| 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 | | | |
| 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 8.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk | th of th (", comp , if ap pursemer (st. D-5 | r "N" for no in his cost report blete Worksheet oplicable. ht for physicia 5. | column 1. If ing period? E-4. If colu ns' services | column 1 Enter "Y" nn 2 is | N | | | 58.0 |
| 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 8.00 If line 56 is yes, did this facility elect cost reimb | th of th (", comp , if ap oursemer (st. D-5 s, compl | "N" for no in his cost report olete Worksheet oplicable. ht for physicia 5. ete Wkst. D-2, | column 1. If ing period? E-4. If colu ns' services Pt. I. | column 1 Enter "Y" nn 2 is as | | | | 58. 0 59. 0 |
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| 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 B.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk 9.00 Are costs claimed on line 100 of Worksheet A? If yes 0.00 Are you claiming nursing school and/or allied health | th of th (", comp , if ap oursemer (st. D-5 s, compl costs f | " "N" for no in his cost report olete Worksheet oplicable. ht for physicia 5. ete Wkst. D-2, for a program t | column 1. If ing period? E-4. If colu ns' services Pt. I. hat meets the | column 1 Enter "Y" nn 2 is as | N | Direct | | 58.0 |
| 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 8.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk 9.00 Are costs claimed on line 100 of Worksheet A? If yes 0.00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" | th of th (", comp , if ap oursement (st. D-5 s, complices for yes Y/N 1.00 | " "N" for no in his cost report olete Worksheet oplicable. ht for physicia 5. ete Wkst. D-2, for a program t <u>s or "N" for no</u> | column 1. If ing period? E-4. If colu ns' services Pt. I. hat meets the . (see instru | column 1 Enter "Y" nn 2 is as ctions) | N N N | Di rect | 00 | 58. 0 59. 0 60. 0 |
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| 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 a. 11 fline 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk b. 00 Are costs claimed on line 100 of Worksheet A? If yes b. 00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y" c. 00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) c. 01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) d. 02 Enter the current year total unweighted primary care | th of th (", comp , if ap oursement (st. D-5 s, complices for yes Y/N 1.00 | "N" for no in his cost report of the Worksheet oplicable. ht for physicia 5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 | column 1. If ing period? E-4. If columns' services a Pt. I. hat meets the <u>(see instrue</u> <u>3.00</u> 4.7 | column 1 Enter "Y" nn 2 is as tions) IME 4.00 | N N N | | 00 | 58.0 59.0 60.0 61.0 |
| 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 a. 00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk b. 00 Are costs claimed on line 100 of Worksheet A? If yes b. 00 Are you claiming nursing school and/or allied heal th provider-operated criteria under §413.85? Enter "Y" column 1. (see instructions) column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) | th of th (", comp , if ap oursement (st. D-5 s, complices for yes Y/N 1.00 | r "N" for no in his cost report of the Worksheet oplicable. ht for physicia 5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 4.21 | column 1. If ing period? E-4. If columns' services a Pt. I. hat meets the . (see instrue Direct GME 3.00 4.7 | column 1 Enter "Y" nn 2 is as tions) IME 4.00 | N N N | | 00 | 58.0 59.0 60.0 61.0 |
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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 | - |
| home office and enter the home of | fice contractor name and | d contractor numb | er. | | | | |
| 1.00 Name: COMMUNITY HEALTH NETWORK 2.00 Street: 1500 N RITTER | Contractor's Name: PO Box: | WI SCONSI N PHYSI C SERVI CES | IAN Contrac | tor's Numl: | ber: 0810 |)1 | 141.0 |
| 3. 00 Ci ty: I NDI ANAPOLI S | State: | IN | Zip Cod | le: | 4621 | 9 | 143.0 |
| | | | | | | 1.00 | _ |
| 4.00 Are provider based physicians' co | sts included in Workshee | et A? | | | | Y | 144. 0 |
| 5.00 If costs for renal services are c | | ine 74, are the o | costs for in | npatient s | ervi ces | Y | 145.0 |
| only? Enter "Y" for yes or "N" fo | | | | | | | |
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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 - 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. | apy 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 <u>Name</u> | D. 15-2, § 4020) I Dr yes or "N" for for yes or "N" for for end of the second sec | f yes, ente no. or no. es or "N" fo <u>Part B</u> 2.00 n the applic and Part B. N N N N N N N N N N N N N N N N N N N | er Ti - 3 cation of (See 42 - Ferent CBS | 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. (148. (149. (155. (156. (157. (158. (159. (161. (161. (161. (165. (- |
| 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 | apy 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 <u>Name</u> | D. 15-2, § 4020) I Dr yes or "N" for for yes or "N" for for end of the second sec | f yes, ente no. or no. es or "N" fo <u>Part B</u> 2.00 n the applic and Part B. N N N N N N N N N N N N N N N N N N N | er Ti - 3 cation of (See 42 - Ferent CBS | N Y N N tle V .000 the lowe CFR §413 N N N N N N N N N As? CBSA | 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. (148. (149. (155. (156. (157. (158. (159. (161. (161. (161. (165. (- |
| 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 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 | | | | | | |
| 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 12.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 173,702 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 14.00 14.00 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 Non cumulative portion 1,495,582 17.00 18.00 18.00 17.00 FICA-Employers Portion Only 1,495,582 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 275,914 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 0 Instructions)) 22.00 22.00 22.00 <t< td=""><td>8.00</td><td>Health Insurance (Purchased or Self Funded)</td><td></td><td></td><td></td><td></td><td>2, 217, 187</td><td>8.00</td></t<> | 8.00 | Health Insurance (Purchased or Self Funded) | | | | | 2, 217, 187 | 8.00 |
| 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 | | | | | | | |
| 13.00Disability 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 Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.016.00Non cumulative portion)1,495,58217.00TAXES11,495,58217.0018.00Medicare Taxes - Employers Portion Only018.0019.00Unemployment Insurance018.000State or Federal Unemployment Taxes020.000THER021.0022.0021.00Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see022.0022.00Day Care Cost and Allowances022.0022.0023.00Tuition Reimbursement24,19923.0024.00Total Wage Related cost (Sum of Lines 1 -23)5,404,75024.00Part B - Other than Core Related Cost24.0024.00 | 11.00 | | | | | | 31, 753 | |
| 14.00Long-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)TAXES016.0017.00FICA-Employers Portion Only1,495,58217.0018.00Medicare Taxes - Employers Portion Only018.0019.00Unemployment Insurance018.0020.00State 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 Allowances022.0022.0023.00Tuition Reimbursement24,19923.0024.00Total Wage Related cost (Sum of Lines 1 -23)5,404,75024.00Part B - Other than Core Related Cost024.00 | | | | | | | - | |
| 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 | | | | | | | | |
| 16.00 Retirement Heal th Care Cost (Only current year, not the extraordinary accrual required by FASB 106. 0 16.00 TAXES 17.00 FICA-Employers Portion Only 1,495,582 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 275,914 19.00 20.00 State or Federal Unemployment Taxes 0 20.00 01HER 0 21.00 22.00 22.00 22.00 Day Care Cost and Allowances 0 22.00 22.00 23.00 Tuit ion Reimbursement 24,199 23.00 24.00 24.00 Part B - Other than Core Related Cost 5,404,750 24.00 | | | ner or beneficiary) | | | | | |
| 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 | | | | | | | | |
| 18.00Medicare 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 | 17 00 | | | | | | 1 405 592 | 17 00 |
| 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 | | 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 | 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 | 0.000053 | |
| 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 | 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 |