu of Form CMS-2	
I NPATI E	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014		pared:
		Ti t	le XIX	Hospi tal	Cost	<u>5 piii</u>
	Cost Center Description		Ratio of Cos To Charges	t Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS		1		1	
	03000 ADULTS & PEDIATRICS			145, 608		30.00
	03100 INTENSI VE CARE UNI T 03200 CORONARY CARE UNI T					31.00 32.00
	03300 BURN INTENSIVE CARE UNIT					32.00
1	03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
	04000 SUBPROVIDER - IPF			C		40.00
41.00 0	04100 SUBPROVI DER – I RF			C		41.00
1	04200 SUBPROVI DER			C		42.00
-	04300 NURSERY			0		43.00
	NCI LLARY SERVI CE COST CENTERS		0.0/74	01 57.100	15.07(50.00
	05000 OPERATING ROOM 05100 RECOVERY ROOM		0.2674			50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM		0.0000			52.00
	05300 ANESTHESI OLOGY		0.0000			53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 2619			54.00
	05500 RADI OLOGY-THERAPEUTI C		0.0000	00 C	0	55.00
	05600 RADI OI SOTOPE		0.0000	00 C	0	56.00
	D5700 CT SCAN		0.0524			57.00
	D5800 MAGNETIC RESONANCE I MAGING (MRI)		0.0748			58.00
	05900 CARDI AC CATHETERI ZATI ON		0.0000			59.00
	06000 LABORATORY 06001 BLOOD_LABORATORY		0. 1663			60.00 60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000			61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		-	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	63.00
64.00 0	06400 I NTRAVENOUS THERAPY		0.0000	00 C	0	64.00
	06500 RESPI RATORY THERAPY		0. 4719			65.00
1	06600 PHYSI CAL THERAPY		0.4644			66.00
1	06700 OCCUPATI ONAL THERAPY		0.3952			67.00
1	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0. 2506			
	07000 ELECTROENCEPHALOGRAPHY		0. 1055		2,000	70.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2405		-	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2405			72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 3189	88 158, 048	50, 415	73.00
	07400 RENAL DI ALYSI S		0. 3941			
	07500 ASC (NON-DI STINCT PART)		0.0000			75.00
	03020 ENDOSCOPY_CENTER 03950 WOUND_OSTOMY		0.0000			76.00 76.01
	03480 CRCC		0. 3312			
	DUTPATIENT SERVICE COST CENTERS		0.2012			/0.00
	08800 RURAL HEALTH CLINIC		0.0000	00 C	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89.00
	D9000 CLINIC		0.0000			90.00
			0.0000		0	90.23
	09025 CLI NI C 09027 CLI NI C		0.3682		0	90.25 90.27
	09100 EMERGENCY		0.0000		-	90.27
1	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7587			92.00
	THER REIMBURSABLE COST CENTERS					1
94.00	09400 HOME PROGRAM DI ALYSI S		0.0000	00 C	0	94.00
	09500 AMBULANCE SERVI CES					95.00
	09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000		0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0	97.00
98.00 C	09851 OTHER REIMBURSABLE COST CENTERS Total (sum of lines 50-94 and 96-98)		0.0000	659, 117	0 0 158, 878	98.00
200.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		007,117	150,070	200.00
202.00	Net Charges (line 200 minus line 201)			659, 117	,	202.00
			1			

Health Financial Systems WESTVIEW HOSP				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 150129	Period: From 01/01/2014	Worksheet D-3	
	Component	CCN: 15T129	To 12/31/2014		
	Title	e XIX	Subprovider -	Cost	5 pili
Cost Center Description		Ratio of Cos	I RF t I npati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
	-	1.00	2.00	2)	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT					30.00
32. 00 03200 CORONARY CARE UNIT					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			(33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF					34.00 40.00
41. 00 04100 SUBPROVI DER - I RF			199, 76	1	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY					42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				<u>יו</u>	43.00
50. 00 05000 OPERATI NG ROOM		0. 26740		0 0	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
53. 00 05300 ANESTHESI OLOGY		0. 00000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 26194			
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI 0I SOTOPE		0.0000		0 0 0	
57. 00 05700 CT SCAN		0. 05244			1
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.07489		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY		0. 00000 0. 16638		0 0 2 6,762	
60. 01 06001 BLOOD LABORATORY		0. 00000			1
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000			
64. 00 06400 I NTRAVENOUS THERAPY		0.0000		0 0	1
65. 00 06500 RESPI RATORY THERAPY		0. 4719			
66. 00 06600 PHYSI CAL_THERAPY 67. 00 06700 0CCUPATI ONAL_THERAPY		0. 46449 0. 3952			
68. 00 06800 SPEECH PATHOLOGY		0. 25063			
69. 00 06900 ELECTROCARDI OLOGY		0. 1653			
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0956 0. 24052		0 0 2 3, 539	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 24053			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 31898			
74. 00 07400 RENAL_DIALYSIS 75. 00 07500 ASC_(NON-DISTINCT_PART)		0. 39418			
76.00 03020 ENDOSCOPY CENTER		0.0000	00	0 0	76.00
76. 01 03950 WOUND OSTOMY 76. 05 03480 CRCC		0. 33120 0. 28420			1 / 0/ 0/
OUTPATIENT SERVICE COST CENTERS		0.20420	55	<u> </u>	70.05
88. 00 08800 RURAL HEALTH CLINIC		0.0000		0 0	
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 90. 00 09000 CLI NI C		0.0000			
90. 23 09023 CLINIC		0.00000			
90. 25 09025 CLI NI C		0.36822	23 (0 0	
90. 27 09027 CLINIC 91. 00 09100 EMERGENCY		0. 00000 0. 1948			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 75874			
		0.0000			1 04 00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES		0.0000		0	94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000		o o	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000			
98.00 09851 OTHER REIMBURSABLE COST CENTERS 200.00 Total (sum of lines 50-94 and 96-98)		0.0000	408, 87	0 0 7 142, 078	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		(201.00
202.00 Net Charges (line 200 minus line 201)			408, 879	9	202.00

	Financial Systems WESTVIEW HOSPIT		001 450400		u of Form CMS	-2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pr 5/27/2015 6:	
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					1 00
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	prior		0		1.00
1 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring	on or		2 149 440		1 02
1.02	after October 1 (see instructions)			2, 148, 440		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCl for discharges occurring prior to October 1 (see instructions)			0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for			0		1.04
2.00	discharges occurring on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)			9, 862		2.00
2.01	Outlier reconciliation amount			0		2. 01
2.02 3.00	Outlier payment for discharges for Model 4 BPCI (see instruction Managed Care Simulated Payments	s)		0 856, 918		2.02
4.00	Bed days available divided by number of days in the cost reporti	ng		20. 52		4.00
	period (see instructions) Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most r			3.44		5.00
6.00	cost reporting period ending on or before 12/31/1996. (see instru FTE count for allopathic and osteopathic programs which meet the			0.00		6.00
	criteria for an add-on to the cap for new programs in accordance	with 42				
7.00	CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified und	er 42		0.00		7.00
7 01	CFR §412.105(f)(1)(iv)(B)(1)	-laur 40		0.00		7 01
7.01	ACA Section 5503 reduction amount to the IME cap as specified un CFR $412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July 1			0.00		7.01
8.00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopathi	c and		1.75		8,00
0.00	osteopathic programs for affiliated programs in accordance with			1.75		0.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).	FR 50069				
8.01	The amount of increase if the hospital was awarded FTE cap slots			2.30		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 20 instructions.	11, see				
8.02	The amount of increase if the hospital was awarded FTE cap slots			0.00		8. 02
9.00	closed teaching hospital under section 5506 of ACA. (see instruc Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			7.49		9.00
10.00	and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the current					10.00
10.00	from your records	уеаг		7.20		10.00
11.00 12.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			1.83 9.03		11.00
13.00	Total allowable FTE count for the prior year.			13. 26		13.00
14.00	Total allowable FTE count for the penultimate year if that year or after September 30, 1997, otherwise enter zero.	ended on		14.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.			12.10		15.00
16.00 17.00	Adjustment for residents in initial years of the program Adjusment for residents displaced by program or hospital closure			0.00 0.00		16.00 17.00
18.00	Adjusted rolling average FTE count			12. 10		18.00
19.00 20.00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 589669 0. 583170		19.00 20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 583170		21.00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			829, 725 0		22. 00 22. 01
	Indirect Medical Education Adjustment for the Add-on for Section		he MMA	1		
23.00	Number of additional allopathic and osteopathic IME FTE resident slots under 42 Sec. 412.105 $(f)(1)(iv)(C)$.	сар		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the low	on of		-0.29		24.00
25.00	line 23 or line 24 (see instructions)	er or		0.00		25.00
26.00 27.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0. 000000 0. 000000		26.00 27.00
28.00	IME add-on adjustment amount (see instructions)			0.000000		28.00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)			0 829, 725		28.01 29.00
29.00	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			027,723		29.00
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pati	ent davs		6. 11		30.00
	(see instructions)	int days				
31.00 32.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			0.00 6.11		31.00
33.00	Allowable disproportionate share percentage (see instructions)			0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		I	0		34.00

	Financial Systems WESTVIEW H ATION OF REIMBURSEMENT SETTLEMENT	OSPITAL Provider CCN: 150129	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	AITON OF KEIMDURSEMENT SETTLEMENT	Provider CCN. 150129	From 01/01/2014 To 12/31/2014		pared: 3 pm
	1	Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
	-	0	0ctober 1 1.00	0ctober 1 2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9, 046, 380, 143		
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0.000016250	0. 000013650 0	35.01 35.02
55. OZ	enter zero on this line) (see instructions)		0	0	55. 02
35.03	Pro rata share of the hospital uncompensated care payment		0	0	35.03
36.00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line		0		36.00
30.00	35. 03)		0		50.00
	Additional payment for high percentage of ESRD beneficiary of	discharges (lines 40 throug	· · ·		
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and		0		40.00
	685 (see instructions)				
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
41.01	682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding		0		41.01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
43.00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
10.00	682, 683, 684 an 685. (see instructions)		0		10.00
44.00	Ratio of average length of stay to one week (line 43		0.00000		44.00
45.00	divided by line 41 divided by 7 days) Average weekly cost for dialysis treatments (see		0.00		45.00
	instructions)				
46.00	Total additional payment (line 45 times line 44 times line		0		46.00
47.00	41.01) Subtotal (see instructions)		2, 988, 027		47.00
48.00	Hospital specific payments (to be completed by SCH and		0		48.00
40.00	MDH, small rural hospitals only. (see instructions)		2 000 007		10.00
49.00	Total payment for inpatient operating costs (see instructions)		2, 988, 027		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		263, 286		50.00
F1 00	and Pt. II, as applicable)				F1 00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4,		247, 051		52.00
52 00	line 49 see instructions). Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
56.00	line 69) Cost of physicians' services in a teaching hospital (see		0		56.00
50.00	intructions)		0		50.00
57.00	Routine service other pass through costs (from Wkst. D,		0		57.00
58.00	Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D,		0		58.00
00.00	Pt. IV, col. 11 line 200)		0		00.00
59.00	Total (sum of amounts on lines 49 through 58)		3, 498, 364		59.00
60.00 61.00	Primary payer payments Total amount payable for program beneficiaries (line 59		0 3, 498, 364		60.00 61.00
51.00	minus line 60)		3, 470, 304		01.00
62.00	Deductibles billed to program beneficiaries		301, 472		62.00
63.00 64.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)		1, 824 15, 184		63.00 64.00
65.00			9, 870		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see		9, 771		66. 00
67.00	instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63)		3, 204, 938		67.00
68.00	Credits received from manufacturers for replaced devices		0		68.00
40.00	for applicable to MS-DRGs (see instructions)		~		40.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70. 89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
70 01	instructions) HSP honus navment HRR adjustment amount (see instructions)		_		70. 91
	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)		0		70.91
70. 93	HVBP payment adjustment amount (see instructions)		3, 094		70. 93
	HRR adjustment amount (see instructions)		- 485		70.94
70.95	Recovery of accelerated depreciation		0		70.9

неагтп	Financial Systems WESTVIEW H	IOSPI TAL	In Lie	eu of Form CMS-	2552-10
CALCULA	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150129	Period: From 01/01/2014 To 12/31/2014		
		Title XVIII	Hospi tal	PPS	
		· · · · · · · · · · · · · · · · · · ·	Prior to	On/After	
			October 1	October 1	
		0	1.00	2.00	
	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0 0		70.96
	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0 0		70.97
70. 98	Low Volume Payment-3		0		70.98
	HAC adjustment amount (see instructions)		0		70.99
	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3, 207, 547		71.00
71.01	Sequestration adjustment (see instructions)		64, 151		71.01
72.00	Interim payments		2, 453, 387		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		690, 009		74.00
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		64, 453		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
	The rate used to calculate the time value of money (see instructions)		0.00		94.00
	Time value of money for operating expenses (see instructions)		0		95.00
	Time value of money for capital related expenses (see instructions)		0		96.00
				0n/After 10/1	
			1.00	2.00	
	HSP Bonus Payment Amount			1	
	HSP bonus amount (see instructions)		0	0	100.00
	HVBP Adjustment for HSP Bonus Payment				
	HVBP adjustment factor (see instructions)		0		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructi	ons)	0	0	102.00
ľ	HRR Adjustment for HSP Bonus Payment			1	
	HRR adjustment factor (see instructions)		0.0000	0 0000	103.00
	HRR adjustment amount for HSP bonus payment (see instructio		0.0000		104.00

	Financial Systems WESTVIEW HOSI ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150129	Period:	u of Form CMS-2 Worksheet E	2552-10
0,12002			From 01/01/2014	Part B	naradi
			To 12/31/2014	Date/Time Pre 5/27/2015 6:1	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			378	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct PPS payments	ions)		5, 827, 913 3, 712, 332	
3.00 4.00	Outlier payment (see instructions)			24, 080	
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions)	V col 12 lino 200		0	
	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	v, cor. 13, trie 200		0	
	Total cost (sum of lines 1 and 10) (see instructions)			378	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable charges				
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, c				12.00
	Total reasonable charges (sum of lines 12 and 13)	.01. 4)		0 1, 251	
11.00	Customary charges			1,201	11.00
	Aggregate amount actually collected from patients liable for p			0	15.00
16.00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(ϵ Ratio of line 15 to line 16 (not to exceed 1.000000)	2)		0.000000	17 00
	Total customary charges (see instructions)			1, 251	
	Excess of customary charges over reasonable cost (complete onl	vifline 18 exceeds li	ne 11) (see	873	
	instructions)	5	<i>,</i> , ,		
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
21 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		378	21.00
	Interns and residents (see instructions)			378	
	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			3, 736, 412	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			53	25.00
	Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions		796, 233	
	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) p			2, 940, 504	
	CAH, see instructions)				
	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		250, 463	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 3, 190, 967	29.00 30.00
	Primary payer payments			0, 170, 707	31.00
	Subtotal (line 30 minus line 31)			3, 190, 967	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 139, 568	
	Adjusted reimbursable bad debts (see instructions)			90, 719	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		120, 588	
37.00	Subtotal (see instructions)			3, 281, 686	37.00
	MSP-LCC reconciliation amount from PS&R			0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00 39.50
	Pioneer ACO demonstration payment adjustment (see instructions Partial or full credits received from manufacturers for replac	-	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			3, 281, 686	40.00
	Sequestration adjustment (see instructions)			65, 634	
	Interim payments Tentative settlement (for contractors use only)			2, 881, 544 0	
	Balance due provider/program (see instructions)			334, 508	42.00 43.00
	Protested amounts (nonallowable cost report items) in accordar	ce with CMS Pub. 15-2.	chapter 1,	0	44.00
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)			0	94.00

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014		
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 453, 3	87 0	2, 881, 544 0	1. (2. (
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02				0	0	3. (
. 03				0	0	3.
. 04 . 05				0	0	3.
. 05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	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, 453, 3	87	2, 881, 544	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
-	Provider to Program	1		0		-
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		690, 0		334, 508	6
01 02	SETTLEMENT TO PROVIDER		090, 0	0	334, 508	6.
02	Total Medicare program liability (see instructions)		3, 143, 3	-	3, 216, 052	7.
			<u> </u>	Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150129 CCN: 15S129	Period: From 01/01/2014 To 12/31/2014		pared
		Ti tl	e XVIII	Subprovider - IPF	PPS	<u>o piii</u>
		I npati er	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
0.0		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		284, 6	0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	3.
04				0	0	3
)5	Desuidan ta Deserver			0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	
53				0	0	3
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3
20	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		204 4	20	0	
00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		284, 62	20	0	4
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0	
)2				0	0	
)3	Dravidar to Dragram		l	0	0	5
50	Provider to Program TENTATIVE TO PROGRAM		1	0	0	5
50 51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		7!	55	0	6
2	SETTLEMENT TO PROGRAM		005 0	0	0	
00	Total Medicare program liability (see instructions)		285, 3	75 Contractor	0 NPR Date	7
				Number	(Mo/Day/Yr)	
			0	1.00	2.00	-

IALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 150129 CCN: 15T129	Period: From 01/01/2014 To 12/31/2014		epared
		Ti tl	e XVIII	Subprovider - IRF	PPS	o pii
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
0.0		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		796, 63	0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER		1	0	0	3.
02	ADJUSTWENTS TO FROVIDER			0	0	
03				0	0	
04				0	0	
05				0	0) 3.
	Provider to Program				1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	-
52				0	0	-
53 54				0	0	
99 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	
, ,	3. 50-3. 98)			0		Ί
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as (appropriate)		796, 63	33	0	4
	TO BE COMPLETED BY CONTRACTOR		<u> </u>		1	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	
)3				0	0	0 5
0	Provider to Program		1	0	2	
50 51	TENTATI VE TO PROGRAM			0	0	
52				0	0	
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		9, 74	18	0	
)2	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		806, 38		0	7 ו
				Contractor Number	NPR Date (Mo/Day/Yr)	
			C	1.00	2.00	-

Heal th	Financial Systems WESTVIEW HOSP	TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150129	Peri od:	Worksheet E-1	
			From 01/01/2014		aarad.
			To 12/31/2014	Date/Time Pre 5/27/2015 6:13	
		Title XVIII	Hospi tal	PPS	
			noopi tui		
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S	S-3, Pt. I col. 15 line	14	839	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-			1, 257	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			475	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		2, 713	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			131, 044, 816	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir	ne 20		0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cen	rtified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)			638, 400	8.00
9.00	Sequestration adjustment amount (see instructions)			12, 768	9.00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		625, 632	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			632, 688	
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	s)	-7,056	32.00

	Financial Systems WESTVIEW HOS			u of Form CMS-2	
CALCU	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150129	Period:	Worksheet E-3	
		Component CCN: 15S129	From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Title XVIII	Subprovider - IPF	5/27/2015 6: 1 PPS	3 pm
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med	ical education payments)		314, 269	1.00
2.00	Net IPF PPS Outlier Payments			0	2.00
3.00	Net IPF PPS ECT Payments		с н	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent c 15, 2004. (see instructions)	ost report filed on or b	efore November	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE coun	t for residents that wer	e displaced by	0.00	4.0 ²
	program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	t a temporary cap adjust	ment under 42		
5.00	New Teaching program adjustment. (see instructions)			0.00	5.0
6.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	
	teaching program" (see instuctions)				
7.00	Current year's unweighted I&R FTE count for residents within teaching program" (see instuctions)	the new program growth p	eriod of a "new	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjus	tment (see instructions)		0.00	8.0
9.00	Average Daily Census (see instructions)			0. 961644	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0.000000	10.0
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0	11.0
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			314, 269	12.0
13.00 14.00	Nursing and Allied Health Managed Care payment (see instructi	on)		0	13.0 14.0
14.00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
16.00	Subtotal (see instructions)			314, 269	
17.00	Primary payer payments			0	17.0
18.00	Subtotal (line 16 less line 17).			314, 269	
19.00	Deducti bl es			18, 144	
20.00	Subtotal (line 18 minus line 19)			296, 125	
21.00 22.00	Coinsurance Subtotal (line 20 minus line 21)			5, 696 290, 429	
23.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		1, 184	
24.00	,			770	
25.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 184	25. C
26.00	Subtotal (sum of lines 22 and 24)			291, 199	
27.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	27.0
28.00 29.00	Other pass through costs (see instructions) Outlier payments reconciliation			0	28.0 29.0
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30.0
30.50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	30.5
30. 99	Recovery of Accel erated Depreciation			0	30. 9
31.00	Total amount payable to the provider (see instructions)			291, 199	31.0
31.01	Sequestration adjustment (see instructions)			5, 824	
32.00 33.00	Interim payments Tentative settlement (for contractor use only)			284, 620 0	
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 a	nd 33)		755	
35.00	Protested amounts (nonallowable cost report items) in accorda		chapter 1,	0	
	§115.2				
50.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2			0	50.00
51.00	5			0	51.0
52.00	3			0.00	52.00
53.00	Time Value of Money (see instructions)			0	53.0

Heal th	Financial Systems WESTVIEW HOSP	PLTAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150129	Period:	Worksheet E-3	
		Component CCN: 15T129	From 01/01/2014 To 12/31/2014	Part III Date/Time Pre	pared [.]
			10 12/01/2011	5/27/2015 6: 1	3 pm
		Title XVIII	Subprovider - IRF	PPS	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1.00	Net Federal PPS Payment (see instructions)			753, 675	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0953	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			72, 880	3.00
4.00	Outlier Payments			11, 483	4.00
5.00	Unweighted intern and resident FTE count in the most recent co	st reporting period en	ding on or prior	0.00	5.00
	to November 15, 2004 (see instructions)				
5.01	Cap increases for the unweighted intern and resident FTE count			0.00	5. 01
	program or hospital closure, that would not be counted without	a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
6.00	New Teaching program adjustment. (see instructions)			0.00	
7.00	Current year's unweighted FTE count of I&R excluding FTEs in t	ne new program growth p	eriod of a new	0.00	7.00
8.00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within t	be new program growth p	eriod of a "new	0.00	8.00
0.00	teaching program" (see instructions)	ne new program growth p		0.00	0.00
9.00	Intern and resident count for IRF PPS medical education adjust	ment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)	(2. 920548	
11.00	Teaching Adjustment Factor (see instructions)			0.00000	
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			838, 038	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction	on)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.00
16.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	
17.00	Subtotal (see instructions)			838, 038	
18.00	Primary payer payments			0	18.00
19.00	Subtotal (line 17 less line 18).			838, 038	
20.00 21.00	Deductibles Subtotal (line 19 minus line 20)			13, 376 824, 662	
22.00	Coinsurance			1, 824	
23.00	Subtotal (line 21 minus line 22)			822, 838	
24.00	Allowable bad debts (exclude bad debts for professional servic	es) (see instructions)		022,000	24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)			822, 838	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 49)		0	28.00
29.00	Other pass through costs (see instructions)			0	29.00
30.00	Outlier payments reconciliation			0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	
31.99	Recovery of Accel erated Depreciation			0	31.99
32.00 32.01	Total amount payable to the provider (see instructions)			822, 838 16, 457	
32.01	Sequestration adjustment (see instructions) Interim payments			796, 633	
34.00	Tentative settlement (for contractor use only)			190, 033	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and	34		9, 748	
36.00	Protested amounts (nonallowable cost report items) in accordan		chapter 1.	,,,,40 0	36.00
20.00	§115. 2				20.00
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			11, 483	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
52.00	The rate used to calculate the Time Value of Money				52.00
55.00	Time Value of Money (see instructions)		I	0	53.00

DIDECT	Financial Systems WESTVIEW HOSP		CON 150100		u of Form CMS-2	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der (Period: From 01/01/2014 To 12/31/2014	Worksheet E-4 Date/Time Pre	
					5/27/2015 6:1	3 pm
		<u> </u>	e XVIII	Hospi tal	PPS	
					1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				4 10	
1.00	Unweighted resident FTE count for allopathic and osteopathic plending on or before December 31, 1996.	rograms for	cost reporti	ng periods	1.42	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR	413.79(e)(1	I) (see instr	uctions)	0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA		<i>,</i> , ,	,	0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance	with 42 CFR	§413.79 (m).	(see	0.00	3. 01
4.00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and or	stoopathic r	programe duo	to a Modicaro	2.77	4.00
4.00	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		or ogranis due		2.77	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instru	uctions for	cost reporti	ng periods	1. 52	4.01
	straddling 7/1/2011)					
4.02	ACA Section 5506 number of additional direct GME FTE cap slots	(see instr	ructions for	cost reporting	0.00	4. 02
5.00	periods straddling 7/1/2011) FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus	s or minus l	ine 4 plus l	ines 4.01 and	5.71	5.00
	4.02 plus applicable subscripts					
6.00	Unweighted resident FTE count for allopathic and osteopathic p	rograms for	the current	year from your	7.03	6.00
7.00	records (see instructions) Enter the lesser of line 5 or line 6				5. 71	7 00
7.00			Primary Care	Other	Total	7.00
			1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopa	thic	7.0	3 0.33	7.36	8.00
9.00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwis	62	5.7	1 0.27	5.98	9,00
7.00	multiply line 8 times the result of line 5 divided by the amount		5.7	0.27	5.70	7.00
	6.					
10.00	Weighted dental and podiatric resident FTE count for the current	nt year		1.60		10.00
11.00 12.00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	Vear (see	5. 7 8. 1			11.00 12.00
12.00	instructions)	year (see	0.1	0.50		12.00
13.00	Total weighted resident FTE count for the penultimate cost rep	orting	9.9	9 3.48		13.00
4.4.00	year (see instructions)		7.0	- 1.05		1 1 0 00
14.00 15.00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	by 3).	7.9 0.0			14.00 15.00
	Adjustment for residents displaced by program or hospital close	ure	0.0			16.00
17.00	Adjusted rolling average FTE count		7.9			17.00
18.00	Per resident amount		79, 190. 4			18.00
19.00	Approved amount for resident costs		629, 56	4 154, 421	783, 985	19.00
					1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FT	E resident o	cap slots rec	eived under 42	0.00	20.00
	Sec. 413.79(c)(4)		·			
21.00	Direct GME FTE unweighted resident count over cap (see instruct				1.32	
22.00 23.00	Allowable additional direct GME FTE Resident Count (see instru- Enter the locally adjustment national average per resident amo		structions)			22.00 23.00
	Multiply line 22 time line 23		structrons)			24.00
	Total direct GME amount (sum of lines 19 and 24)			_	783, 985	
		1	•	t Managed care		
		-	A 1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
	Inpatient Days (see instructions)		2, 21			26.00
26.00			4, 13	0 4, 130		27.00
27.00	Total Inpatient Days (see instructions)					0.0 -
27. 00 28. 00	Ratio of inpatient days to total inpatient days		0. 53583	5 0. 115012		28.00
27.00 28.00				5 0. 115012		28.00 29.00 30.00

Heal th	Financial Systems	WESTVIEW HOSPI	TAL	In Lie	u of Form CMS-2	2552-10
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATI	ENT DIRECT	Provider CCN: 150129	Peri od:	Worksheet E-4	
MEDI CA	L EDUCATION COSTS			From 01/01/2014 To 12/31/2014	Date/Time Pre	narod
				10 12/31/2014	5/27/2015 6:13	
			Title XVIII	Hospi tal	PPS	
					1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSIT	TE RATE - TITLE 2	KVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL	
	EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (1	from Wkst. B, Pt	I, sum of col. 20 an	d 23, lines 74	0	32.00
33.00	and 94) Renal dialysis and home dialysis total charges (col 9 cum of lines	74 and 04)	280, 095	22 00
	Ratio of direct medical education costs to total			74 anu 94)	0. 000000	
	Medicare outpatient ESRD charges (see instruction		52 ÷ 111e 33)		0.000000	35.00
	Medicare outpatient ESRD direct medical education		4 x line 35)		0	
00.00	APPORTIONMENT BASED ON MEDICARE REASONABLE COST					00.00
	Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)				5, 748, 863	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col	. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospi	tal (see instru	ctions)		0	39.00
40.00	Primary payer payments (see instructions)				0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 th	nrough 39 minus	line 40)		5, 748, 863	41.00
	Part B Reasonable Cost					
	Reasonable cost (see instructions)				5, 828, 291	
	Primary payer payments (see instructions)				0	
44.00	Total Part B reasonable cost (line 42 minus line	e 43)			5, 828, 291	
	Total reasonable cost (sum of lines 41 and 44)				11, 577, 154	
	Ratio of Part A reasonable cost to total reasona Ratio of Part B reasonable cost to total reasona				0. 496570	
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN				0. 503430	47.00
18 00	Total program GME payment (line 31)	FART A AND FART	В		497, 514	18 00
	Part A Medicare GME payment (line 46 x 48) (titl	e XVIII only) (see instructions)		247, 051	
	Part B Medicare GME payment (line 47 x 48) (tit				250, 463	
00.00		() () () () () () () () () () () () () (200, 100	00.00

BALANC	Financial Systems WESTVIEW H E SHEET (If you are nonproprietary and do not maintain			Period:	u of Form CMS-2 Worksheet G	
fund-t	ype accounting records, complete the General Fund column onl	y)		From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
					5/27/2015 6:1	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
1 00	CURRENT ASSETS	4 254 420			0	1 1 0
1.00 2.00	Cash on hand in banks Temporary investments	4, 356, 429			0	
3.00	Notes receivable	0			0	
4.00	Accounts receivable	15, 282, 014			0	
5.00	Other receivable	200, 117		0 0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10, 435, 477	(, v	0	
7.00	Inventory	516, 230		, v	0	
B.00 9.00	Prepaid expenses Other current assets	70, 848 975, 634		-	0	
10.00	Due from other funds	0		-	0	
11.00	Total current assets (sum of lines 1-10)	10, 965, 795		0	0	
	FI XED ASSETS					
12.00	Land	1, 710, 000			0	
13.00 14.00	Land improvements	150, 000			0	•
14.00	Accumulated depreciation Buildings	16, 449, 452		, v	0	
16.00	Accumulated depreciation	10, 44 9, 432		, v	0	
17.00	Leasehold improvements	238, 405		-	0	
18.00	Accumulated depreciation	0		0 0	0	18.00
19.00	Fixed equipment	0		0 0	0	
20.00	Accumulated depreciation	0		0	0	
21.00 22.00	Automobiles and trucks Accumulated depreciation			-	0	21.00
22.00	Major movable equipment	7, 617, 121		-	0	22.00
24.00	Accumulated depreciation	-5, 278, 490		-	0	•
25.00	Minor equipment depreciable	0		0 0	0	25.00
26.00	Accumulated depreciation	0	(-	0	
27.00	HIT designated Assets	0		0 0	0	
28.00	Accumulated depreciation	0	(-	0	
29.00 30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	20, 886, 488			0	
50.00	OTHER ASSETS	20,000,400	· · · · ·		0	50.00
31.00	Investments	7, 710, 284	(0 0	0	31.00
32.00	Deposits on Leases	0		0 0	0	
33.00	Due from owners/officers	0		0	0	
34.00 35.00	Other assets Total other assets (sum of lines 31-34)	-16, 883, 640		-	0	
35.00 36.00	Total assets (sum of lines 11, 30, and 35)	-9, 173, 356 22, 678, 927			0	
50.00	CURRENT LIABILITIES	22,010,721	· · · · ·	<u> </u>	0	30.00
37.00	Accounts payable	2, 311, 259	(0 0	0	37.00
38.00	Salaries, wages, and fees payable	1, 563, 232			0	
39.00	Payroll taxes payable	907		0	0	
	Notes and Loans payable (short term)	4, 148			0	
41.00 42.00	Deferred income Accelerated payments		(0	0	41.00
43.00	Due to other funds	0		0	0	43.00
44.00	Other current liabilities	186, 984	(0 0	0	1
45.00	Total current liabilities (sum of lines 37 thru 44)	4, 066, 530	(0 0	0	45.00
	LONG TERM LIABILITIES		1			
46.00	Mortgage payable	0			0	
47.00 48.00	Notes payable Unsecured Loans	305, 295		0	0	
49.00	Other long term liabilities				0	
50.00	Total long term liabilities (sum of lines 46 thru 49	305, 295		0	0	1
51.00	Total liabilites (sum of lines 45 and 50)	4, 371, 825	(0 0	0	51.00
	CAPI TAL ACCOUNTS	-		1		
52.00	General fund balance	18, 307, 102				52.00
53.00 54.00	Specific purpose fund Donor created - endowment fund balance - restricted					53.00 54.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion	10 007 1			-	_
59.00 60.00	Total fund balances (sum of lines 52 thru 58)			0	0	
111 111	Total liabilities and fund balances (sum of lines 51 and	22, 678, 927	1 (, U	0	60.00

Heal th	Financial Systems	WESTVIEW H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014		pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3,00	4,00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23, 859, 261 -5, 552, 160 18, 307, 101 18, 307, 102 18, 307, 102 0 18, 307, 102				$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund			
1.00		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	000			0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

Heal th	Financial Systems WESTVIEW HOSPI	TAL		In Lie	u of Form CMS-2	2552-10
	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet G-2 Parts I & II Date/Time Pre 5/27/2015 6:1	pared: 3 pm
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					
1.00	Hospi tal		2, 705, 8	57	2, 705, 867	1.00
2.00	SUBPROVIDER - IPF		496, 7		496, 740	2.00
3.00	SUBPROVIDER - IRF		1, 357, 1		1, 357, 124	3.00
4.00	SUBPROVI DER			0	0	4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY			0	0	7.00
8.00	NURSING FACILITY			0	0	8.00
9.00	OTHER LONG TERM CARE		4 550 7	0	0	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		4, 559, 7	31	4, 559, 731	10.00
11.00	INTENSIVE CARE UNIT		657, 6	33	657, 683	11.00
12.00	CORONARY CARE UNIT			0	0	12.00
13.00	BURN INTENSIVE CARE UNIT			0	0	13.00
14.00	SURGI CAL INTENSI VE CARE UNI T			0	0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)		(57.4)		(57 (00	15.00
16.00	Total intensive care type inpatient hospital services (sum of I 11-15)	i nes	657, 6	33	657, 683	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		5, 217, 4		5, 217, 414	17.00
18.00	Ancillary services		20, 688, 9		118, 967, 775	18.00
19.00	Outpatient services			0 18, 290, 010	18, 290, 010	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY			0 0	0	22.00
23.00 24.00	AMBULANCE SERVICES			0 0	0	23.00 24.00
24.00	CORF			0 0	0	24.00
24.10	AMBULATORY SURGICAL CENTER (D. P.)			0 0	0	25.00
26.00	HOSPICE			0 0	0	26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	25, 906, 3	75 116, 568, 824	142, 475, 199	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		T			
29.00	Operating expenses (per Wkst. A, column 3, line 200)			60, 663, 640		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00 33.00				0		32.00 33.00
33.00				0		34.00
34.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		60, 663, 640		43.00
	to Wkst. G-3, line 4)		I			

<u>Heal th</u>	Financial Systems WE	STVIEW HOSPITAL			In Lie	u of Form CMS-2	<u>2552-10</u>
STATE	IENT OF REVENUES AND EXPENSES	Provi	der CCN	: 150129	Peri od:	Worksheet G-3	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	nared
					10 12/31/2014	5/27/2015 6: 1	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, colu					142, 475, 199	1.00
2.00	Less contractual allowances and discounts on patient	ts' accounts				90, 283, 615	2.00
3.00	Net patient revenues (line 1 minus line 2)					52, 191, 584	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part					60, 663, 640	4.00
5.00	Net income from service to patients (line 3 minus li	ine 4)				-8, 472, 056	5.00
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					617, 438	
8.00	Revenues from telephone and other miscellaneous com	munication service	S			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					0	10.00
11.00						0	11.00
12.00						0	12.00
13.00	Revenue from Laundry and Linen service					0	13.00
14.00	Revenue from meals sold to employees and guests					0	14.00
15.00	Revenue from rental of living quarters					0	15.00
16.00	Revenue from sale of medical and surgical supplies	to other than pati	ents			0	16.00
17.00	Revenue from sale of drugs to other than patients					0	17.00
18.00	Revenue from sale of medical records and abstracts					0	18.00
19.00						0	19.00
20.00		een				0	20.00 21.00
21.00 22.00	5					0	21.00
	Rental of hospital space					-	
23.00	Governmental appropriations					0	23.00
24.00	MISCELLANEOUS INCOME					2, 302, 458	
25.00 26.00	Total other income (sum of lines 6-24) Total (line 5 plus line 25)					2, 919, 896 -5, 552, 160	
	OTHER EXPENSES (SPECIFY)					-5, 552, 160 0	26.00
27.00)				0	27.00
	Net income (or loss) for the period (line 26 minus l					-5, 552, 160	
∠9.00	Iner income (or ross) for the period (rifle 20 minus i	1110 20)				-0, 002, 160	29.00

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150129	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Pre 5/27/2015 6:13	
		Title XVIII	Hospi tal	PPS	s pin
		· · · · · · · · · · · · · · · · · · ·			
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
~~	CAPITAL FEDERAL AMOUNT			171 75/	1
00 01	Capital DRG other than outlier			171, 756 0	1.
00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			1, 015	1. 2.
00	Model 4 BPCI Capital DRG outlier payments			1,015	2.
00	Total inpatient days divided by number of days in the cost r	oporting poriod (soo inst	ructions)	7.43	2.
00	Number of interns & residents (see instructions)	epoliting period (see this	i uctions)	12.10	4.
. 00	Indirect medical education percentage (see instructions)			52.70	5.
00	Indirect medical education adjustment (multiply line 5 by th	e sum of lines 1 and 1 01)	90, 515	6.
00	Percentage of SSI recipient patient days to Medicare Part A			0.00	7.
. 00	30) (see instructions)			0.00	
. 00	Percentage of Medicaid patient days to total days (see instr	uctions)		0.00	8.
.00	Sum of lines 7 and 8			0.00	
D. 00	Allowable disproportionate share percentage (see instruction	s)		0.00	
I. 00	Disproportionate share adjustment (line 10 times the sum of	lines 1 and 1.01)		0	11
2.00	Total prospective capital payments (sum of lines 1, 1.01, 2,	2.01, 6 and 11)		263, 286	12
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
00	Program inpatient routine capital cost (see instructions)			0	1
00	Program inpatient ancillary capital cost (see instructions)			0	2
00	Total inpatient program capital cost (line 1 plus line 2)			0	3
00	Capital cost payment factor (see instructions)			0	4
00	Total inpatient program capital cost (line 3 x line 4)			0	5
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00	Program inpatient capital costs (see instructions)	/ · · · · ·		0	1
00	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	2
00 00	Net program inpatient capital costs (line 1 minus line 2)			0 0.00	3
00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	4 5
00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6
00	Adjustment to capital minimum payment level for extraordinar		line 6)	0.00	7
	Capital minimum payment level (line 5 plus line 7)			0	8
	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	9
00			less line 9)	0	10
00 00		capital payments (Time o		0	11
00 00 0. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	capital payment (from pri	or year	0	
00 00 0. 00 1. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)		5		12
00 00 00 00 00 00 00 00 00 00 00 00 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p	ayments (line 10 plus lin	ne 11)	0	
. 00 . 00 0. 00 1. 00 2. 00 3. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over	ayments (line 10 plus lin r the amount on this line	ne 11) e)		12. 13. 14.
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente	ayments (line 10 plus lin r the amount on this line capital payment for the f	ne 11) e)	0	13
. 00 . 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	ayments (line 10 plus lin r the amount on this line capital payment for the f	ne 11) e)	0 0 0	13 14