Health Financial Systems PA	RKVIEW WABASH H	OSPITAL, INC.		In Lieu	u of Form CMS-	2552-10
This report is required by law (42 USC 1395g; 42 CFF	R 413.20(b)). Fa	ilure to repo	rt can result ir	n all interim	FORM APPROVED	)
payments made since the beginning of the cost repor-	01	<u> </u>		0,	OMB NO. 0938-	-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT	RT CERTIFICATION	I Provider (	CCN: 151310 Per	i od:	Worksheet S	
AND SETTLEMENT SUMMARY			To	m 01/01/2015 12/31/2015	Parts I-III Date/Time Pre	nared
			10	12/01/2010	7/14/2016 3:5	
PART I – COST REPORT STATUS						
Provider 1. [X] Electronically filed cost rep				Date: 7/14/20	16 Time:	3:52 pm
use only 2. [ ] Manual ly submitted cost repor						
3. [ 0 ] If this is an amended report 4. [ F ] Medicare Utilization. Enter "	F" for full or	r of times the "L" for low.	provider resub	mitted this co	ost report	
	Recei ved:		10. NPR [		un Cada	4
use only (1) As Submitted 7. Contra (2) Settled without Audit 8. [N]	actor No. Enitial Report	for this Provi	der CCN 12 [ 0 ]	actor's Vendo	olumn 1 is 4 <sup>.</sup>	4 Fnter
(3) Settled with Audit 9. [N]	Final Report fo	r this Provide	rCCN	number of tim	es reopened =	0-9.
(4) Reopened					•	
(5) Amended						
PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATIO						
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDI						
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF						
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY				,		
CERTIFICATION BY OFFICER OR ADMINIS	TRATOR OF PROVI	DER(S)				
I HEREBY CERTIFY that I have read the above						
electronically filed or manually submitted						
Expenses prepared by PARKVIEW WABASH HOSPIT. 01/01/2015 and ending 12/31/2015 and to the						
correct, complete and prepared from the boo						
instructions, except as noted. I further c						
provision of health care services, and that						
compliance with such laws and regulations.						
	(a.					
	(Si gne	· ·				
		UTTICE	er or Administra	tor of Provid	er(s)	
		Title				
		Date				
			1			
		Title				
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 Hospital	0	72, 669	-78, 384	264, 209		1.00
2.00 Subprovi der – IPF	o	12,009	-78, 384	204, 209	(	
3.00 Subprovider - IRF	0	0	0		0	
5.00 Swing bed - SNF	0	19, 089	0		C	
6.00 Swing bed - NF	Ő	,,	Ū.		C	
9.00 HOME HEALTH AGENCY I	0	о	0		C	
200_00 Total	0	91, 758	-78, 384	264, 209	C	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.

	2					454040					
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENITFICATION DA	IA	Provi	der CCN:		From 01/01/	/2015 /2015	Part I Date/Ti	me Pre	pared:
	1.00	2.	00		3.00				//14/20	)16 3:4	3 pm
1.00	Street: 710 NORTH EAST STREET				4/000	0540 0	WARACU				1.00
2.00         Dirty         MeAA3H         State:         IV         Dirty         Cole											
Displation         Provider         Displation         Provider         Displation         Provider         Displation         Provider         Displation           1.00         Street         1.00         2.00         1.00         Street         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         2.00         1.00         1.00         2.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00         1.00											
		1.00		0.00		1			-		
	Hospital and Hospital-Based Componen			2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00				151310	15999	1	12/17/2001	N	0	Р	3.00
4 00	Subprovidor	HOSPITAL, INC.									4 00
											•
											•
7.00	Swing Beds - SNF			15Z310	15999		12/17/2001	N	0	N	7.00
8.00	Swing Beds - NF	HUSPITAL SWING BE	EDS								8.00
	Hospital-Based SNF										•
											•
	•	WABASH-MLAML HOME	F .	157061	15999		01/01/1979	N	Р	N	•
121 00			-	0,001							12100
					45000		04 /04 /400/				•
		WABASH-MI AMI HUSH	PICE	151545	15999		01/01/1996				•
											•
											•
											•
17.00		<u> </u>				1	From:		То	:	17.00
											00.00
	Type of Control (see instructions)							015	12/31/	2015	•
211.00											2
22.00							N		N		22.00
							2				
					2.100(0)	(2)(110)(11					
22. 01							N		N		22.01
	for no for the portion of the cost r										
22.02		noguinos final u		+		to to bo	N		N		22.02
22.02									N		22.02
	or "N" for no, for the portion of th	e cost reporting	period pr	ior to	October	1. Enter					
		no, for the porti	on of the	cost r	eporting	period or	n				
22. 03		ic reclassificati	on from u	rban to	rural a	s a result	t N		N		22.03
							_				
				ounted	in accor	dance with	n				
23.00				d∕or 25	bel ow?	In column		2	N		23.00
	1, enter 1 if date of admission, 2 i	f census days, or	3 if dat	e of di	scharge.	Is the					
	5 5 5	1 5									
				In-S	tate 0		Out-of N			ther	
								HMO day			
			pard days							lays	
				day	/s		unpai d				
24.00	If this providen is as LDDC by the	optop the						5.00			24.00
24.00				0	0	0	0		0	0	24.00
	Medicaid eligible unpaid days in col	umn 2,									
	column 5, and other Medicaid days in	column 6.									
25.00				0	0	0	0		0		25.00
	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column	3, out-of-state									
	Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day										
	rime para ana originic nat unpara day			1	I	I	I		1		I

OSPI T	Financial Systems PARKVIEW W AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		HOSPITAL, INC. Provider (		eriod:		u of For Workshe		
				T	rom 01/01/ o 12/31/		Part I Date/Ti		
					Urban/Rur		7/14/20 Date of		
6.00	Enter your standard geographic classification (not wa	ne) sta	atus at the her	inning of the	1.00	2	2.0	00	26.0
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ge) sta "2" fo	atus at the end or rural. If ap	of the cost		2			27.0
5.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.0
					Begi nni i	ng:	Endi		_
5.00	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00		2.0	0	36.0
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	s MDH status		0			37. (
. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N				37. (
3. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. (
					Y/N		Y/		-
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req	)? Ent∉ uiremer	er in column 1 nts in accordan	"Y" for yes ce with 42	1.00 N		2.0 N		39.0
). 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	adjust er 1. E	tment? Enter "Y Enter "Y" for y	" for yes or	N		N		40. (
		(366 1	listi de tronsj			V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1.00	) 2.00	3.00	
. 00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce					N N	N	N	45. 46.
	Pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi	. L, P1	. III and Wkst	. L-1, Pt. I t	hrough	N	N	N	47.
8. 00	Is the facility electing full federal capital payment Teaching Hospitals	? Ente	er "Y" for yes	or "N" for no.		N	N	N	48.
. 00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter Y T	or yes	N			56.
. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or h of th ", comp	r "N" for no in his cost report plete Worksheet	column 1. If ing period? E	column 1 inter "Y"				57.
. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer	nt for physicia	ns' services a	IS				58.
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health					N N			59. 60.
	provider-operated criteria under §413.85? Enter "Y"				tions)		Di rect	GME	00.1
		1.00	2.00	3.00	4.00		5.0		
. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	Ν				0.00		0.00	61.
. 01	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		0. 00	0.00					61.
. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0. 00	0.00					61.
. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00					61.
04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61.
	current cost reporting period. (see instructions). Enter the difference between the baseline primary		0.00	0.00					61.

IOSPI TAI	L AND HOSPITAL HEALTH CARE COMPL	_EX IDENTIFICATION DA	ТА	Provider (		eriod: com 01/01/2015 0 12/31/2015	Worksheet S-2 Part I Date/Time Prep 7/14/2016 3:43	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
u	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0. 00			61. (
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
s f c u	of the FTEs in line 61.05, speci- specialty, if any, and the numbe For each new program. (see instr- column 1, the program name, ente orogram code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
1.200 p r i 3	of the FTEs in Line 61.05, speci- program specialty, if any, and t residents for each expanded prog- nstructions) Enter in column 1, enter in column 2, the program c 8, the IME FTE unweighted count 4, direct GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	61. :
							1.00	
_	ACA Provisions Affecting the Hea					ad far which		(2)
У	Enter the number of FTE resident vour hospital received HRSA PCRE	funding (see instruc	ctions)					62.
d	nter the number of FTE resident luring in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog	gram. (s	ee instruction		your hospital	0.00	62.
3.00 H	las your facility trained reside Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63.
					Unwei ghted FTEs Nonprovi der		Ratio (col. 1/ (col. 1 + col. 2))	
				-	Si te 1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea Deriod that begins on or after J							
1.00 Ē i r s r	Enter in column 1, if line 63 is on the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ty train ו-primar all non מ non-pr ו column	ed residents y care provider imary care 3 the ratio	0. 00	0. 00	0. 000000	64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
it ya Fprtcu rrn c	Enter in column 1, if line 63 s yes, or your facility crained residents in the base vear period, the program name issociated with primary care orogram in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of inweighted primary care FTE residents attributable to rotations occurring in all ion-provider settings. Enter in column 4, the number of inweighted primary care resident FTEs that trained in				0.00	0.00	0. 000000	05.0

Heal th	Financial Systems	PARKVI EW V	NABASH HOSPIT	AL, INC.		l i	n Lie	u of Form CMS	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA I	Provi der	F	Period: From 01/01/ To 12/31/		Worksheet S- Part I Date/Time Pro 7/14/2016 3:-	epared:
					Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n al	Ratio (col. 1 (col. 1 + col 2))	/
	Section 5504 of the ACA Current	Year FTF Residents in	n Nonprovider	Settino	1.00 1sEffective f	2.00		<u>3.00</u> na periods	-
	<u>beginning on or after July 1, 20</u>	10	•						
66.00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider setti ry care resid 3 the ratio o	ngs. ent	0.0		0. 00	0. 00000	5 66.00
		Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n	Ratio (col. 3 (col. 3 + col 4))	
		1.00	2.00	1	3.00	4.00		5.00	-
67.00	Enter in column 1, the program name associated with each of 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)				0.0		0.00		0 67.00
			1						
	Inpatient Psychiatric Facility P	PS					1.00	0 2.00 3.00	
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does	it cont	ain an IPF sub	provi der?	N		70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	)04? Enter " lity train r )(D)? Enter "	Y" for y esidents Y" for y	es or "N" for in a new teac es or "N" for	no. (see hi ng no.		0	71.00
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or d	oes it c	ontain an IRF		Ν		75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	ember 15, 200 new teaching for no. Colu	4? Enter program mn 3: lf	"Y" for yes o in accordance column 2 is Y	r "N" for with 42		0	76.00
								1.00	_
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? Er	nter	N N	80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne \$413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	(excluded uni				no.	N	85. 00 86. 00
87.00	Is this hospital a "subclause (I			1886(d)	(1)(B)(iv)(II)	? Enter "Y		Ν	87.00
	for yes or "N" for no.					V		XIX	
	Title V and VIX Services					1.00		2.00	
90.00	Title V and XIX Services Does this facility have title V		hospital ser	vi ces? E	nter "Y" for	N		Y	90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for		nrough the co	st repor	t either in	N		N	91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy	es or "N" for no in t	the applicabl	e column	I.			N	92.00
	instructions) Enter "Y" for yes	or"N" for no in the	applicable c	olumn.					
93.00	Does this facility operate an IC "Y" for yes or "N" for no in the		urposes of ti	tie V an	a XIX? Enter	N		N	93.00
94.00	Does title V or XIX reduce capit applicable column.		or yes, and "	N" for n	o in the	N		N	94.00

5	HOSPITAL, INC.		In	Lieu	ı of Form		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 151310	Period: From 01/01/2 To 12/31/2		Workshee Part I Date/Tin 7/14/20	ne Pre	epared:
			V		XI X		
			1.00		2.0		05.00
			0. 00 N		0. 0 N	0	95.00 96.00
Rural Providers		٦.	0.00		0.0	0	97.00
		nod of paymen	t N				105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column	n 1. (see insti	ructions) If	t				107.00
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.							108.00
		Occupationa 2.00	I Speech 3.00		Respira 4.0		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N	0	109.00
				-	1.0	0	-
		on project (4	10A Demo)for		N		110.00
			_	1. 00	2.00	3.00	-
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider	lf column 2 i nt for long ter	s "E", enter rm care (incl	in column udes	N		0	115. 00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur			"N" for	N N			116. 00 117. 00
	icy? Enter 1 i	f the policy	is	0			118.00
		Premiums	Losses		Insura	ince	
110 01 List amounts of mal practice promiums and paid losses		1.00 51,1	2.00	0	3.0		2 118. 01
The offerst amounts of marpractice premirums and pard rosses.		51,1					-
			<u>1.00</u> N		2.0	0	118.02
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu	n column 1, "Y ualifies for th	' for yes or ne Outpatient			N		119.00 120.00
	nts? (see insti	fuctions)					
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla		,	Y				121.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th	antable devices Enter "Y" for	s charged to yes or "N"	Y N				121. 00 122. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information	antable devices Enter "Y" for ne Worksheet A	s charged to yes or "N" line number					
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	X IDENTIFICATION DATA	Provi der		eriod: rom 01/01/2015	w of Form CMS- Worksheet S- Part I	2
			Т	o 12/31/2015	Date/Time Pro 7/14/2016 3:	epared: 43 pm
				1.00	2.00	-
3.00 If this is a Medicare certified ot			cation date			133.00
in column 1 and termination date, 4.00 If this is an organ procurement or	ganization (OPO), ent		n column 1			134.00
and termination date, if applicabl All Providers	e, in column 2.					-
10.00 Are there any related organization				Y		140. 00
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the						
1.00		2.00		3.00		
If this facility is part of a chai home office and enter the home off				me and address	of the	
1.00 Name: PARKVIEW HEALTH SYSTEM, INC		ne: WI SCONSI N PHYSI CI SERVI CE		's Number: 0810	)1	141.00
2.00 Street: 10501 CORPORATE DRIVE	PO Box:	5600				142.00
3.00 City: FORT WAYNE	State:	IN	Zip Code:	4684	15	143.00
					1.00	_
14.00 Are provider based physicians' cos	ts included in Worksh	heet A?			1.00 Y	144.00
					•	114.00
			-	1.00	2.00	
15.00 If costs for renal services are cl inpatient services only? Enter "Y" no, does the dialysis facility inc	for yes or "N" for n clude Medicare utiliza	no in column 1. If c	olumn 1 is	N		145.00
period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	gy changed from the pro n column 1. (See CMS P			N		146. 00
Jes, enter the approval date (mm/				1	1.00	-
17.00Was there a change in the statisti	cal basis? Enter "Y"	for ves or "N" for	no.		N 1.00	147.00
48.00 Was there a change in the order of					1	1.17.00
	arrocation. Entor i	" for yes or "N" fo	or no.		N	148.00
19.00Was there a change to the simplifi		od? Enter "Y" for ye	s or "N" for r		N	
19.00 Was there a change to the simplifi		od? Enter "Y" for ye Part A	es or "N" for r Part B	Title V	N Title XIX	
19.00 Was there a change to the simplifi	ed cost finding metho	od? Enter "Y" for ye Part A 1.00	es or "N" for r Part B 2.00	Title V 3.00	N Title XIX 4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "	ed cost finding metho der that qualifies fo	od? Enter "Y" for ye Part A 1.00 or an exemption from	es or "N" for r Part B 2.00 n the applicat and Part B. (1	Title V 3.00 ion of the lowe See 42 CFR §413	N Title XIX 4.00 er of costs 3.13)	149.00
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or charges? Enter "Y" for yes or " 55.00 Hospital 56.00 Subprovider - IPF 57.00 Subprovider - IRF 58.00 SUBPROVIDER 59.00 SNF 50.00 HOME HEALTH AGENCY 51.00 CMHC 55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 56.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in	ed cost finding metho der that qualifies fo 'N" for no for each co mpus hospital that ha Name	bd? Enter "Y" for ye Part A 1.00 or an exemption from ponent for Part A N N N N N N N N N N N N N	es or "N" for r Part B 2.00 In the applicat and Part B. (1 N N N N N N N N State Zip	Title V 3.00 ion of the lowe See 42 CFR §413 N N N N N N N N N N N N N	N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	148. 00 149. 00 155. 00 156. 00 157. 00 158. 00 159. 00 161. 00 161. 00 161. 00 0 166. 00
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Health Financial Systems	PARKVIEW WABASH HOSPI	TAL, INC.	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	IFICATION DATA	Provider CCN: 151310	Period: From 01/01/2015	Worksheet S-2 Part I	
			To 12/31/2015		epared: 3 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginnin period respectively (mm/dd/yyyy)	g date and ending date	for the reporting	10/01/2014	09/30/2015	170.00
				1.00	
171.00 If line 167 is "Y", does this provider ha Medicare cost plans reported on Wkst. S-3 (see instructions)				N	171.00

05PT 1	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 7/14/2016 3:4	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lforall NO re	esponses. Ente	1.00 er all dates in t	2.00 the	
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the			Y	12/31/2014	1.00
	reporting period? If yes, enter the date of the change in o	column 2. (see	instructions) Y/N		V/I	
			1.00	Date 2.00	3.00	-
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N	2.00	0.00	2.00
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home c or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members c of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	N			3. 00
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	°or Compiled,	Y	A		4.00
. 00	Are the cost report total expenses and total revenues diffe		N			5.00
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	-
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is th	ne provider is	s N		6.00
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see ir	etructione		N		7.00
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N		8.00
00	Are costs claimed for Interns and Residents in an approved		cal education	N		9.00
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.		the current	Ν		10.00
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	)/ /NI	11.00
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y Y	12. 00 13. 00
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	<sup>-</sup> yes, see ins	structions.	N	14.00
5.00	Did total beds available change from the prior cost reporti		-		Ν	15.00
			rt A		t B	_
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	-
	PS&R Data	1.00	2.00	5.00	4.00	
6. 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)	Y	05/11/2016	Y	05/11/2016	16.0
7.00	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	N		Ν		17.0
3. 00	in columns 2 and 4. (see instructions) 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	Ν		Ν		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		Ν		19. 0

	Financial Systems PARKVIEW WABASH FAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 151310	Period:	u of Form CMS Worksheet S-	
1051 1 1				From 01/01/2015 To 12/31/2015	Part II	repared:
		Descr	iption	Y/N	Y/N	
	1		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		-	N	N	20.00
		Y/N	Date	Y/N	Date	
1 00	We the set would are not entry with the available	1.00	2.00	3.00	4.00	21.00
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS H	IOSPI TALS)		1.00	_
2.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00
3.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N	23.00
4. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?	Ν	24.00
5.00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	lfyes, see	N	25.00
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.			-	Ν	26.00
7.00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	N	27.00
8. 00		ntered into dur	ing the cost	reporting	N	28.00
9.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	•	ebt Service R	eserve Fund)	Ν	29.00
0.00	Has existing debt been replaced prior to its scheduled matuli instructions.		debt? If yes	, see	Ν	30. 0
1. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	, see	Ν	31.00
	Purchased Services					
2.00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		ed through co	ntractual	N	32.00
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If	Ν	33.0
	Provi der-Based Physi ci ans					
4.00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	n provider-ba	sed physi ci ans?	Y	34.0
5.00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the		Y	35.0
				Y/N	Date	
	Home Office Costs			1.00	2.00	
6, 00	Were home office costs claimed on the cost report?			Y		36.0
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			37.0
8. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38.0
9.00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compor	nents? If yes			39.0
0.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	N		40.0
	I	1.	00	2.	00	
1 00	Cost Report Preparer Contact Information	EDLC		NUCKECON		41.0
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERIC		NI CKESON		41.0
	respectively. Enter the employer/company name of the cost report	PARKVIEW HEALT	H SYSTEM IN	с.		42.0
2. 00	preparer.					

Heal th	Financial Systems PARKVIEW WABASH	I HOSPI	TAL, INC.		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CC	N: 151310	Period: From 01/01/2015	Worksheet S-2 Part II	
					To 12/31/2015		
			3.00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	DI RE(	CTOR, REIMBUR	RSEMENT			41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 151310		eriod: com 01/01/2015 o 12/31/2015	Worksheet S Part I Date/Time F 7/14/2016 S	Pre	
								I/P Days / C	)/P	-
	Component	Worksheet A	No	of Beds	Bed Davs		CAH Hours	<u>Visits / Tri</u> Title V	ps	
	component	Line Number	NO.	OI Beas	Avai l abl e		CAH HOULS	ntie v		
		1.00		2.00	3.00		4.00	5.00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	30.00		25	9, 1	25	41, 664. 00		0	1.
00	for the portion of LDP room available beds) HMO and other (see instructions)									2.
. 00	HMO I PF Subprovider									3.
00	HMO IRF Subprovider									4.
00	Hospital Adults & Peds. Swing Bed SNF								0	5
00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			25	0.1	25	41 ((4 00		0	6
00	beds) (see instructions)			25	9, 1	20	41, 664. 00		0	7
00	INTENSIVE CARE UNIT									8
00	CORONARY CARE UNIT									9
. 00	BURN INTENSIVE CARE UNIT									10
. 00 . 00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY)									11
. 00	NURSERY	43.00							0	13
. 00 . 00	Total (see instructions)	43.00		25	9, 1	25	41,664.00		0	14
. 00	CAH visits			23	Z, 1	25	41,004.00		0	15
. 00	SUBPROVIDER - IPF								0	16
. 00	SUBPROVIDER - IRF									17
. 00	SUBPROVIDER									18
.00	SKILLED NURSING FACILITY									19
. 00	NURSING FACILITY									20
. 00	OTHER LONG TERM CARE									21
. 00	HOME HEALTH AGENCY	101.00							0	22
00	AMBULATORY SURGICAL CENTER (D. P.)									23
. 00	HOSPI CE	116.00		0		0				24
. 10	HOSPICE (non-distinct part)	30.00								24
. 00	CMHC - CMHC									25
. 00	RURAL HEALTH CLINIC									26
. 25	FEDERALLY QUALIFIED HEALTH CENTER			25						26
. 00	Total (sum of lines 14-26) Observation Bed Days			25					0	27 28
. 00	Ambul ance Trips								0	28
. 00	Employee discount days (see instruction)									30
. 00	Employee discount days (see fisting to the second s									31
. 00	Labor & delivery days (see instructions)			0		0				32
. 01	Total ancillary labor & delivery room outpatient days (see instructions)			0						32
00	LTCH non-covered days									33

IOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Pre 7/14/2016 3:4	pared
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	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)	910	88				1.
. 00	HMO and other (see instructions)	363	0				2.
. 00	HMO I PF Subprovi der	0	0				3.
. 00	HMO I RF Subprovi der	o	0				4.
. 00	Hospital Adults & Peds. Swing Bed SNF	82	0	5	32		5.
. 00	Hospital Adults & Peds. Swing Bed NF		0	8	36		6.
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	992	88	1, 90	)4		7.
00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNIT						9
0.00	BURN INTENSIVE CARE UNIT						10
1.00	SURGICAL INTENSIVE CARE UNIT						11
2.00	OTHER SPECIAL CARE (SPECIFY)				0		12
3.00	NURSERY	992	0	1, 90	0	10/ 10	13
4.00 5.00	Total (see instructions) CAH visits	992	88 0	1, 90	0.00	186.40	14
5.00	SUBPROVIDER - IPF	U	0		0		16
7.00	SUBPROVIDER - IRF						17
3.00	SUBPROVI DER						18
9.00	SKILLED NURSING FACILITY						19
). 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY	1, 981	1, 654	8, 6	0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P. )	1,701	.,	0,00	0.00	0.00	23
1.00	HOSPICE	0	0		0 0.00	0.00	
1.10	HOSPICE (non-distinct part)	o	0		0		24
5.00	СМНС – СМНС				-		25
5.00	RURAL HEALTH CLINIC						26
5. 25	FEDERALLY QUALIFIED HEALTH CENTER						26
7.00	Total (sum of lines 14-26)				0.00	186.40	27
3. 00	Observation Bed Days		42	43	38		28
9.00	Ambul ance Trips	О					29
0. 00	Employee discount days (see instruction)				5		30
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
3.00	LTCH non-covered days	0					33

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	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)		0		87 29		1. C
2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 3. 00	HMO and other (see instructions) 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			1.	25 0 0 0		2. ( 3. ( 4. ( 5. ( 6. ( 7. (
. 00 0. 00 1. 00 2. 00 3. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						9. 10. 11. 12. 13.
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0	2	87 29	615	14. 15. 16. 17. 18. 19. 20. 21.
2.00 3.00 4.00 4.10 5.00 6.00 6.25	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00					22. 23. 24. 24. 25. 26. 26.
27.00 28.00 29.00 30.00 31.00 32.00 32.01	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00					20. 27. 28. 29. 30. 31. 32. 32.

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA			CCN: 151310 CCN: 157061	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
					Home Health Agency I	7/14/2016 3: 4 PPS	<u>3 pm</u>
						00	_
0.00	County				1.	00	0.00
		Title V	Title XVIII	Title XIX	Other	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00	Home Health Aide Hours	0	C		0 0		
2.00	Unduplicated Census Count (see instructions)	0.00	111.00		00 0.00 nployees (Full Ti		2.00
		Enter the numb your normal		Staff	Contract	Total	
		C	)	1.00	2.00	3.00	
0.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES			-			
3.00 4.00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0.00	0. 0.			
5.00	Other Administrative Personnel			0.	00 0.00	0.00	5.00
6.00 7.00	Direct Nursing Service Nursing Supervisor			0. 0.			
8.00	Physical Therapy Service			0.			
9.00	Physical Therapy Supervisor			0.			
10.00 11.00	Occupational Therapy Service Occupational Therapy Supervisor			0. 0.			
12.00	Speech Pathol ogy Service			0.			
13.00	Speech Pathol ogy Supervi sor			0.			
14.00 15.00	Medical Social Service Medical Social Service Supervisor			0. 0.			
16.00	Home Heal th Ai de			0.			
17.00	Home Heal th Ai de Supervi sor			0.			
18.00	Other (specify) HOME HEALTH AGENCY CBSA CODES			0.	00 0.00	0.00	18.00
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost				2		19.00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			99915			20.00
20. 01	contains the first code).			50031			20. 01
		Full Ep Without	bisodes With Outliers	LUDA Enicodo	es PEP Only	Total (cols.	
		Outliers	with outriers	LUFA LPI SOUE	Epi sodes	1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	612	C		50 0	662	21.00
22.00	Skilled Nursing Visit Charges	86, 779	C	8, 0		94, 854	22.00
23.00 24.00	Physical Therapy Visits Physical Therapy Visit Charges	990 136, 682	0	1, 2	9 0 59 0	999 137, 941	•
24.00	Occupational Therapy Visits	211	0	1,2	0 0	211	
26.00	Occupational Therapy Visit Charges	26, 102	C		0 0	26, 102	
27.00 28.00	Speech Pathol ogy Visits Speech Pathol ogy Visit Charges	58 7, 908	0			58 58 7, 908	
29.00	Medical Social Service Visits	4	C		0 0	4	29.00
30.00	Medical Social Service Visit Charges	547	0		0 0	547	
31.00 32.00	Home Health Aide Visits Home Health Aide Visit Charges	47 2, 781			0 0	47 2, 781	
33.00	Total visits (sum of lines 21, 23, 25, 27,	1, 922	0		59 0	1, 981	
34.00	29, and 31) Other Charges	0	0		0 0	0	34.00
34.00 35.00	Total Charges (sum of lines 22, 24, 26, 28,	260, 799	0	9, 3			
36.00	30, 32, and 34) Total Number of Episodes (standard/non	116			20 0	136	36.00
37.00	outlier) Total Number of Outlier Episodes		C		0	0	37.00
	Total Non-Routine Medical Supply Charges	103	C	1	12 0		38.00

Heal th	Financial Systems	HOSPITAL, INC.		In Lie	In Lieu of Form CMS-2552-			
H0SPI 1	AL IDENTIFICATION DATA			Provi der	CCN: 151310	Peri od:	Worksheet S-9	
						From 01/01/2015	Parts   &	
				Component	CCN: 151545	To 12/31/2015	Date/Time Prep 7/14/2016 3:43	
						Hospi ce I	77 147 2010 3. 43	
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS				1			
1.00	Continuous Home Care	0	0	0		0 0	0	1.00
2.00	Routine Home Care	4, 536	0	0		0 0	4, 536	
3.00	Inpatient Respite Care	15	0	0		0 0	15	3.00
4.00	General Inpatient Care	0	0	0		0 0	0	4.00
5.00	Total Hospice Days	4, 551	0	0		0 0	4, 551	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	0	0	0		0 0	0	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0.00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	0.00	0.00	0.00	0.0	0.00	0. 00	8.00
	5/line 6)							
9.00	Unduplicated Census Count	69	0	0		0 0	69	9.00

6.00       Medicaid charges       6,423,         7.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1,093,         < zero then enter zero)       State Children's Health Insurance Program (SCHIP) (see instructions for each line)       9.00         9.00       Net revenue from stand-alone SCHIP       10.00         10.00       Stand-alone SCHIP charges       11.00         11.00       Stand-alone SCHIP cost (line 1 times line 10)       12.00         12.00       Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)         00       Other state or local government indigent care program (see instructions for each line)	Prepared 3: 43 pm 4771 1.0 002 2.0 3.0 4.7 045 5.0 363 6.0 589 7.0
To       12/31/2015       Date/Time 7/14/2016         Uncompensated and indigent care cost computation       1.00         1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)       0.344         Medicaid (see instructions for each line)       0.344         2.00       Net revenue from Medicaid       841,         3.00       Did you receive DSH or supplemental payments from Medicaid?       N         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid coard (see instructions for each line)       280,         7.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1,093,         < zero then enter zero)	3: 43 pm 4771 1. ( 002 2. ( 3. ( 4. ( 045 5. ( 363 6. ( 589 7. ( 542 8. ( 0 9. ( 0 9. (
Uncompensated and indigent care cost computation       1.00         1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)       0.344         Medicaid (see instructions for each line)       0.344         2.00       Net revenue from Medicaid       841,         3.00       Did you receive DSH or supplemental payments from Medicaid?       Y         4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid       280,         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid cost (line 1 times line 6)       8, 2, 214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1, 093,         < zero then enter zero)	3: 43 pm 4771 1. ( 002 2. ( 3. ( 4. ( 045 5. ( 363 6. ( 589 7. ( 542 8. ( 0 9. ( 0 9. (
Incompensated and indigent care cost computation       1.00         1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)       0.344         Medicaid (see instructions for each line)       0.344         2.00       Net revenue from Medicaid       841,         3.00       Did you receive DSH or supplemental payments from Medicaid?       Y         4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?       N         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid cost (line 1 times line 6)       6, 423,         7.00       Did ference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1,093,         < zero then enter zero)	4771         1.0           002         2.0           3.0         4.0           045         5.0           363         6.0           589         7.0           542         8.0           0         9.0
Uncompensated and indigent care cost computation         1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)       0.344         Medicaid (see instructions for each line)       0.344         2.00       Net revenue from Medicaid       841,         3.00       Did you receive DSH or supplemental payments from Medicaid?       Y         4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid       280,         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,093, < zero then enter zero)	002 2.0 3.0 4.0 045 5.0 363 6.0 589 7.0 542 8.0 0 9.0
Uncompensated and indigent care cost computation         1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)       0.344         Medicaid (see instructions for each line)       0.344         2.00       Net revenue from Medicaid       841,         3.00       Did you receive DSH or supplemental payments from Medicaid?       Y         4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid       280,         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,093, < zero then enter zero)	002 2.0 3.0 4.0 045 5.0 363 6.0 589 7.0 542 8.0 0 9.0
1.00       Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)       0.344         Medicaid (see instructions for each line)       841,         2.00       Net revenue from Medicaid       841,         3.00       Did you receive DSH or supplemental payments from Medicaid?       841,         4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?       N         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid cost (line 1 times line 6)       2, 214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1, 093,       2, 214,         8.00       Difference from stand-al one SCHIP       (see instructions for each line)       9.00         9.00       Net revenue from stand-al one SCHIP       (see instructions for each line)       1.093,         9.00       Stand-al one SCHIP charges       11.00       Stand-al one SCHIP cost (line 1 times line 10)       12.00       Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)	002 2.0 3.0 4.0 045 5.0 363 6.0 589 7.0 542 8.0 0 9.0
Medicaid (see instructions for each line)         2.00       Net revenue from Medicaid       841,         3.00       Did you receive DSH or supplemental payments from Medicaid?       Y         4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?       N         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid charges       6, 423,         7.00       Medicaid cost (line 1 times line 6)       2, 214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1, 093, < zero then enter zero)	3. ( 4. ( 045 5. ( 363 6. ( 589 7. ( 542 8. ( 0 9. (
2.00       Net revenue from Medicaid       841,         3.00       Did you receive DSH or supplemental payments from Medicaid?       Y         4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?       N         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid charges       6,423,         7.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,093,       2,214,         8.00       Net revenue from stand-al one SCHIP       (see instructions for each line)       9,00         9.00       Net revenue from stand-al one SCHIP       (line 1 times line 10)       10,00       Stand-al one SCHIP cost (line 1 times line 10)       12,00       Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)	3. ( 4. ( 045 5. ( 363 6. ( 589 7. ( 542 8. ( 0 9. (
4.00       If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?       N         5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid charges       6,423,         7.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	4. ( 045 5. ( 363 6. ( 589 7. ( 542 8. ( 0 9. (
5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid charges       6,423,         7.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 2 zero then enter zero)       1,093,         State Children's Heal th Insurance Program (SCHIP) (see instructions for each line)         9.00       Net revenue from stand-al one SCHIP         10.00       Stand-al one SCHIP charges         11.00       Stand-al one SCHIP cost (line 1 times line 10)         12.00       Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)	045 5.0 363 6.0 589 7.0 542 8.0
5.00       If line 4 is "no", then enter DSH or supplemental payments from Medicaid       280,         6.00       Medicaid charges       6,423,         7.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if , zero then enter zero)       1,093,         State Children's Heal th Insurance Program (SCHIP) (see instructions for each line)         9.00       Net revenue from stand-al one SCHIP         10.00       Stand-al one SCHIP charges         11.00       Stand-al one SCHIP cost (line 1 times line 10)         12.00       Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if < zero then enter zero)	363 6.0 589 7.0 542 8.0
6.00       Medicaid charges       6,423,         7.00       Medicaid cost (line 1 times line 6)       2,214,         8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if       1,093,         < zero then enter zero)	589 7.0 542 8.0 0 9.0
8.00       Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 1,093, 2 zero then enter zero)       1,093, 2 zero then enter zero)         9.00       State Children's Health Insurance Program (SCHIP) (see instructions for each line)       9.00         9.00       Net revenue from stand-alone SCHIP       (see instructions for each line)         10.00       Stand-alone SCHIP charges       11.00         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 minus line 9; if < zero then enter zero)	542 8. ( 0 9. (
<pre>&lt; zero then enter zero) State Children's Health Insurance Program (SCHIP) (see instructions for each line) 9.00 Net revenue from stand-alone SCHIP 10.00 Stand-alone 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 minus line 9; if &lt; zero then enter zero) Other state or local government indigent care program (see instructions for each line)</pre>	0 9.0
State Children's Health Insurance Program (SCHIP) (see instructions for each line)         9.00       Net revenue from stand-alone SCHIP         10.00       Stand-alone 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 minus line 9; if < zero then enter zero)	
<ul> <li>9.00 Net revenue from stand-al one SCHIP</li> <li>10.00 Stand-al one SCHIP charges</li> <li>11.00 Stand-al one SCHIP cost (line 1 times line 10)</li> <li>12.00 Difference between net revenue and costs for stand-al one SCHIP (line 11 minus line 9; if &lt; zero then enter zero)</li> <li>0 Other state or local government indigent care program (see instructions for each line)</li> </ul>	
<ul> <li>10.00 Stand-alone SCHIP charges</li> <li>11.00 Stand-alone SCHIP cost (line 1 times line 10)</li> <li>12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if &lt; zero then enter zero)</li> <li>Other state or local government indigent care program (see instructions for each line)</li> </ul>	
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 minus line 9; if < zero then enter zero)	0 10.0
12.00 Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero) Other state or local government indigent care program (see instructions for each line)	
enter zero) Other state or local government indigent care program (see instructions for each line)	0 11.0
Other state or local government indigent care program (see instructions for each line)	0 12.0
Other state or local government indigent care program (see instructions for each line)	
	058 13.0
5 1 5 1	873 14. (
10)	
15.00       State or local indigent care program cost (line 1 times line 14)       1,031,	
	453 16.0
13; if < zero then enter zero)	
Uncompensated care (see instructions for each line) 17.00 Private grants, donations, or endowment income restricted to funding charity care	0 17.0
18.00 Government grants, appropriations or transfers for support of hospital operations	0 17.0
19.00 Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines) 1,812,	
8, 12 and 16)	775 17.0
Uni nsured I nsured Total (col	
patients patients + col. 2	)
1.00 2.00 3.00	
	233 20. 0
charges excluding non-reimbursable cost centers) for the entire facility	270 21
21.00 Cost of initial obligation of patients approved for charity care (line 1 47,081 233,298 280, times line 20)	379 21.0
22.00 Partial payment by patients approved for charity care 34 344	378 22.0
	001 23.0
	001 23.1
1 00	
24.00 Does the amount in line 20 column 2 include charges for natient days beyond a length of stay limit N	24 (
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit N	24. (
24.00 Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit N imposed on patients covered by Medicaid or other indigent care program?	24.0
24.00       Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?       N         25.00       If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit       N	0 25.0
24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N25.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00N26.00Total bad debt expense for the entire hospital complex (see instructions)3,546,	0 25.0
24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N25.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00N26.00Total bad debt expense for the entire hospital complex (see instructions)3,546,	0 25.0 009 26.0 997 27.0
24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N25.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00Notal bad debt expense for the entire hospital complex (see instructions)3,546, 319, 3,226,27.00Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)3,226,	0 25.0 009 26.0 997 27.0 012 28.0
24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?N25.00If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit 26.00N25.00Total bad debt expense for the entire hospital complex (see instructions)3,546, 319,	0 25.0 009 26.0 997 27.0 012 28.0 235 29.0

ECLASSI FI CATI ON	Systems F AND ADJUSTMENTS OF TRIAL BALANCE	PARKVIEW WABASH HO OF EXPENSES			Period:	u of Form CMS-2 Worksheet A	
					From 01/01/2015 To 12/31/2015	Data /Tima Dra	naro
					To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
Cost	Center Description	Sal ari es	Other	Total (col. 1	Reclassi fi cati	Recl assi fi ed	- p
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SE	ERVICE COST CENTERS						
. 00 00100 CAP	REL COSTS-BLDG & FIXT		5, 025, 163	5, 025, 16	3 -629, 354	4, 395, 809	1.
. 00 00200 CAP	REL COSTS-MVBLE EQUIP		0		0 870, 206	870, 206	2.
. 00 00400 EMPL	OYEE BENEFITS DEPARTMENT	67, 938	3, 928, 389	3, 996, 32	7 -257	3, 996, 070	4.
. 00 00500 ADMI	NI STRATI VE & GENERAL	3, 492, 727	4, 691, 625	8, 184, 35	2 -22, 537	8, 161, 815	5.
. 00 00700 OPEF	ATION OF PLANT	329, 162	861, 620	1, 190, 78	2 -41	1, 190, 741	7.
. 00 00800 LAUN	IDRY & LINEN SERVICE	0	0		0 0	0	8.
. 00 00900 HOUS	SEKEEPI NG	206, 219	277, 139	483, 35	8 0	483, 358	9.
D. 00 01000 DI ET	ARY	433, 231	359, 597	792, 82	8 -495, 633	297, 195	10.
1. 00 01100 CAFE	TERIA	0	0		0 494, 382	494, 382	11.
3. 00 01300 NURS	SENG ADMENISTRATION	134, 572	36, 234	170, 80	6 -101	170, 705	13.
4. 00 01400 CENT	RAL SERVICES & SUPPLY	0	220	22	0 0	220	14.
5. 00 01500 PHAF		642, 120	2, 627, 850	3, 269, 97	0 -2, 536, 092	733, 878	15.
	CAL RECORDS & LI BRARY	0	0		0 0	0	
	ROUTINE SERVICE COST CENTERS						
	TS & PEDIATRICS	1, 204, 974	446, 511	1, 651, 48	5 -205	1, 651, 280	30.
3.00 04300 NURS		0	0		0 0	0	
	SERVICE COST CENTERS	-					
	ATING ROOM	665, 317	494, 776	1, 160, 09	3 -196, 906	963, 187	50.
1.00 05100 RECO		0	0		0 0	0	
	VERY ROOM & LABOR ROOM	0	0		0 0	0	
	THESI OLOGY	0	65	6	-1.972	-1,907	
	OLOGY-DI AGNOSTI C	812, 508	822.742	1, 635, 25	-	1, 629, 306	
6. 00 05600 RADI		012,000	022, 7 12	1,000,20	0 0	0	56.
0.00 06000 LABC		0	1, 651, 491	1, 651, 49	-	1, 651, 030	
	D STORING, PROCESSING & TRANS.	0	1,001,171	1,001,17	0 0	1,001,000	63.
	GI CAL THERAPY	914, 906	155, 176	1, 070, 08	0	917, 721	
	IPATIONAL THERAPY	914, 900	155, 170		0 57,886	57, 886	
	CH PATHOLOGY	0	0		0 37,000	0	
	TROCARDI OLOGY	543, 223	-115, 202	428, 02	-	426, 780	
	CAL SUPPLIES CHARGED TO PATIENT	545, 225	908, 134	428, 02 908, 13		428, 780 537, 582	
	DEV. CHARGED TO PATIENT	0	908, 134		4 -370, 552 0 436, 001	436, 001	
	S CHARGED TO PATTENTS	0	0		0 2, 538, 773		
	SERVICE COST CENTERS	U	0		2, 556, 775	2,000,773	1 / 3.
D. 00 09000 CLIN		0	109, 245	109, 24	5 1, 175	110, 420	90.
0. 01 09001 SENI		152, 661	109, 243			256, 818	
I. 00 09100 EMER		841, 362	1, 352, 248			2, 189, 306	
	RVATION BEDS (NON-DISTINCT PART	041, 302	1, 332, 240	2, 193, 01	-4, 304	2, 109, 300	92.
	IBURSABLE COST CENTERS						92.
01.00 10100 HOME		692, 567	156, 440	849, 00	7 0	849, 007	101
	JRPOSE COST CENTERS	092, 307	150, 440	049,00	1 0	049,007	101.
16. 00 11600 HOSE		250, 515	129, 359	379, 87	4 0	379, 874	1116
	OTALS (SUM OF LINES 1-117)	11, 384, 002	24, 022, 979				
	RSABLE COST CENTERS	11, 304, 002	24,022,919	35, 400, 90	-17, 550	55, 567, 445	1110.
	, FLOWER, COFFEE SHOP & CANTEEN		0		0 0		190.
	, FLOWER, COFFEE SHOP & CANTEEN GICLANS' PRIVATE OFFICES	46, 339	15, 597	61, 93		61, 936	
		40, 339	15, 597	01, 93			
94.0007950 FI TN		0	0				194
94.0107951 FOUN		0	-9, 045	-9, 04	0	-9, 045	
4.0207952 NEW		0	10 150	10.45	0		194
	IUNI TY & VOLUNTEER SERVICES	0	12, 450	12, 45		12, 450	
94.0407954 WELL		0	0		0 0		194.
	IPATIONAL HEALTH	0	0		0 19, 538	19, 538	
00.00 TOTA	L (SUM OF LINES 118-199)	11, 430, 341	24, 041, 981	35, 472, 32	2 0	35, 472, 322	1200

Health F	- inancial Systems PA	ARKVIEW WABASH	HOSPI	TAL, INC.		In Lie	u of Form CMS	-2552-10
RECLASS	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES		Provi der	CCN: 151310	Peri od:	Worksheet A	
						From 01/01/2015 To 12/31/2015	Date/Time Pr	epared.
							7/14/2016 3:	43 pm
	Cost Center Description	Adjustments		Expenses				
		(See A-8) 6.00		<u>Allocation</u> 7.00				
G	ENERAL SERVICE COST CENTERS	0.00		7.00				
	00100 CAP REL COSTS-BLDG & FIXT	-3, 808, 509		587, 300				1.00
2.00 0	0200 CAP REL COSTS-MVBLE EQUIP	17, 735		887, 941				2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 167, 310		2,828,760				4.00
	00500 ADMINISTRATIVE & GENERAL	-1, 654, 181		6, 507, 634				5.00
	00700 OPERATION OF PLANT	-72, 541		1, 118, 200	1			7.00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0		402 250				8.00 9.00
	1000 DI ETARY	0		483, 358 297, 195				9.00
	1100 CAFETERI A	-197, 534		296, 848				11.00
	1300 NURSI NG ADMI NI STRATI ON	0		170, 705				13.00
	1400 CENTRAL SERVICES & SUPPLY	0		220				14.00
15.00 0	1500 PHARMACY	-131, 950		601, 928				15.00
16.00	1600 MEDICAL RECORDS & LIBRARY	0		0				16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	1						
	3000 ADULTS & PEDIATRICS	-246, 764		1,404,516	1			30.00
	14300 NURSERY	0		0				43.00
F0.00	NCI LLARY SERVI CE COST CENTERS	0	1	0(2 107	1			
	05100 RECOVERY ROOM	0		963, 187 0				50.00 51.00
	5200 DELIVERY ROOM & LABOR ROOM	0		0	1			52.00
	5300 ANESTHESI OLOGY	0		-1, 907				53.00
	05400 RADI OLOGY-DI AGNOSTI C	-111	•	1, 629, 195				54.00
	5600 RADI OI SOTOPE	0		0				56.00
	06000 LABORATORY	-1, 807		1, 649, 223				60.00
	6300 BLOOD STORING, PROCESSING & TRANS.	0		0				63.00
	06600 PHYSI CAL THERAPY	-139, 269		778, 452				66.00
	06700 OCCUPATIONAL THERAPY	0		57, 886				67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0		424 790				68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		426, 780 537, 582				71.00
	7200 I MPL. DEV. CHARGED TO PATIENTS	0		436, 001				72.00
	7300 DRUGS CHARGED TO PATIENTS	0		2, 538, 773				73.00
	UTPATIENT SERVICE COST CENTERS				1			
90.00	99000 CLI NI C	0		110, 420				90.00
	99001 SENI OR CARE	0		256, 818				90. 01
	09100 EMERGENCY	-911, 574		1, 277, 732				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
	THER REIMBURSABLE COST CENTERS	0	I	0.40, 007	1			101 00
	0100 HOME HEALTH AGENCY PECIAL PURPOSE COST CENTERS	0		849, 007				101.00
	1600 HOSPI CE	0		379, 874				116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-8, 313, 815		27,073,628				118.00
	IONREI MBURSABLE COST CENTERS			, , 520				
190.001	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0				190. 00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0		61, 936				192.00
	7950 FITNESS CENTER	0		0				194.00
	7951 FOUNDATION	0		-9, 045				194.01
		0		10 450				194.02
	07953 COMMUNITY & VOLUNTEER SERVICES 07954 WELL CHILD CLINIC	0		12, 450				194. 03 194. 04
	17954 WELL CHILD CLINIC 17955 OCCUPATIONAL HEALTH	0		19, 538				194.04
200.00	TOTAL (SUM OF LINES 118-199)	-8, 313, 815	2	27, 158, 507				200.00
					1			

	Financial Systems	PA	RKVIEW WABASH H				u of Form CMS-25	552-1
RECLAS	SIFICATIONS			Provi der CC	N: 151310	Period: From 01/01/2015	Worksheet A-6	
						To 12/31/2015	Date/Time Prep	
		Increases					7/14/2016 3:43	3 pm
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - REHAB THERAPY RECLASS							
1.00	OCCUPATI ONAL THERAPY	<u>67.00</u>	<u> </u>	711				1.00
	0 B - CLINIC DIETICIAN		57, 233	711				
1.00		90.00	1, 175	0				1.0
			1, 175	- <u> </u>				
	C – CAFETERIA RECLASS	1						
1.00		<u> </u>	269,816	224, 566				1.00
			269, 816	224, 566				
1.00	D - DRUGS CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	73.00	0	2, 541, 863				1.0
2.00	DRUGS CHARGED TO FATTENTS	0.00	0	2, 341, 003				2.00
3.00		0.00	0	Ö				3.00
4.00		0.00	0	0				4.0
	0		0	2, 541, 863				
	E - SALARY RECLASS							
1.00	ADMI NI STRATI VE & GENERAL		<u>0</u>	746, 217				1.0
	0 F - OCCUPATIONAL HEALTH		0	746, 217				
1.00	OCCUPATIONAL HEALTH	194.05	0	19, 538				1.0
2.00		0.00	0	0				2.0
3.00		0.00	0	0				3.0
4.00		0.00	0	0				4.0
6.00		0.00	0	0				6.0
7.00		0.00	0	0				7.0
8.00 9.00		0.00 0.00	0	0				8. 0 9. 0
9.00 10.00		0.00	0	0				10.0
10.00	TOTALS — — — —			19, 538				10.0
	G - DEPRECIATION	1	- 1					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	<u>0</u>	734, 916				1.0
	TOTALS		0	734, 916				
1 00	H - EQUIP & BLDG LEASE	2.00		125 200				1 0
1.00 2.00	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-BLDG & FIXT	2.00 1.00	0	135, 290 93, 600				1.0 2.0
3.00	CAI NEE COSTS-DEDG & TTAT	0.00	0	y3, 000 0				3.00
4.00		0.00	0	0				4.0
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.0
7.00		0.00	0	0				7.0
8.00		0.00	0	0				8.0
9. 00 10. 00		0.00 0.00	0	0				9. 0 10. 0
11.00		0.00	0	0				11.0
12.00		0.00	0	0				12.0
	TOTALS			228, 890				
	I - IMPLANTABLE MEDICAL SUP.							
1.00	IMPL. DEV. CHARGED TO	72.00	0	436, 001				1.00
	PATIENTS	+		426.001				
	TOTALS J - RECLASS TAXES		0	436, 001				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11, 962				1.0
	TOTALS		<u>0</u>	11, 962				
	K - RECLASS CENTRAL SVS	<b>!</b>						
		71.00	0	69, 233				1.0
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	9	07,200				1.0
1.00	MEDICAL SUPPLIES CHARGED TO <u>PATIENT</u>			69, 233				1. 0

CLASSI FI CATI ONS			Provi de	r CCN: 151310	Period: From 01/01/2015	Worksheet A-6
					To 12/31/2015	Date/Time Prepare 7/14/2016 3:43 pr
	Decreases			_	1	
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	<u>.</u>	
6. 00	7.00	8.00	9.00	10.00		
A - REHAB THERAPY RECLASS						
DO PHYSICAL THERAPY	66.00	57, 233	71	1	0	1
0		57, 233	71	1	7	
B - CLINIC DIETICIAN					1	
DO DI ETARY	10.00	1, 175		D	0	1
		1, 175		<u> </u>		'
C - CAFETERIA RECLASS		1, 175		J		
	10.00	2(0.01/	224 54		0	1
00 <u>DIETARY</u>		269, 816	224,560		이	1
0		269, 816	224, 560	2		
D - DRUGS CHARGED TO PATIE						
00 PHARMACY	15.00	0	2, 488, 689		0	1
O OPERATING ROOM	50.00	0	52, 914		0	2
00 RADI OLOGY-DI AGNOSTI C	54.00	0	183	3	0	3
DO EMERGENCY	91.00	0	7	7	o	4
0	$\top$ $ +$	0	2, 541, 863	3	7	[
E - SALARY RECLASS	· · ·		,			
ADMI NI STRATI VE & GENERAL	5.00	746, 217	(	D	0	1
	<u> </u>	746, 217			7	'
F - OCCUPATIONAL HEALTH		740,217	,	5		
	50.00		54	4	0	1
		0				1
00 ANESTHESI OLOGY	53.00	0	1, 97		0	2
00 RADI OLOGY-DI AGNOSTI C	54.00	0	5, 579		0	3
DO LABORATORY	60.00	0	46	1	0	4
00 ELECTROCARDI OLOGY	69.00	0	863	3	0	6
00 OCCUPATI ONAL THERAPY	67.00	0	58	3	0	7
DO MEDICAL SUPPLIES CHARGED T	0 71.00	0	3, 784		0	8
PATI ENT		Ŭ.	0,70			
DO DRUGS CHARGED TO PATIENTS	73.00	0	3, 090	h	o	9
00 EMERGENCY	91.00	0	3, 67		0	10
TOTALS		0	<u>3, 6</u> / 19, 538			10
		U	19, 030			
G - DEPRECIATION	1.00		704.04	,		
00 CAP REL COSTS-BLDG & FIXT			734,910		9	1
TOTALS		0	734, 910	5		
H - EQUIP & BLDG LEASE						
DO RADI OLOGY-DI AGNOSTI C	54.00	0	182	2 1	0	1
00 ADMINISTRATIVE & GENERAL	5.00	0	10, 57	5 1	0	2
O OPERATION OF PLANT	7.00	0	4		0	3
DO DI ETARY	10.00	0	70		0	4
NURSING ADMINISTRATION	13.00	0	10		0	5
00 PHARMACY	15.00	0	47, 403		õ	6
		s			0	
ADULTS & PEDIATRICS	30.00	0	20		0	7
OO OPERATING ROOM	50.00	0	74, 70		U C	8
00 ELECTROCARDI OLOGY	69.00	0	378		0	9
00 PHYSI CAL THERAPY	66.00	0	94, 41		0	10
00 EMERGENCY	91.00	0	550	C	0	11
00 EMPLOYEE BENEFITS DEPARTME	NT 4.00	0	25	7	o	12
TOTALS			228, 890		7	[
I - IMPLANTABLE MEDICAL SU	JP.					
MEDICAL SUPPLIES CHARGED T		0	436, 00	1	0	1
PATI ENT	,	5	+50, 00	.	Ĩ	'
TOTALS	++	— — — <sub>0</sub>	436,00		+	
		U	430,00	1		
J - RECLASS TAXES	E col	cl	44 01	-	2	
00 ADMI NI STRATI VE & GENERAL		0	1 <u>1, 9</u> 62		3	1
TOTALS		0	11, 962	2		
K - RECLASS CENTRAL SVS				1		
00 OPERATING ROOM	50.00	0	6 <u>9, 2</u> 33	3	o	1
TOTALS		0	69, 23	3		
). 00 Grand Total: Decreases		1, 074, 441	4, 267, 680	-1		500

Heal th	Financial Systems PA	ARKVIEW WABASH	alth Financial Systems PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form CMS-2552-10									
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015		pared:					
				Acqui si ti on	S							
		Begi nni ng	Purchases	Donati on	Total	Disposals and						
		Bal ances				Retirements						
		1.00	2.00	3.00	4.00	5.00						
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		_								
1.00	Land	1, 295, 014	0		0 0	0	1.00					
2.00	Land Improvements	314, 699	0		0 0	0	2.00					
3.00	Buildings and Fixtures	12, 580, 090	6, 439		0 6, 439	0	3.00					
4.00	Building Improvements	4, 150, 859	0		0 0	0	4.00					
5.00	Fixed Equipment	868, 330	52, 763		0 52, 763	0	5.00					
6.00	Movable Equipment	13, 991, 813	25, 425		0 25, 425	0	6.00					
7.00	HIT designated Assets	1, 821, 934	286, 475		0 286, 475	0	7.00					
8.00	Subtotal (sum of lines 1-7)	35, 022, 739	371, 102		0 371, 102	0	8.00					
9.00	Reconciling Items	0	0		0 0	0	9.00					
10.00	Total (line 8 minus line 9)	35, 022, 739	371, 102		0 371, 102	0	10.00					
		Ending Balance	Fully									
		Ũ	Depreci ated									
			Assets									
		6.00	7.00									
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET											
1.00	Land	1, 295, 014	0				1.00					
2.00	Land Improvements	314, 699	198, 753				2.00					
3.00	Buildings and Fixtures	12, 586, 529	11, 937, 891				3.00					
4.00	Building Improvements	4, 150, 859	1, 958, 744				4.00					
5.00	Fixed Equipment	921, 093	474, 169				5.00					
6.00	Movable Equipment	14, 017, 238	10, 076, 913				6.00					
7.00	HIT designated Assets	2, 108, 409	1, 476, 650				7.00					
8.00	Subtotal (sum of lines 1-7)	35, 393, 841	26, 123, 120				8.00					
9.00	Reconciling Items	0	0				9.00					
10.00	Total (line 8 minus line 9)	35, 393, 841	26, 123, 120				10.00					

Heal th	Financial Systems P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151310	Period:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015		nared
					10 12/01/2010	7/14/2016 3:4	<u>3 pm</u>
			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 WOR			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	5, 025, 163	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)	5, 025, 163			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	5, 025, 163				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	5, 025, 163				3.00

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col . 1 - col 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1				
1.00 CAP REL COSTS-BLDG & FIXT	19, 268, 194					1.00
2.00 CAP REL COSTS-MVBLE EQUIP	14, 017, 237					2.00
3.00 Total (sum of lines 1-2)	33, 285, 431		00/200/10			3.00
	ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				al 150.005	00. (00	
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 459, 395		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 734, 916		2.00
3.00 Total (sum of lines 1-2)	0	0	I JMMARY OF CAPI	0 1, 194, 311	228, 890	3.00
			• • • • •			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14.00	13.00	
1.00 CAP REL COSTS-BLDG & FIXT	0	22, 343	11, 96	2 0	587, 300	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0			0 0		2.00
3.00 Total (sum of lines 1-2)	0			-		3.00
				1		

nci al	Suctome	DADKVLEW WARASH HOSDITAL	LNC

	Financial Systems MENTS TO EXPENSES	PA	<u>RKVIEW WABASH</u>	F	In Lie eriod: rom 01/01/2015 o 12/31/2015	Worksheet A-8 Worksheet A-8 Date/Time Prep 7/14/2016 3:43	pared:
				Expense Classification on To/From Which the Amount is			<u>, pm</u>
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		(	DCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		(		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		(		0.00	0	4.00
	discounts (chapter 8)						
5.00	Refunds and rebates of expenses (chapter 8)		(		0.00	0	5.00
5.00	Rental of provider space by suppliers (chapter 8)		(	D	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		(		0.00	0	7.00
B. 00	Television and radio service	В	-3, 038	BOPERATION OF PLANT	7.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		(	D	0.00	0	9.00
	Provider-based physician adjustment Sale of scrap, waste, etc.	A-8-2	-772, 195	5	0.00	0	10.00
	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-1, 522, 798	3		0	12.00
	Laundry and linen service		(	ס	0.00	0	
	Cafeteria-employees and guests Rental of quarters to employee and others		-197, 534 (	4CAFETERI A D	11.00 0.00	0	
16. 00	Sale of medical and surgical supplies to other than patients		C		0.00	0	16. 00
17.00	Sale of drugs to other than patients	В	-129, 048	BPHARMACY	15.00	0	17.00
18.00	Sale of medical records and		(	ס	0.00	0	18.00
19. 00	abstracts Nursing school (tuition, fees,		(	D	0.00	0	19.00
20. 00	books, etc.) Vending machines	В	-32	2 OPERATION OF PLANT	7.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		(	D	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		(		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	0*** Cost Center Deleted ***	65.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		(	D*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		(	DCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		(	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	COSTS-MVBLE EQUIP Non-physician Anesthetist			)*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		(	ס	0.00	0	29.00
30. 00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	(	DOCCUPATI ONAL THERAPY	67.00		30. 00
30. 99	Hospice (non-distinct) (see		(	DADULTS & PEDIATRICS	30.00		30. 9
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	(	SPEECH PATHOLOGY	68.00		31. 0
22.00	limitation (chapter 14)		,		0.00		22 04
	CAH HIT Adjustment for Depreciation and Interest		(	J	0.00		32.00
33.00	DEPRECIATION HIT ASSETS 2015	A	-38, 194	4 ADMI NI STRATI VE & GENERAL	5.00	0	33.00

From 01/01/2015         Date/Time Prepart/7/14/2016         Date/7/2016         Date/7/2016         <		Financial Systems	FA	RKVIEW WABASH		Period:	eu of Form CMS-	
Cost Center Description         Basis/Code (2)         Amount         Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted         V14/2016 3:43 pr 7/14/2016 3:45 pr 7/14/2016 3	ADJUS I	MENTS TO EXPENSES						
Cost Center Description         Basi s/Code (2)         Amount         Expense Classification on Worksheet A         7/14/2016 3: 43 pr           33.01         DEPRECIATION HIT ASSETS         A         -         Cost Center         Line #         Wkst. A-7 Ref.           33.01         DEPRECIATION HIT ASSETS         A        83, 245 ADMI NI STRATI VE & GENERAL         5.00         0         33           35.00         RECRUI TMENT         A        686 ADMI NI STRATI VE & GENERAL         5.00         0         33           38.00         SELF INSURANCE ADJUSTMENT         A        11.66. 208 EMPLOYEE BENEFI TS DEPARTMENT         4.00         0         38           00         DEBY NG         A         -4.372/ADMI NI STRATI VE & GENERAL         5.00         0         33           01.00         A         -4.3507/ADMI NI STRATI VE & GENERAL         5.00         0         34           02.00         MARKETI NG         A         -4.3507/ADMI NI STRATI VE & GENERAL         5.00         0         44           20.01         CUQIOR ADJUSTMENT         A         -3.830.852         CAP REL COSTS-BLDG & FI XT         1.00         9         44           45.00         TELEMETRY MONI TORI NG         A         8.236 ADULTS & PEDI ATRICS         30.00         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>pared:</td>								pared:
Cost Center Description         Basis/Code (2)         Amount         Cost Center         Line #         Wkst. A-7 Ref.           33.01         DEPRECIATION HIT ASSETS PRIOR         A         -83,245         ADMINISTRATIVE & GENERAL         5.00         33           35.00         RECRUTMENT         A         -83,245         ADMINISTRATIVE & GENERAL         5.00         0         33           36.00         SELF INSURANCE ADJUSTMENT         A         -1,166,208 EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           39.00         LOBBYING         A         -4,372 ADMINISTRATIVE & GENERAL         5.00         0         33           40.00         LOBBYING         A         -4,372 ADMINISTRATIVE & GENERAL         5.00         0         34           41.00         DEPRECIATION FOR         A         -4,372 ADMINISTRATIVE & GENERAL         5.00         0         42           42.00         LIQUOR ADJUSTMENT         A         -36/ADMINISTRATIVE & GENERAL         5.00         0         42           43.00         DEPRECIATION FOR         A         -3,830,852 CAP         REL COSTS-BLDG & FIXT         1.00         9         44           45.01         FILESS CENTER         B         -1,102 EMPLOYEE BENEFITS DEPARTMENT         4.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>7/14/2016 3:4</td> <td>3 pm</td>							7/14/2016 3:4	3 pm
Cost Center Description         Basis/Code (2)         Amount         Cost Center         Line #         Wkst. A-7 Ref.           33.01         DEPRECIATION HIT ASETS PRIOR         A         -83.245 ADMINISTRATIVE & GENERAL         5.00         0         33           35.00         RECRUITMENT         A         -686 ADMINISTRATIVE & GENERAL         5.00         0         33           36.00         RECRUITMENT         A         -686 ADMINISTRATIVE & GENERAL         5.00         0         38           30.00         ABJUSTMENT         A         -1,166,208 EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           30.00         LOBBYING         A         -4,372/ADMINISTRATIVE & GENERAL         5.00         0         39           40.00         LDBYING         A         -4,507/ADMINISTRATIVE & GENERAL         5.00         0         40           42.00         LIQUOR ADJUSTMENT         A         -3,830,852 CAP REL COSTS-BLDG & FIXT         1.00         9         44           45.00         TELEMETRY MONI TORING         A         -2,902 PHARMACY         1.00         0         45           45.01         FILEMETRY MONI TORING         A         -255,000 ADULTS & PEDIATRICS         30.00         0         45								
1.00         2.00         3.00         4.00         5.00           33.01         DEPRECIATION HIT ASSETS PRIOR         A         -83,245         ADMINISTRATIVE & GENERAL         5.00         0         33           35.00         RECRUITMENT         A         -686         ADMINISTRATIVE & GENERAL         5.00         0         35           36.00         SELF INSURANCE ADJUSTMENT         A         -1,166,208         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           39.00         LOBBYING         A         -1,362,008         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           40.00         MARKETING         A         -4,372 ADMINISTRATIVE & GENERAL         5.00         0         40           42.00         LIQUOR ADJUSTMENT         A         -3,64DMINISTRATIVE & GENERAL         5.00         0         42           44.00         DEPRECIATION REDUCTION FOR         A         -3,830,852         CAP REL COSTS-BLDG & FIXT         1.00         9         44           45.00         TELEMETRY MONITORING         A         -3,830,ADULTS & PEDIATRICS         30.00         0         45           45.01         FILTRESS CENTER         B         -1,102         EMPLOYEE BENEFITS DEPARTMENT					To/From Which the Amount is	to be Adjusted		
1.00         2.00         3.00         4.00         5.00           33.01         DEPRECIATION HIT ASSETS PRIOR         A         -83,245         ADMINISTRATIVE & GENERAL         5.00         0         33           35.00         RECRUITMENT         A         -686         ADMINISTRATIVE & GENERAL         5.00         0         35           36.00         SELF INSURANCE ADJUSTMENT         A         -1,166,208         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           39.00         LOBBYING         A         -1,362,008         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           40.00         MARKETING         A         -4,372 ADMINISTRATIVE & GENERAL         5.00         0         40           42.00         LIQUOR ADJUSTMENT         A         -3,64DMINISTRATIVE & GENERAL         5.00         0         42           44.00         DEPRECIATION REDUCTION FOR         A         -3,830,852         CAP REL COSTS-BLDG & FIXT         1.00         9         44           45.00         TELEMETRY MONITORING         A         -3,830,ADULTS & PEDIATRICS         30.00         0         45           45.01         FILTRESS CENTER         B         -1,102         EMPLOYEE BENEFITS DEPARTMENT								
1.00         2.00         3.00         4.00         5.00           33.01         DEPRECIATION HIT ASSETS PRIOR         A         -83,245         ADMINISTRATIVE & GENERAL         5.00         0         33           35.00         RECRUITMENT         A         -686         ADMINISTRATIVE & GENERAL         5.00         0         35           36.00         SELF INSURANCE ADJUSTMENT         A         -1,166,208         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           39.00         LOBBYING         A         -1,362,008         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           40.00         MARKETING         A         -4,372 ADMINISTRATIVE & GENERAL         5.00         0         40           42.00         LIQUOR ADJUSTMENT         A         -3,64DMINISTRATIVE & GENERAL         5.00         0         42           44.00         DEPRECIATION REDUCTION FOR         A         -3,830,852         CAP REL COSTS-BLDG & FIXT         1.00         9         44           45.00         TELEMETRY MONITORING         A         -3,830,ADULTS & PEDIATRICS         30.00         0         45           45.01         FILTRESS CENTER         B         -1,102         EMPLOYEE BENEFITS DEPARTMENT								
1.00         2.00         3.00         4.00         5.00           33.01         DEPRECIATION HIT ASSETS PRIOR         A         -83,245         ADMINISTRATIVE & GENERAL         5.00         0         33           35.00         RECRUITMENT         A         -686         ADMINISTRATIVE & GENERAL         5.00         0         35           36.00         SELF INSURANCE ADJUSTMENT         A         -1,166,208         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           39.00         LOBBYING         A         -1,362,008         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           40.00         MARKETING         A         -4,372 ADMINISTRATIVE & GENERAL         5.00         0         40           42.00         LIQUOR ADJUSTMENT         A         -3,64DMINISTRATIVE & GENERAL         5.00         0         42           44.00         DEPRECIATION REDUCTION FOR         A         -3,830,852         CAP REL COSTS-BLDG & FIXT         1.00         9         44           45.00         TELEMETRY MONITORING         A         -3,830,ADULTS & PEDIATRICS         30.00         0         45           45.01         FILTRESS CENTER         B         -1,102         EMPLOYEE BENEFITS DEPARTMENT								
1.00         2.00         3.00         4.00         5.00           33.01         DEPRECIATION HIT ASSETS PRIOR         A         -83,245         ADMINISTRATIVE & GENERAL         5.00         0         33           35.00         RECRUITMENT         A         -686         ADMINISTRATIVE & GENERAL         5.00         0         35           36.00         SELF INSURANCE ADJUSTMENT         A         -1,166,208         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           39.00         LOBBYING         A         -1,362,008         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         38           40.00         MARKETING         A         -4,372 ADMINISTRATIVE & GENERAL         5.00         0         40           42.00         LIQUOR ADJUSTMENT         A         -3,64DMINISTRATIVE & GENERAL         5.00         0         42           44.00         DEPRECIATION REDUCTION FOR         A         -3,830,852         CAP REL COSTS-BLDG & FIXT         1.00         9         44           45.00         TELEMETRY MONITORING         A         -3,830,ADULTS & PEDIATRICS         30.00         0         45           45.01         FILTRESS CENTER         B         -1,102         EMPLOYEE BENEFITS DEPARTMENT		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
PRI OR			· · · ·					
35.00       RECRUITMENT       A       -686 ADMI NI STRATI VE & GENERAL       5.00       0       35         38.00       SELF INSURANCE ADJUSTMENT       A       -1,166,208 EMPLOYEE BENEFITS DEPARTMENT       4.00       0       38         39.00       LOBBYING       A       -4,372 ADMI NI STRATI VE & GENERAL       5.00       0       39         40.00       MARKETING       A       -4,577 ADMI NI STRATI VE & GENERAL       5.00       0       42         42.00       LIQUOR ADJUSTMENT       A       -3,830,852       CAP REL COSTS-BLDG & FIXT       1.00       9       44         45.00       DEPRECIATION REDUCTION FOR       A       -3,830,852       CAP REL COSTS-BLDG & FIXT       1.00       9       44         45.01       FI TNESS CENTER       B       -1,102       EMPLOYEE BENEFITS DEPARTMENT       4.00       0       45         45.02       PURCHASING DI SCOUNTS       A       -3,830,852       CAP REL COSTS-BLDG & FIXT       1.00       0       45         45.02       PURCHASING DI SCOUNTS       A       -3,830,852       CAP REL COSTS-BLDG & FIXT       1.00       0       46         47.00       HI POPERATING INCOME       A       -2,902       PHARMACY       15.00       0       45 <td>33.01</td> <td>DEPRECIATION HIT ASSETS</td> <td>A</td> <td>-83, 245</td> <td>ADMI NI STRATI VE &amp; GENERAL</td> <td>5.00</td> <td>0</td> <td>33.01</td>	33.01	DEPRECIATION HIT ASSETS	A	-83, 245	ADMI NI STRATI VE & GENERAL	5.00	0	33.01
38.00       SELF INSURANCE ADJUSTMENT       A       -1,166,208       EMPLOYEE BENEFITS DEPARTMENT       4.00       0       38         39.00       LOBBYING       A       -4,372/ADMINISTRATIVE & GENERAL       5.00       0       40         40.00       MARKETING       A       -4,372/ADMINISTRATIVE & GENERAL       5.00       0       40         42.00       LIQUOR ADJUSTMENT       A       -4,507/ADMINISTRATIVE & GENERAL       5.00       0       40         42.00       DEPRECIATION REDUCTION FOR       A       -3,830,852       CAP REL COSTS-BLDG & FIXT       1.00       9       44         45.00       TELEMETRY MONITORING       A       8,236       ADULTS & PEDIATRICS       30.00       0       45         45.01       FINESS CENTER       B       -1,102       EMPLOYEE BENEFITS DEPARTMENT       4.00       0       45         45.02       PURCHASING DI SCOUNTS       A       -2,902       PHARMACY       15.00       0       45         46.01       OTHER OPERATING REV       A       -2,902       PHARMACY       15.00       0       47         47.00       OTHER OPERATING REV       A       -111RADIOLOGY-DI AGNOSTIC       54.00       0       47         48.00		PRIOR						
39.00       LOBBYING       A       -4,372 ADMI NI STRATI VE & GENERAL       5.00       0       39         40.00       MARKETI NG       A       -4,507 ADMI NI STRATI VE & GENERAL       5.00       0       40         42.00       LI QUOR ADJUSTMENT       A       -36 ADMI NI STRATI VE & GENERAL       5.00       0       42         44.00       DEPRECIATION REDUCTION FOR       A       -3830,852 CAP REL COSTS-BLDG & FIXT       1.00       9       44         45.00       TELEMETRY MONI TORI NG       A       8,236 ADULTS & PEDIATRICS       30.00       0       45         45.01       FI TNESS CENTER       B       -1,102 EMPLOYEE BENEFITS DEPARTMENT       4.00       0       45         45.02       PURCHASI NG DI SCOUNTS       A       -343 ADMI NI STRATI VE & GENERAL       5.00       0       46         47.00       HOSPI TALI ST       A       -255,000 ADULTS & PEDI ATRICS       30.00       0       47         48.00       OTHER OPERATI NG REV       A       -11,807 LABORATORY       50.00       0       48         49.00       OTHER OPERATI NG REV       A       -139,379       EMERGENCY       91.00       0       49         49.01       OTHER OPERATI NG REV       A       -139,379	35.00	RECRUI TMENT	A	-686	ADMI NI STRATI VE & GENERAL	5.00	0	35.00
40.00       MARKETING       A       -4,507       ADMINISTRATIVE & GENERAL       5.00       0       40         42.00       LIQUOR ADJUSTMENT       A       -36       ADMINISTRATIVE & GENERAL       5.00       0       42         44.00       DEPRECIATION REDUCTION FOR ACCELERAT       A       -3,830,852       CAP REL COSTS-BLDG & FIXT       1.00       9       44         45.00       TELEMETRY MONITORING       A       8,236       ADULTS & PEDIATRICS       30.00       0       45         45.01       FITNESS CENTER       B       -1,102       EMPLOYEE BENEFITS DEPARTMENT       4.00       0       45         46.01       OTHER OPERATING INCOME       A       -25,000       DULTS & PEDIATRICS       30.00       0       45         47.00       OBSPITALIST       A       -255,000       DULTS & PEDIATRICS       30.00       0       47         48.00       OTHER OPERATING REV       A       -111       RADIOLOGY-DIAGNOSTIC       54.00       0       48         49.00       OTHER OPERATING REV       A       -139,269       PHYSICAL THERAPY       66.00       0       49         49.02       ORTHO / GENERAL SURGEON ON       A       -139,379       EMERGENCY       91.00       0 <td>38.00</td> <td>SELF INSURANCE ADJUSTMENT</td> <td>A</td> <td>-1, 166, 208</td> <td>EMPLOYEE BENEFITS DEPARTMEN</td> <td>4.00</td> <td>0</td> <td>38.00</td>	38.00	SELF INSURANCE ADJUSTMENT	A	-1, 166, 208	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	38.00
42.00LI QUOR ADJUSTMENTA-36ADMI NI STRATI VE & GENERAL5.0004244.00DEPRECIATION REDUCTION FOR ACCELERATA-3,830,852CAP REL COSTS-BLDG & FIXT1.0094445.00TELEMETRY MONI TORI NGA8,236ADULTS & PEDI ATRI CS30.0004545.01FI TNESS CENTERB-1,102EMPLOYEE BENEFITS DEPARTMENT4.0004546.01OTHER OPERATI NG I SCOUNTSA-343 ADMI NI STRATI VE & GENERAL5.0004647.00HOSPI TALI STA-2,902PHARMACY15.0004649.00OTHER OPERATI NG REVA-111 RADI OLOGY-DI AGNOSTI C54.0004849.01OTHER OPERATI NG REVA-139, 269PHYSI CAL THERAPY66.0004949.02ORTHO / GENERAL SURGEON ON CALL & EXA-139, 379EMERGENCY91.0004949.03INSURANCE ADD BACKA17, 735CAP REL COSTS-BLDG & FIXT1.00124949.05PHYSI CI AN CLINI C RENT OFFSET FUNCH CALL & EX-69, 471OPERATION OF PLANT7.0004950.00TOTAL (Sum of Lines 1 thru 49)-8, 313, 815-8, 313, 8155050	39.00	LOBBYI NG	A	-4, 372	ADMINISTRATIVE & GENERAL	5.00	0	39.00
44.00DEPRECIATION REDUCTION FOR ACCELERATA-3,830,852CAP REL COSTS-BLDG & FIXT1.0094445.00TELEMETRY MONITORINGA8,236ADULTS & PEDIATRICS30.0004545.01FITNESS CENTERB-1,102EMPLOYEE BENEFITS DEPARTMENT4.0004545.02PURCHASING DISCOUNTSA-343-343ADMINISTRATIVE & GENERAL5.0004546.01OTHER OPERATING INCOMEA-2,902PHARMACY15.0004647.00HOSPITALISTA-255,000ADULTS & PEDIATRICS30.0004748.00OTHER OPERATING REVA-111RADIOLOGY-DIAGNOSTIC54.0004849.00OTHER OPERATING REVA-139,269PHYSICAL THERAPY66.0004949.02ORTHO / GENERAL SURGEON ONA-139,379EMERGENCY91.004949.03INSURANCE ADD BACKA22,343CAP REL COSTS-BLDG & FIXT1.00124949.05PHYSICIAN CLINIC RENT OFFSETB-69,471OPERATION OF PLANT7.0004950.00TOTAL (sum of lines 1 thru 49)-8,313,815-8,313,815505050	40.00	MARKETING	A	-4, 507	ADMINISTRATIVE & GENERAL	5.00	0	40.00
ACCELERATACCELERAT45.00TELEMETRY MONI TORI NGA8, 236ADULTS & PEDI ATRI CS30.0004545.01FI TNESS CENTERB-1, 102EMPLOYEE BENEFI TS DEPARTMENT4.0004545.02PURCHASI NG DI SCOUNTSA-343ADMI NI STRATI VE & GENERAL5.0004546.01OTHER OPERATI NG INCOMEA-2, 902PHARMACY15.0004647.00HOSPI TALI STA-255, 000ADULTS & PEDI ATRI CS30.0004748.00OTHER OPERATI NG REVA-111RADI OLOGY - DI AGNOSTI C54.0004849.00OTHER OPERATI NG REVA-139, 269PHYSI CAL THERAPY60.0004949.01OTHER OPERAL SURGEON ONA-139, 379EMERGENCY91.0004949.02ORTHO / GENERAL SURGEON ONA-139, 379EMERGENCY91.0004949.03INSURANCE ADD BACKA17, 735CAP REL COSTS-BLDG & FIXT1.00124949.04INSURANCE ADD BACKA17, 735CAP REL COSTS-MVBLE EQUI P2.00124949.05PHYSI CIAN CLI NI C RENT OFFSETB-69, 471OPERATI ON OF PLANT7.0004950.00TOTAL (sum of Lines 1 thru 49)-8, 313, 815-8, 313, 8155050	42.00	LIQUOR ADJUSTMENT	A	-36	ADMINISTRATIVE & GENERAL	5.00	0	42.00
45.00TELEMETRY MONI TORI NGA8,236ADULTS & PEDI ATRI CS30.0004545.01FI TNESS CENTERB-1,102EMPLOYEE BENEFITS DEPARTMENT4.0004545.02PURCHASI NG DI SCOUNTSA-343ADMI NI STRATI VE & GENERAL5.0004546.01OTHER OPERATI NG INCOMEA-2,902PHARMACY15.0004647.00HOSPI TALI STA-22,50,00ADULTS & PEDI ATRI CS30.0004748.00OTHER OPERATI NG REVA-111RADI LABORATORY60.0004849.00OTHER OPERATI NG REVA-139, 269PHYSI CAL THERAPY66.0004949.01OTHER OPERAL SURGEON ONA-139, 379EMERGENCY91.0004949.03INSURANCE ADD BACKA17, 735CAP REL COSTS-BLDG & FIXT1.00124949.05PHYSI CI AN CLI NI C RENT OFFSETB-69, 471OPERATI ON OF PLANT7.0004950.00TOTAL (sum of lines 1 thru 49)-8, 313, 815-8, 313, 8155050	44.00		A	-3, 830, 852	CAP REL COSTS-BLDG & FIXT	1.00	9	44.00
45.01FI TNESS CENTERB-1, 102EMPLOYEE BENEFITS DEPARTMENT4.0004545.02PURCHASI NG DI SCOUNTSA-343ADMI NI STRATI VE & GENERAL5.0004546.01OTHER OPERATI NG I NCOMEA-2, 902PHARMACY15.0004647.00HOSPI TALI STA-255, 000ADULTS & PEDI ATRI CS30.0004748.00OTHER OPERATI NG REVA-111RADI OLOGY-DI AGNOSTI C54.0004849.00OTHER OPERATI NG REVA-13,807LABORATORY60.0004949.01OTHER OPERATI NG REVA-139, 269PHYSI CAL THERAPY66.0004949.02ORTHO / GENERAL SURGEON ON CALL & EXA-139, 379EMERGENCY91.0004949.03INSURANCE ADD BACKA17, 735CAP REL COSTS-BLDG & FI XT1.00124949.05PHYSI CI AN CLI NI C RENT OFFSET FOOB-69, 471OPERATI ON OF PLANT7.0004950.00TOTAL (sum of lines 1 thru 49)-8, 313, 815-8, 313, 8155050		ACCELERAT						
AS. 02PURCHASI NG DI SCOUNTSA-343/ADMI NI STRATI VE & GENERAL5.0004546. 01OTHER OPERATI NG INCOMEA-2,902/PHARMACY15.0004647. 00HOSPI TALI STA-255,000/ADULTS & PEDI ATRI CS30.0004748. 00OTHER OPERATI NG REVA-111 RADI OLOGY-DI AGNOSTI C54.0004849. 00OTHER OPERATI NG REVA-1,807 LABORATORY60.0004949. 01OTHER OPERATI NG REVA-139, 269 PHYSI CAL THERAPY66.0004949. 02ORTHO / GENERAL SURGEON ON CALL & EXA-139, 379 EMERGENCY91.0004949. 03INSURANCE ADD BACKA22, 343 CAP REL COSTS-BLDG & FIXT1.00124949. 04INSURANCE ADD BACKA17, 735 CAP REL COSTS-MVBLE EQUI P2.00124949. 05PHYSI CI AN CLI NI C RENT OFFSETB-69, 471 OPERATI ON OF PLANT7.0004950. 00TOTAL (sum of lines 1 thru 49)-8, 313, 815-8, 313, 81550	45.00							1 .0.0
46. 01       OTHER OPERATING INCOME       A       -2,902 PHARMACY       15.00       0       46         47. 00       HOSPITALIST       A       -255,000 ADULTS & PEDIATRICS       30.00       0       47         48. 00       OTHER OPERATING REV       A       -111 RADIOLOGY-DIAGNOSTIC       54.00       0       48         49. 00       OTHER OPERATING REV       A       -111 RADIOLOGY-DIAGNOSTIC       54.00       0       49         49. 01       OTHER OPERATING REV       A       -139,269 PHYSICAL THERAPY       66.00       0       49         49. 02       ORTHO / GENERAL SURGEON ON CALL & EX       A       -139,379 EMERGENCY       91.00       0       49         49. 04       INSURANCE ADD BACK       A       22,343 CAP REL COSTS-BLDG & FIXT       1.00       12       49         49. 04       INSURANCE ADD BACK       A       17,735 CAP REL COSTS-MVBLE EQUIP       2.00       12       49         49. 04       INSURANCE ADD BACK       A       17,735 CAP REL COSTS-MVBLE EQUIP       2.00       12       49         49. 04       INSURANCE ADD BACK       A       17,735 CAP REL COSTS-MVBLE EQUIP       2.00       12       49         49. 05       PHYSICIAN CLINIC RENT OFFSET       B       -69,471 OP	45.01		В					1 .0.0
47.00       HOSPITALIST       A       -255,000       ADULTS & PEDIATRICS       30.00       0       47         48.00       OTHER OPERATING REV       A       -111       RADIOLOGY-DIAGNOSTIC       54.00       0       48         49.00       OTHER OPERATING REV       A       -1,807       LABORATORY       60.00       0       49         49.01       OTHER OPERATING REV       A       -139,269       PHYSICAL THERAPY       66.00       0       49         49.02       ORTHO / GENERAL SURGEON ON CALL & EX       A       -139,379       EMERGENCY       91.00       0       49         49.03       INSURANCE ADD BACK       A       22,343       CAP REL COSTS-BLDG & FIXT       1.00       12       49         49.04       INSURANCE ADD BACK       A       17,735       CAP REL COSTS-MVBLE EQUIP       2.00       12       49         49.05       PHYSICIAN CLINIC RENT OFFSET       B       -69,471       OPERATION OF PLANT       7.00       0       49         50.00       TOTAL (sum of lines 1 thru 49)       -8,313,815       -8,313,815       50       50	45.02							1 .0.01
48.00OTHER OPERATING REVA-111 RADIOLOGY-DIAGNOSTIC54.0004849.00OTHER OPERATING REVA-1,807 LABORATORY60.0004949.01OTHER OPERATING REVA-139,269 PHYSICAL THERAPY66.0004949.02ORTHO / GENERAL SURGEON ON CALL & EXA-139,379 EMERGENCYEMERGENCY91.0004949.03INSURANCE ADD BACKA22,343 CAP REL COSTS-BLDG & FIXT1.00124949.04INSURANCE ADD BACKA17,735 CAP REL COSTS-MVBLE EQUIP2.00124949.05PHYSICIAN CLINIC RENT OFFSET TOTAL (sum of lines 1 thru 49)B-69,471 -8,313,815-69,471 OPERATION OF PLANT7.0004950.00TOTAL (sum of lines 1 thru 49)-8,313,815-8,313,815505050			A					1 .0.0
49.00OTHER OPERATING REVA-1,807LABORATORY60.0004949.01OTHER OPERATING REVA-139,269PHYSICAL THERAPY66.0004949.02ORTHO / GENERAL SURGEON ON CALL & EXA-139,379EMERGENCY91.0004949.03INSURANCE ADD BACKA22,343CAP REL COSTS-BLDG & FIXT1.00124949.04INSURANCE ADD BACKA17,735CAP REL COSTS-MVBLE EQUIP2.00124949.05PHYSICIAN CLINIC RENT OFFSETB-69,471OPERATION OF PLANT7.0004950.00TOTAL (sum of lines 1 thru 49)-8,313,815-8,313,8155050	47.00							1
49. 01OTHER OPERATING REVA-139, 269PHYSICAL THERAPY66. 0004949. 02ORTHO / GENERAL SURGEON ON CALL & EXA-139, 379EMERGENCY91. 0004949. 03INSURANCE ADD BACKA22, 343CAP REL COSTS-BLDG & FIXT1. 00124949. 04INSURANCE ADD BACKA17, 735CAP REL COSTS-MVBLE EQUIP2. 00124949. 05PHYSICIAN CLINIC RENT OFFSETB-69, 471OPERATION OF PLANT7. 0004950. 00TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,-8, 313, 815-8, 313, 81550								1 .0.00
49. 02 CALL & EXORTHO / GENERAL SURGEON ON CALL & EXA-139, 379 EMERGENCYPMERGENCY91. 0004949. 03INSURANCE ADD BACKA22, 343 ACAP REL COSTS-BLDG & FIXT1. 00124949. 04INSURANCE ADD BACKA17, 735 CAP REL COSTS-MVBLE EQUIP2. 00124949. 05PHYSI CI AN CLINIC RENT OFFSETB-69, 471 -8, 313, 815-69, 471 -8, 313, 8157. 0004950. 00TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,-8, 313, 815-85050								1
CALL & EXA22,343CAP REL COSTS-BLDG & FIXT1.00124949.04INSURANCE ADD BACKA17,735CAP REL COSTS-BLDG & FIXT1.00124949.05PHYSICIAN CLINIC RENT OFFSETB-69,471OPERATION OF PLANT7.0004950.00TOTAL (sum of lines 1 thru 49)-8,313,815-8,313,81550	49.01							1
49.03       INSURANCE ADD BACK       A       22,343       CAP REL COSTS-BLDG & FIXT       1.00       12       49         49.04       INSURANCE ADD BACK       A       17,735       CAP REL COSTS-MVBLE EQUIP       2.00       12       49         49.05       PHYSICIAN CLINIC RENT OFFSET       B       -69,471       OPERATION OF PLANT       7.00       0       49         50.00       TOTAL (sum of lines 1 thru 49)       -8,313,815       -8,313,815       50	49. 02		A	-139, 379	EMERGENCY	91.00	0	49.02
49. 04       INSURANCE ADD BACK       A       17, 735       CAP REL COSTS-MVBLE EQUIP       2.00       12       49         49. 05       PHYSI CI AN CLINI C RENT OFFSET       B       -69, 471       OPERATION OF PLANT       7.00       0       49         50. 00       TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,       -8, 313, 815       -8, 313, 815       50	40.02			22.242		1 00	10	40.0
49.05         PHYSICIAN CLINIC RENT OFFSET         B         -69, 471         OPERATION OF PLANT         7.00         0         49           50.00         TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,         -8, 313, 815         -8, 313, 815         50								
50. 00 TOTAL (sum of Lines 1 thru 49) -8, 313, 815 50 (Transfer to Worksheet A,								
(Transfer to Worksheet A,			-			7.00	0	49.08 50.00
	50.00			-8, 313, 815				50.00
		column 6, line 200.)						

(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.

Heal th	Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	IE Provi der CC		Period: From 01/01/2015	Worksheet A-8	8-1	
OFFICE					To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
	Line No.	Cost Center	Expense It		Amount of	Amount	
					Allowable Cost		
						Wks. A, column	
						5	
	1.00	2.00	3.00		4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH	RELATED OR	GANIZATIONS OR	CLAI MED	
1.00		ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCA	ATION	4, 929, 921	3, 073, 441	1.00
2.00		ADMINISTRATIVE & GENERAL	RELATED PARTY SUBS		0	3, 379, 278	2.00
3.00	0.00				0	0	3.00
4.00	0.00				0	0	4.00
5.00	TOTALS (sum of lines 1-4).				4, 929, 921	6, 452, 719	5.00
	Transfer column 6, line 5 to						
	Worksheet A-8, column 2,						
	line 12.						

\* 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.

na	5 1101	been posted to worksheet A,				FOI this part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Nama	Democratore of	Nama	Democrateria of	<u> </u>
		Symbol (1)	Name	Percentage of	Name	Percentage of	
				Ownershi p		Ownershi p	
		1.00	2.00	3.00	4.00	5.00	
		B INTERPRIATIONSHIP TO REL	TED OPCANIZATION(S) AND/OP I	OME DEELCE			

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

6.00 B		0. 00 PARKVI EW HEALTH	100.00	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 (financia	lor			100.00
non-financial) spe	ci fv:			

(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 PARKVIEW WABASH HOSPI	TAL, INC.	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 151310		Worksheet A-8-1
OFFICE COSTS		From 01/01/2015 To 12/31/2015	Date/Time Prepared:

			7/14/2016 3:4	43 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	1, 856, 480	0		1.00
2.00	-3, 379, 278	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-1, 522, 798			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.

1103 1101	been posted to worksheet A,		
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	51		
	6, 00		
	B. INTERRELATIONSHIP TO RELA	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

i ei iibui	Sement under title Aviii.	
6.00	HEALTH SYSTEM	6.00
7.00 8.00		7.00
		8.00
9. 00 10. 00		9.00
10.00		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	PARKVI EW WABASH	HOSPITAL, INC		In Li	eu of Form CMS-	2552-10
	R BASED PHYSIC				r CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet A-	3-2 epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	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	91.00	AGGREGATE-EMERGENCY	20, 000		20, 00	0 0	C	1.00
2.00	91.00	AGGREGATE-EMERGENCY	1, 053, 806	772, 19	5 281, 61	1 0	0	2.00
3.00	90. 01	AGGREGATE-SENI OR CARE	24, 402		24, 40	2 0	C	3.00
4.00	0.00		0	(		o o	0	4.00
5.00	0.00		0			o l	0	5.00
6.00	0.00		0	(		o l	0	6.00
7.00	0.00		0	(		o l	0	7.00
8.00	0.00		0	(		o l	0	8.00
9.00	0.00		0			o o	C	9.00
10.00	0.00		0	(		o o	0	10.00
200.00			1, 098, 208	772, 19	5 326, 01	3	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadj usted RCI	Memberships 8	Component	of Mal practi ce	
				Limit	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		AGGREGATE-EMERGENCY	0			0 0	-	
2.00		AGGREGATE-EMERGENCY	0			0 0	C	
3.00		AGGREGATE-SENI OR CARE	0		-	0 0	C	
4.00	0.00		0			0 0	C	
5.00	0.00		0			0 0	0	
6.00	0.00		0		-	0 0	C	
7.00	0.00		0			0 0	0	
8.00	0.00		0	(		0 0	0	0.00
9.00	0.00		0		-	0 0	0	
10.00	0.00		0		-	0 0	0	
200.00			0		-		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
			Share of col.					
	1.00	2.00	14 15. 00	16.00	17.00	18.00	-	
1 00		2.00 AGGREGATE-EMERGENCY	15.00			0 18.00		1.00
1.00 2.00		AGGREGATE - EMERGENCY				0 772, 195		2.00
2.00		AGGREGATE-EMERGENCY AGGREGATE-SENIOR CARE				0 772, 195		2.00
3.00 4.00	0.00							4.00
4.00 5.00	0.00							4.00 5.00
5.00 6.00	0.00							6.00
8.00 7.00	0.00							7.00
7.00 8.00	0.00							8.00
8.00 9.00	0.00							9,00
9.00 10.00	0.00							9.00
	0.00					0 0 772, 195		200.00
200.00	I	I	1 0	I I	וי	0 772, 195	1	200.00

Health Financial Systems P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS				Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Pre 7/14/2016 3:4	
		CAPI TAL REL	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	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	587, 300	587, 300				1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	887, 941	007,000	887, 94	1		2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 828, 760	11, 410		2, 840, 170		4.00
5.00 00500 ADMINI STRATI VE & GENERAL	6, 507, 634	60, 042	268, 86		7, 571, 316	•
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	1, 118, 200	118, 966		1 88,061 0 0	1, 349, 188 0	7.00 8.00
9. 00 00900 HOUSEKEEPING	483, 358	8, 928		5 55, 170	547, 456	•
10. 00 01000 DI ETARY	297, 195	23, 058			372, 354	10.00
11. 00 01100 CAFETERI A	296, 848	7, 151	(	72, 184	376, 183	11.00
13.00 01300 NURSING ADMINISTRATION	170, 705	2, 232		36, 002	208, 939	•
14. 00 01400 CENTRAL SERVICES & SUPPLY	220	24, 341		0 0	24, 561	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	601, 928 0	21, 798 19, 004		0 171, 788 0 0	795, 514 19, 004	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	19,004		0	19,004	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 404, 516	50, 519	(	322, 369	1, 777, 404	30.00
43. 00 04300 NURSERY	0	0		0 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	0(2,107	42 (20	2/0 77	177 004	1 452 505	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	963, 187	42, 638 0	269, 77	6 177, 994 0 0	1, 453, 595 0	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	-1, 907	795	(	0 0	-1, 112	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 629, 195	30, 767	244, 810	217, 372	2, 122, 144	54.00
56. 00 05600 RADI OI SOTOPE	0	0	(	0 C	0	56.00
	1, 649, 223	15, 837			1, 665, 060	•
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 66. 00 06600 PHYSI CAL THERAPY	778, 452	3, 906	24, 68	0	0 1, 036, 496	63.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	57,886	0, 700		0 15, 312	73, 198	•
68. 00 06800 SPEECH PATHOLOGY	0	0	(	0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	426, 780	9, 299	20, 26	6 145, 330	601, 675	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	537, 582	0		0 0	537, 582	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	436,001	0			436, 001	72.00
OUTPATIENT SERVICE COST CENTERS	2, 538, 773	0		0 0	2, 538, 773	73.00
90. 00 09000 CLINIC	110, 420	6, 765	(	314	117, 499	90.00
90. 01 09001 SENI OR CARE	256, 818	9, 555		40, 842	307, 215	•
91.00 09100 EMERGENCY	1, 277, 732	15, 284	26, 88	8 225, 091	1, 544, 995	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	849,007	8, 881		0 185, 284	1, 043, 172	101 00
SPECIAL PURPOSE COST CENTERS	047,007	0,001		5 105, 204	1, 043, 172	101.00
116. 00 11600 HOSPI CE	379, 874	0	(	0 67, 021	446, 895	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	27, 073, 628	491, 176	887, 94	1 2, 827, 773	26, 965, 107	118.00
NONREI MBURSABLE COST CENTERS		0.700			0.700	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0 61, 936	3, 720 73, 322		0 0 0 12,397	3, 720 147, 655	190.00
194. 00 07950 FI TNESS CENTER	01, 930	17, 957		0 12, 397	17, 957	•
194. 01 07951 FOUNDATI ON	-9,045	1, 125		0 0		194.01
194. 02 07952 NEW DIRECTION	0	0	(	0 0	0	194. 02
194.03 07953 COMMUNITY & VOLUNTEER SERVICES	12, 450	0		0 0		194.03
194. 04 07954 WELL CHILD CLINIC	10 500	0		0		194.04
194.05 07955 0CCUPATIONAL HEALTH 200.00  Cross Foot Adjustments	19, 538	0		0		194. 05 200. 00
201.00 Negative Cost Centers		0		0 0		200.00
202.00 TOTAL (sum lines 118-201)	27, 158, 507	587, 300	887, 94	2, 840, 170		
•						

Heal th	Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151310	Period:	Worksheet B	
					From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	nared
						7/14/2016 3:4	3 pm
	Cost Center Description	ADMI NI STRATI VE			HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE		10.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	7, 571, 316					5.00
7.00	00700 OPERATION OF PLANT	523, 238					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	(			8.00
9.00	00900 HOUSEKEEPI NG	212, 313	51, 663	(	811, 432		9.00
10.00	01000 DI ETARY	144, 405			59, 466	709, 660	1
11.00	01100 CAFETERI A	145, 890				0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	81,030			5, 756	0	1
14.00	01400 CENTRAL SERVICES & SUPPLY	9, 525			62,776	0	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	308, 514 7, 370			0 56, 216 0 49, 009	0	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,370	109,972		49,009	0	10.00
30.00	03000 ADULTS & PEDI ATRI CS	689, 307	292, 351	(	130, 289	709, 660	30.00
43.00	04300 NURSERY	0			0 0	0	1
101 00	ANCI LLARY SERVI CE COST CENTERS			· · · · · ·			
50.00	05000 OPERATI NG ROOM	563, 729	246, 744	(	109, 962	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	.,		2, 051	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	823, 004			79, 348	0	
56.00	05600 RADI OI SOTOPE	0	-		0	0	
60.00	06000 LABORATORY	645, 739		1	40, 843	0	60.00
63.00 66.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06600 PHYSI CAL THERAPY	401, 971			0 0 0 10,073	0	
67.00	06700 OCCUPATIONAL THERAPY	28, 387	22, 602		0 10, 073 0 0	0	
68.00	06800 SPEECH PATHOLOGY	20, 307		1		0	1
69.00	06900 ELECTROCARDI OLOGY	233, 340	-		23, 983	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	208, 483			0 0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	169, 089	0	(	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	984, 586	0	(	0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	45, 568					1
90.01	09001 SENI OR CARE	119, 143				0	
91.00	09100 EMERGENCY	599, 175	88, 446	(	39, 416	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101 00	DIOTONE HEALTH AGENCY	404, 560	51, 394		22, 904	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	404, 300	51, 574		22,704	0	
116.00	D 11600 HOSPI CE	173, 313	0	(	0 0	0	116.00
118.00		7, 521, 679			752, 626		
	NONREI MBURSABLE COST CENTERS				· · · · · · ·		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 443	21, 526	(	9, 593	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	28, 825			0 0	0	192.00
	07950 FITNESS CENTER	6, 964			46, 311		194.00
	07951 FOUNDATI ON	0		1	2, 902		194.01
		0	0		0		194.02
	07953 COMMUNITY & VOLUNTEER SERVICES	4, 828	0		0		194.03
		0					194. 04 194. 05
200.00	07955 OCCUPATIONAL HEALTH Cross Foot Adjustments	7,577			0 0	0	194.05 200.00
200.00		0	<u>م</u>			n	200.00
201.00	5	7, 571, 316	1, 872, 426		811, 432		
		.,,	, , , , , , , , , , , , , , , , , , , ,		0.1, 02	,	1

		PARKVIEW WABASH				u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151310	Period: From 01/01/2015	Worksheet B Part I	
					To 12/31/2015	Date/Time Prep	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	7/14/2016 3: 43 MEDI CAL	3 pm
	· · · · · · · · · · · · · · · · · · ·		ADMI NI STRATI ON			RECORDS &	
		11.00	13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	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						4.00
5.00	00500 ADMINISTRATIVE & 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 CAFETERIA	581, 900					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	12, 768					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	12,700		237, 72	24		14.00
15.00	01500 PHARMACY	53, 065	-	201712	0 1, 339, 452		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	C			0 0	185, 355	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	123, 116			0 0	11, 216	
43.00	04300 NURSERY	C	00		0 0	0	43.00
	ANCI LLARY SERVICE COST CENTERS					10.000	
50.00	05000 OPERATING ROOM	65, 716			0 0	18, 392	
51.00	05100 RECOVERY ROOM	0	-		0 0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		-		0 0	0 1, 837	52.00 53.00
54.00	05400 RADI OLOGY – DI AGNOSTI C	83, 170			0 156, 471	44, 760	
56.00	05600 RADI OLOGI - DI AGNOSTI C	03, 170			0 130, 471	44,700	56.00
60.00	06000 LABORATORY		-		0 0	27, 276	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0 0	0	63.00
66.00	06600 PHYSI CAL THERAPY	C	0		0 9,955	6, 608	66.00
67.00	06700 OCCUPATI ONAL THERAPY	C	0 0		0 530	99	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	1	68.00
69.00	06900 ELECTROCARDI OLOGY	141, 157	0		0 0	5, 407	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0 0	237, 72	24 0	486	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	-		0 0	3, 133	
73.00	07300 DRUGS CHARGED TO PATIENTS	C	0		0 1, 172, 496	42, 493	73.00
~~~~~	OUTPATIENT SERVICE COST CENTERS					1 ( 10	00.00
90.00		117			0 0	1, 648	
90. 01 91. 00	09001 SENI OR CARE 09100 EMERGENCY	14, 408	-		0 0	1, 120 20, 879	90. 01 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	00, 303	102, 492		0	20, 879	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
101.00	10100 HOME HEALTH AGENCY	0	0 0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS				-, -,	-	
116.00	11600 HOSPI CE	C			0 0		116. 00
118.00		581, 900	321, 409	237, 72	1, 339, 452	185, 355	118.00
	NONREI MBURSABLE COST CENTERS		1		T		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	-		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	07950 FI TNESS CENTER		0		0		194.00
			0		0		194.01
	207952 NEW DIRECTION 307953 COMMUNITY & VOLUNTEER SERVICES						194. 02 194. 03
	07953 COMMONITY & VOLUNTEER SERVICES						194. 03 194. 04
	07955 OCCUPATIONAL HEALTH						194.04 194.05
200.00							200.00
200.00			0		0 0		201.00
202.00		581, 900	321, 409	237, 72	1, 339, 452	185, 355	
					· · · · · · · · · · · · · · · · · · ·		

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	PARKVIEW WABASH	Provi der	CCN	151310	Peri od:	eu of Form CN Worksheet B	
0001 A	LEUCATION - GENERAL SERVICE COSTS		Trovider	CON.	131310	From 01/01/201 To 12/31/201	5 Part I	
	Cost Conton Decembration	Cultated			Tatal		7/14/2016 3	<u>3:43 pm</u>
	Cost Center Description	Subtotal	Intern & Residents Cost		Total			
			& Post					
			Stepdown					
			Adjustments					
		24.00	25.00		26.00			
	GENERAL SERVICE COST CENTERS							
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							4.00
5.00	00500 ADMINI STRATI VE & GENERAL							5.00
7.00	00700 OPERATION OF PLANT							7.00
8.00	00800 LAUNDRY & LINEN SERVICE							8.00
9.00	00900 HOUSEKEEPI NG							9.00
10.00	01000 DI ETARY							10.00
11.00	01100 CAFETERI A							11.00
	01300 NURSI NG ADMI NI STRATI ON							13.00
	01400 CENTRAL SERVICES & SUPPLY							14.00
	01500 PHARMACY							15.00
	01600 MEDI CAL RECORDS & LI BRARY							16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3, 876, 081	0		3, 876, 0	81		30.00
	04300 NURSERY	0	0		0,0,0,0	0		43.00
101.00	ANCI LLARY SERVICE COST CENTERS					0		
50.00	05000 OPERATI NG ROOM	2, 534, 317	0		2, 534, 3	17		50.00
	05100 RECOVERY ROOM	2,001,017	0		2,001,0	0		51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0			0		52.00
	05300 ANESTHESI OLOGY	7,377	0		7,3	0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 486, 945	0		3, 486, 9			54.00
	05600 RADI OI SOTOPE	0, 100, 710	0		0, 100, 7	0		56.00
60.00	06000 LABORATORY	2, 470, 566	0		2, 470, 5	-		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 170, 000	0		2, 170, 0	0		63.00
	06600 PHYSI CAL THERAPY	1, 487, 705	0		1, 487, 7	05		66.00
	06700 OCCUPATI ONAL THERAPY	102, 214	0		102, 2			67.00
	06800 SPEECH PATHOLOGY	102, 211	0		102,2	1		68.00
	06900 ELECTROCARDI OLOGY	1, 059, 377	0		1, 059, 3	77		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	984, 275	0		984, 2			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	608, 223	0		608, 2			72.00
	07300 DRUGS CHARGED TO PATIENTS	4, 738, 348	0		4, 738, 3			73.00
75.00	OUTPATIENT SERVICE COST CENTERS	4,730,340	0		4,730,3	40		/ 3. 00
90.00	09000 CLINIC	221, 431	0		221, 4	21		90.00
	09001 SENI OR CARE	521, 824	0		521, 9			90.0
	09100 EMERGENCY	2, 483, 786	0		2, 483, 7			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,403,700	0		2,403,7	00		92.00
72.00	OTHER REIMBURSABLE COST CENTERS		0					72.00
101 00	10100 HOME HEALTH AGENCY	1, 522, 030	0		1, 522, 0	30		101.00
101.00	SPECIAL PURPOSE COST CENTERS	1, 522, 030	0	1	1, 322, 0	50		
116 00	11600 HOSPICE	620, 208			620, 2	0.0		116. 00
118.00		26, 724, 708	0 0		620, 2 26, 724, 7			118.00
118.00		20, 724, 708	0		20, 724, 7	08		118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	36, 282	0		36, 2	02		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	30, 282 176, 480						
			0		176, 4			192.00
	07950 FI TNESS CENTER	175, 150	0		175, 1			194.00
	07951 FOUNDATION	1, 494	0		1, 4	94		194.0
		0	0		47 0	70		194.02
	07953 COMMUNITY & VOLUNTEER SERVICES	17, 278	0		17, 2	/8		194.03
	07954 WELL CHILD CLINIC	0	0			1		194.04
	07955 OCCUPATI ONAL HEALTH	27, 115	0		27, 1	15		194.05
200.00		0	0			0		200.00
201.00		0	0			0		201.00
202.00	TOTAL (sum lines 118-201)	27, 158, 507	0		27, 158, 5			202.00

	ancial Systems F I OF CAPITAL RELATED COSTS	PARKVIEW WABASH I			Peri od:	u of Form CMS-2 Worksheet B	
					From 01/01/2015 To 12/31/2015	Part II Date/Time Pre 7/14/2016 3:4	pared: 3 pm
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	ERAL SERVICE COST CENTERS						1.00
2.00         0020           4.00         0040           5.00         0050           7.00         0070	00 CAP REL COSTS-DEDG & THAT 00 CAP REL COSTS-MVBLE EQUIP 00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL 00 OPERATION OF PLANT 00 LAUNDRY & LINEN SERVICE	0 745, 847 0	11, 410 60, 042 118, 966	268, 86 23, 96		11, 410 2, 951 354 0	2.00 4.00 5.00 7.00 8.00
9.00     0090       10.00     0100       11.00     0110	DO HOUSEKEEPING DO LIETARY DO CAFETERIA DO NURSING ADMINISTRATION	0	8, 928 23, 058 7, 151	8, 69	0 8, 928 97 31, 755 0 7, 151	222 174 290	9.00 10.00 11.00
14.00     0140       15.00     0150       16.00     0160	DO NORSENG ADMENTSTRATION DO CENTRAL SERVICES & SUPPLY DO PHARMACY DO MEDICAL RECORDS & LIBRARY ATLENT ROUTINE SERVICE COST CENTERS	000000000000000000000000000000000000000	2, 232 24, 341 21, 798 19, 004		0 2,232 0 24,341 0 21,798 0 19,004	145 0 690 0	13.00 14.00 15.00 16.00
30.00 0300 43.00 0430	DO ADULTS & PEDIATRICS DO NURSERY	0	50, 519 0		0 50, 519 0 0	1, 295 0	30. 00 43. 00
	LLARY SERVICE COST CENTERS	0	42, 638	269, 77	312, 414	715	50.00
51.00 0510 52.00 0520	DO RECOVERY ROOM DO DELIVERY ROOM & LABOR ROOM	0	0 0		0 0 0 0	0 0	51.00 52.00
54.00 0540	00 ANESTHESI OLOGY 00 RADI OLOGY-DI AGNOSTI C 00 RADI OI SOTOPE	0	795 30, 767 0	244, 81	0 795 0 275, 577 0 0	0 873 0	53.00 54.00 56.00
63.00 0630	DO LABORATORY DO BLOOD STORING, PROCESSING & TRANS. DO PHYSICAL THERAPY	0	15, 837 0 3, 906	24, 68	0 15, 837 0 0 3 28, 589	0 0 922	60.00 63.00 66.00
67.00 0670 68.00 0680	DO OCCUPATIONAL THERAPY DO SPEECH PATHOLOGY	0	0 0		0 0 0 0	62 0	67.00 68.00
71.00 0710 72.00 0720	DO ELECTROCARDIOLOGY DO MEDICAL SUPPLIES CHARGED TO PATIENT DO IMPL. DEV. CHARGED TO PATIENTS DO DRUGS CHARGED TO PATIENTS	0 0 0	9, 299 0 0 0	20, 26	6 29, 565 0 0 0 0 0 0	584 0 0 0	69.00 71.00 72.00 73.00
	PATIENT SERVICE COST CENTERS	-					
90.01 0900 91.00 0910 92.00 0920	DO CLINIC D1 SENIOR CARE D0 EMERGENCY D0 OBSERVATION BEDS (NON-DISTINCT PART	0 0	6, 765 9, 555 15, 284		0 6, 765 0 9, 555 8 42, 172 0	1 164 904	90.00 90.01 91.00 92.00
101.001010	ER REIMBURSABLE COST CENTERS DO HOME HEALTH AGENCY CIAL PURPOSE COST CENTERS	0	8, 881		0 8, 881	745	101. 00
116.001160 118.00	DO HOSPICE SUBTOTALS (SUM OF LINES 1-117)	0 745, 847	0 491, 176	887, 94	0 0 1 2, 124, 964	269 11, 360	116. 00 118. 00
190.001900 192.001920 194.000795	REIMBURSABLE COST CENTERS DO GIFT, FLOWER, COFFEE SHOP & CANTEEN DO PHYSICIANS' PRIVATE OFFICES 50 FITNESS CENTER	000000000000000000000000000000000000000	3, 720 73, 322 17, 957		0 3, 720 0 73, 322 0 17, 957	50 0	190.00 192.00 194.00
194. 02 0795 194. 03 0795 194. 04 0795	51 FOUNDATION 52 NEW DIRECTION 53 COMMUNITY & VOLUNTEER SERVICES 54 WELL CHINIC 55 OSCUPATIONALIJIA	000000000000000000000000000000000000000	1, 125 0 0 0		0 1, 125 0 0 0 0 0 0 0 0	0 0 0	194.01 194.02 194.03 194.04
194. 05 0795 200. 00 201. 00 202. 00	55 OCCUPATIONAL HEALTH Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118-201)	0 745, 847	0 0 587, 300	887, 94	0 0 0 0 1 2, 221, 088	0	194. 05 200. 00 201. 00

Heal th	Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der	CCN: 151310	Period: From 01/01/2015	Worksheet B Part II	
					To 12/31/2015		epared:
	Cost Center Description		OPERATION OF		HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
	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						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	1,077,700					5.00
7.00	00700 OPERATION OF PLANT	74, 478	217, 759				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	-		C		8.00
9.00	00900 HOUSEKEEPI NG	30, 221			0 45, 379		9.00
10.00	01000 DI ETARY	20, 555			3, 326	71, 328	
11.00	01100 CAFETERI A	20, 766			1, 031	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	11, 534			322	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 356			3, 511	0	
15.00	01500 PHARMACY	43, 914				0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	1,049	12, 789	(	2, 741	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	00.44/	04.004		7.00/	74.000	0.00
30.00	03000 ADULTS & PEDI ATRI CS	98, 116			7, 286	71, 328	
43.00		0	0	(	0 0	0	43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS	00.041	20.404		( 150	0	1 50 00
50.00 51.00	05100 RECOVERY ROOM	80, 241				0	
51.00	05200 DELIVERY ROOM & LABOR ROOM		-			0	
52.00	05300 ANESTHESI OLOGY		-		0 115	0	
53.00	05400 RADI OLOGY – DI AGNOSTI C	117, 147			4,438	0	
56.00	05600 RADI OLOGI - DI AGNOSTI C	0	-		0 0	0	
60.00	06000 LABORATORY	91, 915	-		2, 284	0	
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	57, 217	-		563	0	
67.00	06700 OCCUPATIONAL THERAPY	4, 041			0 0	0	
68.00	06800 SPEECH PATHOLOGY	0			-	0	
69.00	06900 ELECTROCARDI OLOGY	33, 214	6, 259	(	1, 341	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29,676				0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	24, 068	0	(	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	140, 141	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	6, 486	4, 553	(	976	0	90.00
90.01	09001 SENI OR CARE	16, 959	6, 431		1, 378	0	90.01
91.00	09100 EMERGENCY	85, 287	10, 286	(	2, 204	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS			1	1		
101.00	10100 HOME HEALTH AGENCY	57, 585	5, 977	(	1, 281	0	101.00
	SPECIAL PURPOSE COST CENTERS		-		-	-	
	11600 HOSPI CE	24, 669			0		116.00
118.00		1, 070, 635	202, 414	[ (	42, 091	/1, 328	118.00
100.00	NONREI MBURSABLE COST CENTERS	205	2 502		52/	0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	205					190.00
	07950 FITNESS CENTER	4, 103			-		192.00
	107950 FTTNESS CENTER	991			2, 590 162		194.00
	207952 NEW DIRECTION	0			0 0		194.01
	3 07953 COMMUNITY & VOLUNTEER SERVICES	687					194.02
	407954 WELL CHILD CLINIC	007					194.03
	507955 OCCUPATIONAL HEALTH	1,079					194.05
200.00		1,077	Ĭ	Ì	0	0	200.00
200.00		0	0		0 0	n	201.00
202.00	5	1, 077, 700	217, 759		45, 379		202.00
0.		,, ,				, 520	

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Pre	anarod.
						7/14/2016 3:4	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & 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	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	34,051					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	747	1				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0		45, 59	0		14.00
15.00	01500 PHARMACY	3, 105	0		0 87, 321		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0			0 0	35, 583	
	INPATIENT ROUTINE SERVICE COST CENTERS	-				· · · · ·	
30.00	03000 ADULTS & PEDIATRICS	7,204	7, 319		0 0	2, 153	30.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS	1	-		-r		
50.00	05000 OPERATI NG ROOM	3, 846	3, 907		0 0	3, 531	
51.00	05100 RECOVERY ROOM	0			0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
53.00	05300 ANESTHESI OLOGY	0			0 0	353	
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 867	0		0 10, 201	8, 590	
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	
60.00	06000 LABORATORY	0	0		0 0	5, 237	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0 649	1, 269	
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 35	19	
68.00		0	-		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	8, 260			0 0	1, 038	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0		45, 59		93	
72.00 73.00		0	-		°	602	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	<u>1</u> 0		0 76, 436	8, 158	73.00
90.00	09000 CLINIC	7	0		0 0	316	90.00
90.00 90.01	09001 SENI OR CARE	843			0 0	215	
91.00	09100 EMERGENCY	5, 172			0 0	4,009	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0,172	0,200		Ŭ Ŭ	1,007	92.00
/2:00	OTHER REIMBURSABLE COST CENTERS						1 /2/ 00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
116.00	0 11600 HOSPI CE	0	0 0		0 0		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	34, 051	16, 482	45, 59	0 87, 321	35, 583	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	07950 FITNESS CENTER	0	0		0 0		194.00
	07951 FOUNDATI ON	0	0		0 0		194.01
	2 07952 NEW DIRECTION	0	0		0 0		194.02
	3 07953 COMMUNITY & VOLUNTEER SERVICES	0	0		0 0		194.03
	4 07954 WELL CHILD CLINIC	0	0		0 0		194.04
	07955 OCCUPATI ONAL HEALTH	0	0		0 0	0	194.05
200.00							200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	34, 051	16, 482	45, 59	0 87, 321	35, 583	

ALLOCATION OF CAPITAL RELATE				AL, INC. Provider	CCN	151310	In Lieu of For Period: Workshe	
ALLOWING OF GATTINE RELATE				1001 del	CON.	131310	From 01/01/2015 Part II To 12/31/2015 Date/Ti	me Prepared: 16 3:43 pm
Cost Center Desc	cription	Subtotal		ern &		Total		
				nts Cost				
				Post pdown				
				stments				
		24.00		5.00		26.00		
GENERAL SERVICE COST	CENTERS		1					
1.00 00100 CAP REL COSTS-BL	_DG & FIXT							1.0
2.00 00200 CAP REL COSTS-M								2.0
4.00 00400 EMPLOYEE BENEFIT								4.0
5. 00 00500 ADMI NI STRATI VE &								5.0
7.00 00700 OPERATION OF PLA 8.00 00800 LAUNDRY & LINEN								7.0
8. 00 00800 LAUNDRY & LI NEN 9. 00 00900 HOUSEKEEPI NG	SERVICE							8. 0 9. 0
10. 00 01000 DI ETARY								10.0
11. 00 01100 CAFETERIA								11.0
13.00 01300 NURSI NG ADMI NI ST	TRATI ON							13.0
14.00 01400 CENTRAL SERVICES								14.0
15.00 01500 PHARMACY								15.0
16.00 01600 MEDICAL RECORDS								16.0
INPATIENT ROUTINE SER		1						
30. 00 03000 ADULTS & PEDI ATF	RICS	279, 221		0		279, 2		30.0
43.00 04300 NURSERY		0		0			0	43.0
ANCI LLARY SERVICE COS	T CENTERS	400.500				100 5		
50. 00 05000 OPERATI NG ROOM		439, 500		0		439, 5		50.0
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM &	LAROD DOOM	0		0			0	51.0 52.0
53.00 05300 ANESTHESI OLOGY	LABOR ROOM	1, 798	1	0		1, 7		53.0
54. 00 05400 RADI OLOGY-DI AGNO	OSTLC	442, 400		0		442, 4		54.0
56. 00 05600 RADI OI SOTOPE	55110	142,400		0			0	56.0
60. 00 06000 LABORATORY		125, 931		0		125, 9		60.0
63.00 06300 BLOOD STORING, F	PROCESSING & TRANS.	0	D	0			0	63.0
66. 00 06600 PHYSI CAL THERAPY	ſ	91, 838	3	0		91, 8	38	66.0
67.00 06700 OCCUPATIONAL THE		4, 157	7	0		4, 1	57	67.0
68.00 06800 SPEECH PATHOLOGY		0		0			0	68.0
69.00 06900 ELECTROCARDI OLO		80, 261		0		80, 2		69.0
71.00 07100 MEDI CAL SUPPLIES		75, 359		0		75, 3		71.0
72.00 07200 I MPL. DEV. CHARC 73.00 07300 DRUGS CHARGED TO		24, 670 224, 735		0		24, 6 224, 7		72.0 73.0
OUTPATIENT SERVICE CO		224,730	2	0	1	224, 7	35	/3.0
90. 00 09000 CLINIC	ST CENTERS	19, 104	1	0		19, 1	04	90.0
90. 01 09001 SENI OR CARE		35, 545		0		35, 5		90.0
91.00 09100 EMERGENCY		155, 290		0		155, 2		91.0
92.00 09200 OBSERVATION BEDS	S (NON-DISTINCT PART			0				92.0
OTHER REIMBURSABLE COS								
101.00 10100 HOME HEALTH AGEN		74, 469	9	0		74, 4	69	101.0
SPECIAL PURPOSE COST	CENTERS		1					
116.00 11600 HOSPI CE		24, 938		0		24, 9		116.0
118.00 SUBTOTALS (SUM O		2, 099, 216		0		2,099,2	16	118. 0
NONREI MBURSABLE COST (		4.044	d.	0	1	( 0	4.4	100.0
190. 00 19000 GI FT, FLOWER, CC 192. 00 19200 PHYSI CI ANS' PRI V		6, 964 77, 475		0		6, 9 77, 4		190. 0 192. 0
194. 00 07950 FI TNESS CENTER		33, 623		0		33, 6		192.0
194. 01 07951 FOUNDATI ON		2,044		0		2, 0		194.0
194. 02 07952 NEW DI RECTI ON		0		0		2,0	0	194.0
194. 03 07953 COMMUNI TY & VOLU	JNTEER SERVICES	687	/	0		6	87	194.0
194.04 07954 WELL CHILD CLINI		0	D	0			0	194. 0
194. 05 07955 OCCUPATI ONAL HEA		1, 079	2	0		1, 0	79	194. 0
200.00 Cross Foot Adjus		0	D	0			0	200. 0
201.00 Negative Cost Ce		0	D	0			0	201.0
202.00 TOTAL (sum lines	s 118-201)	2, 221, 088	3	0	1	2, 221, 0	88	202.0

		ARKVIEW WABASH		0011 4 = 1 =		u of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2015	Worksheet B-1	
					0 12/31/2015		
		CAPITAL RE	ATED COSTS			7/14/2016 3:4	<u>3 pm</u>
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS		1	1			
1.00	00100 CAP REL COSTS-BLDG & FIXT	126, 308					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 454	772, 494	10, 616, 186			2.00
5.00	00500 ADMI NI STRATI VE & GENERAL	12, 913				19, 522, 895	
7.00	00700 OPERATION OF PLANT	25, 585				1, 349, 188	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900 HOUSEKEEPI NG	1, 920		206, 219		547, 456	
10.00	01000 DI ETARY	4, 959				372, 354	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	1, 538 480		269, 816 134, 572		376, 183 208, 939	
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 235		134, 372	0	208, 939	
15.00	01500 PHARMACY	4, 688		642, 120	0	795, 514	
16.00	01600 MEDI CAL RECORDS & LI BRARY	4, 087		0		19, 004	
	INPATIENT ROUTINE SERVICE COST CENTERS	1	I	T	1		
30.00	03000 ADULTS & PEDIATRICS	10, 865				1, 777, 404	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43.00
50.00	O5000 OPERATING ROOM	9, 170	234, 700	665, 317	0	1, 453, 595	50.00
51.00	05100 RECOVERY ROOM	9,170	234,700	003, 317	0	1, 433, 375	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
53.00	05300 ANESTHESI OLOGY	171	0	0	1, 112	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 617	212, 981	812, 508		2, 122, 144	
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	3, 406	0	0	0	1, 665, 060 0	
66.00	06600 PHYSI CAL THERAPY	840	21, 474	857, 673	0	1, 036, 496	
67.00	06700 OCCUPATI ONAL THERAPY	040	0	57, 233		73, 198	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	2,000	17, 631	543, 223	0	601, 675	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	537, 582	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	-	436, 001	
73.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	2, 538, 773	73.00
90.00	09000 CLINIC	1, 455	0	1, 175	0	117, 499	90.00
90.01	09001 SENI OR CARE	2, 055		152, 661		307, 215	
91.00	09100 EMERGENCY	3, 287	23, 392	841, 362	0	1, 544, 995	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	1 010		(02 5/7		1 042 172	101 0
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 910	0	692, 567	0	1, 043, 172	
116.00	11600 HOSPICE	0	0	250, 515	0	446, 895	116. 00
118.00		105, 635				19, 394, 903	
	NONREIMBURSABLE COST CENTERS		r				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	800		0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	15, 769		46, 339	-73, 328	74, 327	
	07950 FI TNESS CENTER 07951 FOUNDATI ON	3,862			0 7, 920	17, 957	
	07951 FOUNDATION 07952 NEW DIRECTION	242			7, 920		194. 0 <sup>°</sup> 194. 0
	07953 COMMUNITY & VOLUNTEER SERVICES	0	0		0	12, 450	
	07954 WELL CHILD CLINIC	0	0	0	o o		194. 04
194.05	07955 OCCUPATIONAL HEALTH	0	0	0	0	19, 538	
200.00	5						200. 00
201.00	5					<b>-</b> · ·	201.00
202.00		587, 300	887, 941	2, 840, 170		7, 571, 316	202.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	4. 649745	1. 149447	0. 267532		0. 387817	203 0
203.00		4.047/40	1. 14744/	11, 410		1, 077, 700	
	Part II)					., ., ., ,	
205.00	Unit cost multiplier (Wkst. B, Part			0. 001075		0. 055202	205.00
	11)	1	1	1	1		1

IST A	ALLOCATION - STATISTICAL BASIS		Provi der	F	Period: rom 01/01/2015	Worksheet B-1	
				T	o 12/31/2015	Date/Time Pre 7/14/2016 3:4	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(HOURS)	
			LAUNDR)				
		7.00	8.00	9.00	10.00	11.00	
~ ~	GENERAL SERVICE COST CENTERS	-			1		۰.
00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1	1
00 00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	2
00	00500 ADMI NI STRATI VE & GENERAL					1	5
00	00700 OPERATI ON OF PLANT	69, 587				1	7
00	00800 LAUNDRY & LINEN SERVICE	0				1	8
00	00900 HOUSEKEEPI NG	1, 920	1	67, 667	,	1	9
. 00	01000 DI ETARY	4, 959	0	4, 959	26, 006	1	10
. 00		1, 538		1, 538		9, 935	
. 00		480		480		218	
. 00		5, 235		5, 235		0	
00		4,688	0			906 0	
00	INPATIENT ROUTINE SERVICE COST CENTERS	4, 087	0	4, 087	0	0	
. 00		10, 865	1, 711	10, 865	26,006	2, 102	30
00		0				0	
	ANCILLARY SERVICE COST CENTERS						
. 00		9, 170	1, 300			1, 122	
. 00		0	0	C		0	
00		0	0	0	-	0	
00		171	0	171		0	
. 00		6, 617	2, 510 0			1, 420 0	
. 00		3, 406			-	0	
. 00		0	0			0	
. 00		840	1, 473			0	
. 00	06700 OCCUPATI ONAL THERAPY	0	0	C	0 0	0	67
00		0	0	C	0 0	0	68
. 00		2,000	0	2,000	1	2, 410	
00		0	-	-		0	
. 00		0	-			0	
00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	C	0 0	0	73
00		1, 455	0	1, 455	i o	2	90
. 01		2,055				246	
. 00		3, 287				1, 509	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	OTHER REIMBURSABLE COST CENTERS		<b>I</b>		1		
1.00	0 10100 HOME HEALTH AGENCY	1, 910	0	1, 910	0 0	0	10
4 00	SPECIAL PURPOSE COST CENTERS 0 11600 HOSPI CE		0			0	116
8.00 8.00		64, 683	10, 000		, U	0	
J. UC	NONREI MBURSABLE COST CENTERS	04,003	10,000	02,700	20,000	7, 733	
D. OC	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	800	0 0	0	190
	0 19200 PHYSICIANS' PRIVATE OFFICES	0	0				192
	0 07950 FI TNESS CENTER	3, 862		3, 862			194
4.01	1 07951 FOUNDATI ON	242	0	242			194
	2 07952 NEW DIRECTION	0	0	C	-		194
	3 07953 COMMUNITY & VOLUNTEER SERVICES	0	0	0	-		194
	4 07954 WELL CHILD CLINIC	0			0		) 194 ) 194
1. US ). OC	5 07955 0CCUPATIONAL HEALTH 0  Cross Foot Adjustments	0			0	0	200
). UC 1. OC	· · · · · · · · · · · · · · · · · · ·						200
2.00		1, 872, 426	0	811, 432	709, 660	581, 900	
	Part I)	1, 0, 2, 420	ĺ		, , , , , , , , , , , , , , , , , , , ,		
3.00		1) 26.907698	0. 000000	11. 991547	27. 288318	58. 570710	203
4.00	0 Cost to be allocated (per Wkst. B,	217, 759	0	45, 379	71, 328	34, 051	204
	Part II)						
5.00	0 Unit cost multiplier (Wkst. B, Part	3. 129306	0. 000000	0. 670622	2.742752	3. 427378	

Health F	Financial Systems P	ARKVIEW WABASH I	HOSPITAL, INC.		In Lie	u of Form CMS-2552-1
COST AL	LOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015	Worksheet B-1
					To 12/31/2015	Date/Time Prepared
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	7/14/2016 3:43 pm
	•	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS REV)	
		HR)	REQUIS.)		(GRUSS REV)	
		13.00	14.00	15.00	16.00	
	SENERAL SERVICE COST CENTERS	1 1		1	1	
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.0
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.0
	00500 ADMINI STRATI VE & GENERAL					5.0
7.00 C	00700 OPERATION OF PLANT					7.0
	DO800 LAUNDRY & LINEN SERVICE					8.0
	00900 HOUSEKEEPING					9.0
	01000 DI ETARY 01100 CAFETERI A					10.0
	01300 NURSI NG ADMI NI STRATI ON	98, 719				13.0
	01400 CENTRAL SERVICES & SUPPLY	0,717	10, 000			14.0
	01500 PHARMACY	0	0		з	15.0
	01600 MEDICAL RECORDS & LIBRARY	0	0	(	75, 704, 610	16. 0
	NPATIENT ROUTINE SERVICE COST CENTERS	1		1		
	03000 ADULTS & PEDIATRICS	43, 841	0		4, 581, 567	30.0
	04300 NURSERY NCILLARY SERVICE COST CENTERS	0	0	(	0 0	43.0
	D5000 OPERATING ROOM	23, 398	0		7, 513, 146	50.0
	D5100 RECOVERY ROOM	20,070	0		0 0	51.0
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	52.0
53.00 C	05300 ANESTHESI OLOGY	0	0		750, 332	53.0
	05400 RADI OLOGY-DI AGNOSTI C	0	0	18, 312		54.0
	05600 RADI OI SOTOPE	0	0	(	-	56.0
	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 11, 142, 236 0 0	60. 0 63. 0
	06600 PHYSI CAL THERAPY	0	0	1, 16	-	66.0
	06700 OCCUPATI ONAL THERAPY	0	0	62		67.0
68. OO 🛛	06800 SPEECH PATHOLOGY	0	0		300	68.0
	06900 ELECTROCARDI OLOGY	0	0	(	2, 208, 685	69.0
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	10, 000			71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 279, 902 9 17, 358, 317	72.0
	DUTPATIENT SERVICE COST CENTERS	<u> </u>	0	137,21	7 17, 330, 317	/3.0
	09000 CLINIC	0	0	(	0 673, 078	90.0
90. 01 C	09001 SENI OR CARE	0	0		457, 575	90.0
	09100 EMERGENCY	31, 480	0	(	8, 529, 029	91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.0
	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	101.0
	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		5 0	101.0
	1600 HOSPI CE	0	0	(	0 0	116. 0
118.00	SUBTOTALS (SUM OF LINES 1-117)	98, 719	10, 000			
	IONREI MBURSABLE COST CENTERS			1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190. 0
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	192.0
	07950 FI TNESS CENTER 07951 FOUNDATI ON	0	0			194. 0 194. 0
	07952 NEW DIRECTION		0			194. 0
1	07953 COMMUNITY & VOLUNTEER SERVICES	0	0			194.0
	07954 WELL CHILD CLINIC	0	0		o o	194. 0
	07955 OCCUPATIONAL HEALTH	0	0	(	0	194. 0
200.00	Cross Foot Adjustments					200. 0
201.00	Negative Cost Centers	001 100		1 000	105 055	201.0
202.00	Cost to be allocated (per Wkst. B, Part I)	321, 409	237, 724	1, 339, 452	2 185, 355	202.0
203.00	Unit cost multiplier (Wkst. B, Part I)	3. 255797	23. 772400	8. 544712	0. 002448	203. 0
203.00	Cost to be allocated (per Wkst. B,	16, 482	45, 590			203.0
	Part II)		, 570		, 500	
205.00	Unit cost multiplier (Wkst. B, Part	0. 166959	4. 559000	0. 557043	3 0. 000470	205. 0
	11)			1	1	

Health Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 7/14/2016 3:4	
		Titl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-	•	1			
30. 00 03000 ADULTS & PEDI ATRI CS	3, 876, 081		3, 876, 08		0	
43. 00 04300 NURSERY	C			0 0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1	1		-		
50.00 05000 OPERATING ROOM	2, 534, 317		2, 534, 31	7 0	0	50.00
51.00 05100 RECOVERY ROOM	C			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	)		0 0	0	
53.00 05300 ANESTHESI OLOGY	7,377		7, 37		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 486, 945		3, 486, 94	5 0	0	54.00
56. 00 05600 RADI OI SOTOPE	C	)		0 0	0	
60. 00 06000 LABORATORY	2, 470, 566		2, 470, 56	6 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C			0 0	0	63.00
66. 00 06600 PHYSI CAL THERAPY	1, 487, 705		1, 487, 70		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	102, 214	. 0	102, 21	4 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1	0		1 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 059, 377		1, 059, 37		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	984, 275		984, 27		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	608, 223		608, 22		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 738, 348		4, 738, 34	8 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLINIC	221, 431		221, 43		0	
90. 01 09001 SENI OR CARE	521, 824		521, 82	4 0	0	
91. 00 09100 EMERGENCY	2, 483, 786		2, 483, 78	6 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	752, 537	,	752, 53	7	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1, 522, 030	)	1, 522, 03	0	0	101.00
SPECIAL PURPOSE COST CENTERS		•				
116. 00 11600 HOSPI CE	620, 208		620, 20			116. 00
200.00 Subtotal (see instructions)	27, 477, 245					200.00
201.00 Less Observation Beds	752, 537		752, 53			201.00
202.00   Total (see instructions)	26, 724, 708	0	26, 724, 70	0 8	0	202.00

Health Fina	ancial Systems F	PARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
	N OF RATIO OF COSTS TO CHARGES				Period: From 01/01/2015 To 12/31/2015		
		_		e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 0300	00 ADULTS & PEDIATRICS	3, 339, 260		3, 339, 26	0		30.00
43.00 0430	DONURSERY	0			0		43.00
ANCI	LLARY SERVICE COST CENTERS						1
50.00 0500	DO OPERATING ROOM	386, 241	5, 287, 658	5, 673, 89	9 0. 446662	0. 000000	50.00
51.00 0510	DO RECOVERY ROOM	0	0		0 0.000000	0.00000	51.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0. 000000	52.00
53.00 0530	DO ANESTHESI OLOGY	59, 461	690, 871	750, 33	2 0.009832	0. 000000	53.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	790, 762	17, 481, 473	18, 272, 23	5 0. 190833	0. 000000	54.00
56.00 0560	DO RADI OI SOTOPE	0	0		0 0.000000	0. 000000	56.00
60.00 0600	DOLABORATORY	1, 189, 270	9, 952, 966	11, 142, 23	6 0. 221730	0. 000000	60.00
63.00 0630	DO BLOOD STORING, PROCESSING & TRANS.	0	0		0 0.000000	0. 000000	63.00
66.00 0660	DO PHYSI CAL THERAPY	145, 884	2, 472, 451	2, 618, 33	5 0. 568187	0. 000000	66.00
67.00 0670	OO OCCUPATI ONAL THERAPY	68, 825	40, 612	109, 43	0. 933999	0. 000000	67.00
68.00 0680	DO SPEECH PATHOLOGY	12,074	300	12, 37	4 0.000081	0. 000000	68.00
69.00 0690	DO ELECTROCARDI OLOGY	797, 934	1, 410, 751	2, 208, 68	5 0. 479642	0. 000000	69.00
71.00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENT	423, 326	1, 614, 283			0. 000000	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	85, 379	1, 194, 523	1, 279, 90	2 0. 475211	0. 000000	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	2, 192, 608	15, 165, 709			0. 000000	73.00
OUTF	PATIENT SERVICE COST CENTERS						1
90.00 0900	DO CLINIC	0	673, 078	673, 07	8 0. 328983	0.00000	90.00
90.01 0900	D1 SENI OR CARE	0	457, 575	457, 57	5 1.140412	0.00000	90.01
91.00 0910	DO EMERGENCY	250, 629	8, 278, 400	8, 529, 02	9 0. 291216	0.00000	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART	0	1, 242, 306	1, 242, 30	6 0.605758	0.00000	92.00
OTHE	R REIMBURSABLE COST CENTERS						
101.001010	DO HOME HEALTH AGENCY	0	1,039,936	1, 039, 93	6		101.00
	CIAL PURPOSE COST CENTERS						1
116.001160		0	769, 881	769, 88	1		116.00
200.00	Subtotal (see instructions)	9, 741, 653	67, 772, 773				200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	9, 741, 653	67, 772, 773	77, 514, 42	6		202.00

alth Financial Systems OMPUTATION OF RATIO OF COSTS TO CHARGES		SPITAL, INC. Provider CCN: 151310	In Lie Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 7/14/2016 3:4	epared
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
D. 00 03000 ADULTS & PEDIATRICS					30.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVICE COST CENTERS					
D. OO 05000 OPERATING ROOM	0. 000000				50.0
1.00 05100 RECOVERY ROOM	0. 000000				51.
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.
3. 00 05300 ANESTHESI OLOGY	0. 000000				53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.
6. 00 05600 RADI OI SOTOPE	0. 000000				56.
D. 00 06000 LABORATORY	0. 000000				60.
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.
6. 00 06600 PHYSI CAL THERAPY	0. 000000				66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.
8.00 06800 SPEECH PATHOLOGY	0. 000000				68.
9. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN					71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.
OUTPATIENT SERVICE COST CENTERS					-
D. 00 09000 CLINIC	0. 000000				90.
0. 01 09001 SENI OR CARE	0. 000000				90.
1. 00 09100 EMERGENCY	0. 000000				91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR					92.
OTHER REIMBURSABLE COST CENTERS					- '-'
D1. 00 10100 HOME HEALTH AGENCY					1101.
SPECIAL PURPOSE COST CENTERS					1.0
16. 00 11600 HOSPI CE					116.
00.00 Subtotal (see instructions)					200.
01.00 Less Observation Beds					200.
02.00 Total (see instructions)					201.

Health Financial Systems	5	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF	COSTS TO CHARGES		Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 7/14/2016 3:4	pared: 3 pm
			Ti t	le XIX	Hospi tal	PPS	- <b>-</b>
					Costs		
Cost Center	Description	Total Cost (from Wkst. B, Part I, col. 26)	,	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	SERVICE COST CENTERS		i				-
30.00 03000 ADULTS & PE	DI ATRI CS	3, 876, 081		3, 876, 08		3, 876, 081	
43.00 04300 NURSERY		0			0 0	0	43.00
ANCI LLARY SERVI CE			1	1			-
50.00 05000 OPERATING R		2, 534, 317		2, 534, 31	17 0	2, 534, 317	
51.00 05100 RECOVERY RO		0			0 0	0	
52.00 05200 DELIVERY R0		0			0 0	0	
53.00 05300 ANESTHESI OL		7, 377		7, 37		7,377	
54.00 05400 RADI OLOGY-D		3, 486, 945		3, 486, 94	15 0	3, 486, 945	
56. 00 05600 RADI 0I SOTOP	E	0			0 0	0	
60.00 06000 LABORATORY		2, 470, 566		2, 470, 56	6 0	2, 470, 566	
	NG, PROCESSING & TRANS.	0			0 0	0	
66. 00 06600 PHYSI CAL TH		1, 487, 705		.,		1, 487, 705	
67.00 06700 0CCUPATI ONA		102, 214	0	102, 21	4 0	102, 214	•
68.00 06800 SPEECH PATH		1	0		1 0	1	
69.00 06900 ELECTROCARD		1, 059, 377		1, 059, 37		1, 059, 377	
	PLIES CHARGED TO PATIENT	984, 275		984, 27		984, 275	
	CHARGED TO PATIENTS	608, 223		608, 22		608, 223	
73.00 07300 DRUGS CHARG		4, 738, 348		4, 738, 34	18 0	4, 738, 348	73.00
OUTPATIENT SERVIC	E COST CENTERS						
90. 00 09000 CLINIC		221, 431		221, 43		221, 431	
90. 01 09001 SENI OR CARE		521, 824		521, 82		521, 824	
91.00 09100 EMERGENCY		2, 483, 786		2, 483, 78		2, 483, 786	
	BEDS (NON-DISTINCT PART	752, 537		752, 53	37	752, 537	92.00
OTHER REI MBURSABL							
101.0010100 HOME HEALTH		1, 522, 030		1, 522, 03	30	1, 522, 030	101.00
SPECIAL PURPOSE C	OST CENTERS		1				-
116. 00 11600 HOSPI CE		620, 208		620, 20		620, 208	
	ee instructions)	27, 477, 245					
201.00 Less Observ		752, 537		752, 53		752, 537	
202.00   Total (see	instructions)	26, 724, 708	C	26, 724, 70	0 8	26, 724, 708	202.00

Health Fin	ancial Systems F	PARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
COMPUTATIC	N OF RATIO OF COSTS TO CHARGES				Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
				le XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS			•			
30.00 0300	00 ADULTS & PEDIATRICS	3, 339, 260		3, 339, 26	0		30.00
43.00 0430	DO NURSERY	0			0		43.00
ANCI	ILLARY SERVICE COST CENTERS						1
50.00 050	OO OPERATING ROOM	386, 241	5, 287, 658	5, 673, 89	9 0. 446662	0. 000000	50.00
51.00 0510	DO RECOVERY ROOM	0	0		0 0.000000	0. 000000	51.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0. 000000	52.00
53.00 0530	00 ANESTHESI OLOGY	59, 461	690, 871	750, 33	2 0.009832	0. 000000	53.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	790, 762	17, 481, 473	18, 272, 23	5 0. 190833	0. 000000	54.00
56.00 0560	00 RADI OI SOTOPE	0	0		0 0.000000	0. 000000	56.00
60.00 0600	00 LABORATORY	1, 189, 270	9, 952, 966	11, 142, 23	6 0. 221730	0. 000000	60.00
63.00 0630	00 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0.000000	0. 000000	63.00
66.00 0660	00 PHYSI CAL THERAPY	145, 884	2, 472, 451	2, 618, 33	5 0. 568187	0. 000000	66.00
67.00 0670	00 OCCUPATIONAL THERAPY	68, 825	40, 612	109, 43	0. 933999	0. 000000	67.00
68.00 068	00 SPEECH PATHOLOGY	12,074	300	12, 37	4 0.000081	0. 000000	68.00
69.00 0690	00 ELECTROCARDI OLOGY	797, 934	1, 410, 751	2, 208, 68	5 0. 479642	0. 000000	69.00
71.00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENT	423, 326	1, 614, 283			0. 000000	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENTS	85, 379	1, 194, 523	1, 279, 90	2 0. 475211	0. 000000	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	2, 192, 608	15, 165, 709			0. 000000	73.00
	PATIENT SERVICE COST CENTERS	· · · · · ·					
90.00 090	DO CLINIC	0	673, 078	673, 07	8 0. 328983	0.00000	90.00
90.01 090	01 SENI OR CARE	0	457, 575	457, 57	5 1.140412	0.00000	90.01
91.00 0910	DO EMERGENCY	250, 629	8, 278, 400	8, 529, 02	9 0. 291216	0.00000	91.00
92.00 0920	00 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 242, 306	1, 242, 30	6 0.605758	0.00000	92.00
OTHE	ER REIMBURSABLE COST CENTERS	· ·					1
	DO HOME HEALTH AGENCY	0	1,039,936	1, 039, 93	6		101.00
	CIAL PURPOSE COST CENTERS						1
116.00116		0	769, 881	769, 88	1		116.00
200.00	Subtotal (see instructions)	9, 741, 653					200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	9, 741, 653	67, 772, 773	77, 514, 42	6		202.00

		PARKVIEW WABASH HOS			u of Form CMS-	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 7/14/2016 3:4	
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	FLENT ROUTINE SERVICE COST CENTERS					
	D ADULTS & PEDIATRICS					30.00
	NURSERY					43.00
ANCI L	LARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0. 446662				50.00
51.00 05100	RECOVERY ROOM	0. 000000				51.00
52.00 05200	D DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 05300	ANESTHESI OLOGY	0. 009832				53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 190833				54.00
6. 00 0560	RADI OI SOTOPE	0. 000000				56.00
60.00 06000	LABORATORY	0. 221730				60.00
3.00 0630	BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
6. 00 0660	PHYSICAL THERAPY	0. 568187				66.00
57.00 06700	OCCUPATIONAL THERAPY	0, 933999				67.00
8. 00 0680	SPEECH PATHOLOGY	0. 000081				68.00
	D ELECTROCARDI OLOGY	0. 479642				69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 483054				71.00
	IMPL. DEV. CHARGED TO PATIENTS	0. 475211				72.00
	D DRUGS CHARGED TO PATIENTS	0. 272973				73.00
	ATIENT SERVICE COST CENTERS					-
	DICLINIC	0. 328983				90.00
	I SENI OR CARE	1. 140412				90.01
	EMERGENCY	0. 291216				91.00
	OBSERVATION BEDS (NON-DISTINCT PART	0. 605758				92.00
	REIMBURSABLE COST CENTERS					1
	HOME HEALTH AGENCY					101.00
	AL PURPOSE COST CENTERS	<u> </u>				1
16.001160						116. 00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
	Total (see instructions)					202.00

Health Financial Systems	PARKVI EW WABASH	HOSPI TAL, INC.		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015		pared: 3 pm
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cos	t Capital	Operating Cost	
	(Wkst. B, Part	(Wkst. B, Part	Net of Capita	al Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col . 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 534, 317	439, 500	2, 094, 81	7 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	0	52.00
53. 00 05300 ANESTHESI OLOGY	7,377	1, 798	5, 57	<sup>7</sup> 9 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 486, 945	442, 400	3, 044, 54	15 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	C		0 0	0	56.00
60. 00 06000 LABORATORY	2, 470, 566	125, 931	2, 344, 63	35 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	c c		0 0	0	63.00
66. 00 06600 PHYSI CAL THERAPY	1, 487, 705	91, 838	1, 395, 86	07 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	102, 214	4, 157	98, 05	57 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1	c c		1 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 059, 377	80, 261	979, 11	6 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	984, 275	75, 359	908, 91	6 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	608, 223	24, 670	583, 55	i3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 738, 348	224, 735	4, 513, 6 <sup>-</sup>	3 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	221, 431	19, 104	202, 32	27 0	0	90.00
90. 01 09001 SENI OR CARE	521, 824	35, 545	486, 27	<sup>7</sup> 9 0	0	90.01
91.00 09100 EMERGENCY	2, 483, 786	155, 290	2, 328, 49	06 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	752, 537	54, 211	698, 32	26 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
101.00 10100 HOME HEALTH AGENCY	1, 522, 030	74, 469	1, 447, 56	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 H0SPI CE	620, 208	24, 938	595, 27	0 0	0	116.00
200.00 Subtotal (sum of lines 50 thru 199)	23, 601, 164	1, 874, 206	21, 726, 95	0 8	0	200.00
201.00 Less Observation Beds	752, 537	54, 211	698, 32	26 0	0	201.00
202.00 Total (line 200 minus line 201)	22, 848, 627	1, 819, 995	21, 028, 63	32 0	0	202.00

Health Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF		CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part II Date/Time Pre 7/14/2016 3:4	epared:
			le XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and	(Worksheet C,				
	Operating Cost			6		
	Reduction	8)	/ col . 7)	_		
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS		1		. 1		_
50.00 O5000 OPERATING ROOM	2, 534, 317					50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000			52.00
53. 00 05300 ANESTHESI OLOGY	7,377					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 486, 945	18, 272, 235				54.00
56. 00 05600 RADI 0I SOTOPE	0		010000			56.00
60. 00 06000 LABORATORY	2, 470, 566	11, 142, 236				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000			63.00
66. 00 06600 PHYSI CAL THERAPY	1, 487, 705	2, 618, 335				66.00
67.00 06700 OCCUPATI ONAL THERAPY	102, 214					67.00
68.00 06800 SPEECH PATHOLOGY	1	12, 374	0.0008	31		68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 059, 377	2, 208, 685	0. 47964	12		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	984, 275	2,037,609	0. 48305	54		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	608, 223	1, 279, 902	0. 4752	11		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 738, 348	17, 358, 317	0. 2729	73		73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	221, 431	673, 078	0. 32898	33		90.00
90. 01 09001 SENI OR CARE	521, 824	457, 575	1. 1404	12		90.01
91. 00 09100 EMERGENCY	2, 483, 786	8, 529, 029	0. 2912	16		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	752, 537	1, 242, 306	0.6057	58		92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1, 522, 030	1,039,936	1.46358	30		101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPI CE	620, 208	769, 881	0.80558	39		116.00
200.00 Subtotal (sum of lines 50 thru 199)	23, 601, 164					200.00
201.00 Less Observation Beds	752, 537					201.00
202.00 Total (line 200 minus line 201)	22, 848, 627	74, 175, 166				202.00

Health Financial Systems P	ARKVIEW WABASH	HOSPI TAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 01/01/2015 To 12/31/2015		
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. 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	1		1		-	
50.00 05000 OPERATI NG ROOM	439, 500	5, 673, 899			8, 797	50.00
51.00 05100 RECOVERY ROOM	0	0	0.0000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000		0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 798					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	442, 400	18, 272, 235			8, 484	54.00
56. 00 05600 RADI OI SOTOPE	0	0	0.0000		0	56.00
60. 00 06000 LABORATORY	125, 931	11, 142, 236	0. 01130	597, 986	6, 758	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-	0.0000		0	63.00
66. 00 06600 PHYSI CAL THERAPY	91, 838					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 157					67.00
68.00 06800 SPEECH PATHOLOGY	0	12, 374			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	80, 261	2, 208, 685	0. 03633	416, 328	15, 129	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	75, 359	2, 037, 609	0. 03698	217, 622	8, 049	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	24, 670	1, 279, 902	0. 01927	5 54, 415	1, 049	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	224, 735	17, 358, 317	0. 01294	7 1, 120, 890	14, 512	73.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	19, 104	673, 078	0. 02838	3 0	0	90.00
90. 01 09001 SENI OR CARE	35, 545	457, 575	0. 07768	0 0	0	90.01
91.00 09100 EMERGENCY	155, 290	8, 529, 029	0. 01820	4, 454	81	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	54, 211	1, 242, 306	0. 04363	0	0	92.00
200.00   Total (lines 50-199)	1, 774, 799	72, 365, 349		2, 993, 470	66, 394	200. 00

Health Financial Systems	PARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PASS	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician I Anesthetist Cost	5		Medical Education Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 OPERATING ROOM	0	C		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
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
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
	0	0		0 0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	U		0 0	0	63.00
66.00 06600 PHYSI CAL THERAPY	0	U		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	67.00 68.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07200 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	1	0 0	0	/ 3. 00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 SENI OR CARE	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	
200.00 Total (lines 50-199)	0	0		0 0	-	200.00
	1				-	

Health Financial Systems P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	narodi
				10 12/31/2015	7/14/2016 3:4	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
		(from Wkst. C,		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.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	11		1			
50.00 05000 OPERATI NG ROOM	0	5, 673, 899				50.00
51.00 05100 RECOVERY ROOM	0	0	0. 00000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000			52.00
53. 00 05300 ANESTHESI OLOGY	0	750, 332				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	18, 272, 235				54.00
56. 00 05600 RADI OI SOTOPE	0	0	0.00000			56.00
60. 00 06000 LABORATORY	0	11, 142, 236				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000			63.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 618, 335				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	109, 437				67.00
68.00 06800 SPEECH PATHOLOGY	0	12, 374	0.00000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 208, 685	0.00000	0. 000000	416, 328	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,037,609	0.00000	0. 000000	217, 622	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 279, 902	0.00000	0. 000000	54, 415	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	17, 358, 317	0.00000	0. 000000	1, 120, 890	73.00
OUTPATIENT SERVICE COST CENTERS			-			
90. 00 09000 CLINIC	0	673, 078	0.00000	0. 000000	0	90.00
90. 01 09001 SENI OR CARE	0	457, 575	0.00000	0. 000000	0	90. 01
91.00 09100 EMERGENCY	0	8, 529, 029	0.00000	0. 000000	4, 454	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 242, 306	0.00000	0. 000000	0	92.00
200.00 Total (lines 50-199)	0	72, 365, 349			2, 993, 470	200. 00

Health Financial Systems F	PARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS		CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 7/14/2016 3:4	epared: 13 pm
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Inpatient Program	Outpatient Program	Outpatient Program			
	Pass-Through	Charges	Pass-Through	n		
	Costs (col. 8	J	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	C		0		50.00
51.00 05100 RECOVERY ROOM	0	C	)	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	0	)	0		54.00
56. 00 05600 RADI OI SOTOPE	0	0	)	0		56.00
60. 00 06000 LABORATORY	0	0	)	0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	)	0		63.00
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	0	)	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	)	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C	)	0		90.00
90. 01 09001 SENI OR CARE	0	C		0		90.01
91. 00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.00
200.00 Total (lines 50-199)	0	C		0		200.00

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 7/14/2016 3:4	pared: 3 pm
		Ti tl	e XVIII	Hospi tal	Cost	•
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	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			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		-	1			
50.00 05000 OPERATI NG ROOM	0. 446662		1, 223, 20	0 80	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 009832	0	146, 62	22 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 190833	0	5, 281, 22	26 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
60. 00 06000 LABORATORY	0. 221730	0	3, 302, 69	93 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
66. 00 06600 PHYSI CAL THERAPY	0. 568187	0	815, 64	13 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 933999	0	31, 10	66 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000081	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 479642	0	670, 60	05 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 483054	0	399, 7	75 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 475211	0	275, 34	16 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 272973	0	5, 842, 0	1, 698	0	73.00
OUTPATIENT SERVICE COST CENTERS	·	•	•			1
90. 00 09000 CLINIC	0. 328983	0	125, 14	18 782	0	90.00
90. 01 09001 SENI OR CARE	1. 140412	0	403, 78	31 0	0	90.01
91.00 09100 EMERGENCY	0. 291216	0	2, 483, 49	93 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 605758	0	232, 14	19 0	0	92.00
200.00 Subtotal (see instructions)		0	21, 232, 80	5 2, 480	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
0nl y Charges 202.00 Net Charges (line 200 +/- line 201)		0	21, 232, 80	2, 480	0	202.00

Health Financial Systems	PARKVI EW WABASH	HOSPI TAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider CC		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 7/14/2016 3:4	
		Title	XVIII	Hospi tal	Cost	
	Со	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	546, 361	1				50.00
51.00 05100 RECOVERY ROOM	C	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0				52.00
53. 00 05300 ANESTHESI OLOGY	1, 442					53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1,007,832	0				54.00
56. 00 05600 RADI OI SOTOPE	C	0				56.00
60. 00 06000 LABORATORY	732, 306	0				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	0				63.00
66. 00 06600 PHYSI CAL THERAPY	463, 438	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	29, 109	0				67.00
68.00 06800 SPEECH PATHOLOGY	C	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	321, 650	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	193, 113	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	130, 847	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 594, 711	464				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	41, 172	257				90.00
90. 01 09001 SENI OR CARE	460, 477	0				90.01
91. 00 09100 EMERGENCY	723, 233	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	140, 626					92.00
200.00 Subtotal (see instructions)	6, 386, 317	721				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	n C					201.00
202.00 Net Charges (line 200 +/- line 201)	6, 386, 317	721				202.00

Heal th	Financial Systems Pr	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2015	Worksheet D Part V	
			Component	CCN: 15Z310			pared <sup>.</sup>
			component	00111 102010	10 12/01/2010	7/14/2016 3:4	3 pm
			Ti tl	e XVIII	Swing Beds - SNF	Cost	
				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			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS		-		-	-	
50.00		0. 446662			0 0	0	
	05100 RECOVERY ROOM	0. 000000			0 0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
53.00	05300 ANESTHESI OLOGY	0. 009832	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 190833			0 0	0	54.00
56.00	05600 RADI OI SOTOPE	0. 000000			0 0	0	56.00
60.00	06000 LABORATORY	0. 221730			0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
66.00	06600 PHYSI CAL THERAPY	0. 568187	0		0 0	0	66.00
	06700 OCCUPATIONAL THERAPY	0. 933999	0		0 0	0	67.00
	06800 SPEECH PATHOLOGY	0. 000081	0		0 0	0	68.00
	06900 ELECTROCARDI OLOGY	0. 479642			0 0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 483054	0		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 475211	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 272973	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	1	r		- 1		
90.00	09000 CLI NI C	0. 328983			0 0	0	
90.01	09001 SENI OR CARE	1. 140412			0 0	0	
	09100 EMERGENCY	0. 291216			0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 605758	0		0 0	0	
200.00			0		0 0	0	200. 00
201.00					0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0		0 0	0	202.00

PPORTIONMENT OF MEDICAL. OTHER HEALTH SERVICES AN	D MAGGINE GOOT					2552-10
	ND VACCINE COST		CCN: 151310	Period: From 01/01/2015	Worksheet D Part V	
		Component	t CCN: 15Z310	To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
		Titl	e XVIII	Swing Beds - SNF	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS						1 50 00
50. 00 05000 OPERATING ROOM	0	0				50.00
1.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
3. 00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
66. 00 05600 RADI OI SOTOPE	0	0				56.00
0.00 06000 LABORATORY	0	0				60.00
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
6.00 06600 PHYSI CAL THERAPY	0	0				66.00
57.00 06700 OCCUPATIONAL THERAPY	0	0				67.00
8.00 06800 SPEECH PATHOLOGY	0	0				68.00
9.00 06900 ELECTROCARDI OLOGY	0	0				69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
20.00 09000 CLINIC	0	-	1			90.00
20. 01 09001 SENI OR CARE	0	0				90.01
21.00 09100 EMERGENCY	0	0				91.00
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1			92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges		_				000 00
202.00  Net Charges (line 200 +/- line 201)	0	0	1			202.00

Health Financial Systems P	PARKVIEW WABASH HOSPITAL, INC. In Lieu of Form CMS						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 151310	Peri od:	Worksheet D		
				From 01/01/2015			
				To 12/31/2015			
		т: +	le XIX	Hospi tal	7/14/2016 3:4 PPS	<u>3 pili</u>	
Cost Conton Decemination	ntor Description Capital Swit						
Cost Center Description	Capital	Swing Bed	Reduced		Per Diem (col.		
	Related Cost	Adjustment	Capital	Days	3 / col. 4)		
	(from Wkst. B,		Related Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 ADULTS & PEDIATRICS	279, 221	10, 149	269, 07	2, 174	123.77	30.00	
43.00 NURSERY	0			0 0	0.00	43.00	
200.00 Total (lines 30-199)	279, 221		269, 07	2, 174		200.00	
Cost Center Description	I npati ent	Inpati ent					
· ·	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6,00	7.00	1				
INPATIENT ROUTINE SERVICE COST CENTERS					-		
30. 00 ADULTS & PEDIATRICS	88	10, 892				30.00	
43.00 NURSERY	0					43.00	
200.00 Total (lines 30-199)	88	10, 892				200.00	
	00	1 10,072	1			200.00	

Health Financial Systems	PARKVI EW WABASH				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPITAL COSTS	Provi der		Period: From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	439, 500	5, 673, 899	0. 07746	0 79, 267	6, 140	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	1, 798	750, 332	0. 00239	10, 998	26	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	442, 400	18, 272, 235	0. 02421	2 84, 159	2, 038	54.00
56. 00 05600 RADI OI SOTOPE	0	0	0. 00000	0 0	0	56.00
60. 00 06000 LABORATORY	125, 931	11, 142, 236	0. 01130	73, 511	831	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRAN	S. 0	0	0. 00000	0 0	0	63.00
66. 00 06600 PHYSI CAL THERAPY	91, 838	2, 618, 335	0. 03507	1, 751	61	66.00
67.00 06700 OCCUPATIONAL THERAPY	4, 157	109, 437	0. 03798	435	17	67.00
68.00 06800 SPEECH PATHOLOGY	0	12, 374	0.00000	0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	80, 261	2, 208, 685	0. 03633	41, 219	1, 498	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENT 75, 359	2,037,609	0. 03698	23, 971	887	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	24,670	1, 279, 902	0, 01927	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	224, 735			7 134, 914	1, 747	73.00
OUTPATIENT SERVICE COST CENTERS				1		
90.00 09000 CLINIC	19, 104	673, 078	0. 02838	3 0	0	90.00
90. 01 09001 SENI OR CARE	35, 545				0	
91.00 09100 EMERGENCY	155, 290				1, 266	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PA					0	
200.00 Total (lines 50-199)	1, 774, 799			519, 782	-	

Health Financial Systems	PARKVI EW WABASH	HOSPI 1	AL, INC.		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS	TS	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015		nared:
						7/14/2016 3:4	
				le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allie	d Health	All Other	Swi ng-Bed	Total Costs	
		(	Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	st Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00	2	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	C	)	0	)	0 0	0	30.00
43. 00 04300 NURSERY	C		0		0	0	43.00
200.00 Total (lines 30-199)	C	D	0	)	0	0	200.00
Cost Center Description	Total Patient	Per Di	em (col.	I npati ent	I npati ent		
	Days	5 ÷	col. 6)	Program Days	s Program		
					Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6.00	7	7.00	8.00	9.00	]	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDIATRICS	2, 174	ţ	0.00	8	38 0		30.00
43.00 04300 NURSERY	0	)	0.00		0 0		43.00
200.00 Total (lines 30-199)	2, 174	t		8	38 O		200. 00

51.00         05100         RECOVERY ROOM         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         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         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         0	52-10
Initiodal costs         To         12/31/2015         Date/Time Preparity           Title XIX         Hospital         PPS           Cost Center Description         Non Physician         Nursing School         Allied Health         All Other         Total Cost           Anesthetist         Cost         Cost         Cost         Cost         Allied Health         All Other         Guardian of Cost           Ansthetist         Cost         0         0         0         0         0         0         0           Soloo         OPERATING ROOM         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         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         <	
Cost Center Description         Non Physician Anesthetist Cost         Nursing School         Allied Health I         All Other Medical Education Cost         Total Cost (sum of col 1 through col. 4)           ANCILLARY SERVICE COST CENTERS         0         0         0         0         0         0         0           50.00         05000         OPERATING ROOM         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         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         0         0         0         0         0         0         0         0         0         0	red
Cost Center Description       Non Physician Anesthetist Cost       Nursing School       Allied Health       Allother       Total Cost         Anesthetist Cost       Cost       0       0       0       0       1.00       2.00       3.00       4.00       5.00         ANCILLARY SERVICE COST CENTERS       0       0       0       0       0       0         50.00       05000 OPERATING ROOM       0       0       0       0       0       0         51.00       05100       RECOVERY ROOM       0       0       0       0       0       0         52.00       05200       DELIVERY ROOM & LABOR ROOM       0       0       0       0       0       0	
Anesthetist Cost         Medical Education Cost         (sum of col 1 through col. 4)           1.00         2.00         3.00         4.00         5.00           ANCI LLARY SERVICE COST CENTERS         1.00         0         0         0         0           50.00         05000         OPERATI NG ROOM         0         0         0         0         0         0           51.00         05100         RECOVERY ROOM         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         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         0	
Cost         Education Cost         through col. 4)           1.00         2.00         3.00         4.00         5.00           ANCI LLARY SERVICE COST CENTERS         50.00         05000 OPERATING ROOM         0         0         0         0           51.00         05100 RECOVERY ROOM         0         0         0         0         0         0         0           52.00         05200 DELI VERY ROOM & LABOR ROOM         0         0         0         0         0         0	
ANCI LLARY SERVICE COST CENTERS         4)           50.00         05000         OPERATI NG ROOM         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         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         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	
ANCI LLARY SERVICE COST CENTERS         0         2.00         3.00         4.00         5.00           50.00         05000         OPERATI NG ROOM         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         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         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<	
ANCI LLARY         SERVICE         COST         CENTERS           50.00         05000         OPERATI NG ROOM         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         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         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	
50.00         05000         OPERATING ROOM         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         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         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         0	
51.00         05100         RECOVERY ROOM         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         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         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         0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0	51.00
	52.00
	53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0 0	54.00
56. 00 05600 RADI 0I SOTOPE 0 0 0 0	56.00
60. 00 06000 LABORATORY 0 0 0 0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0	63.00
66.00 06600 PHYSICAL THERAPY 0 0 0 0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0	67.00
	68.00
	69.00
	71.00
	72.00
	73.00
OUTPATI ENT SERVI CE COST CENTERS	
	90.00
	90.01
	91.00 92.00
	92.00 00.00
	JU. UU

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS	S Provi der		Period: From 01/01/2015 To 12/31/2015		
					7/14/2016 3:4	3 pm
i			tle XIX	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		Inpati ent	
	Outpati ent	(from Wkst. C	5	Ratio of Cost		
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	I	1	1		
50.00 05000 OPERATI NG ROOM	0	5, 673, 89				
51.00 05100 RECOVERY ROOM	0		0.0000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0.0000			52.00
53. 00 05300 ANESTHESI OLOGY	0	750, 33	2 0. 00000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	18, 272, 23	5 0. 00000			54.00
56. 00 05600 RADI OI SOTOPE	0		0.0000			56.00
60. 00 06000 LABORATORY	0	11, 142, 23	6 0. 00000	0.000000	73, 511	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0.0000	0.000000	0	63.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 618, 33	5 0. 00000	0.000000	1, 751	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	109, 43	7 0. 00000	0.000000	435	67.00
68.00 06800 SPEECH PATHOLOGY	0	12, 37	4 0. 00000	0.000000	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 208, 68	5 0. 00000	0.000000	41, 219	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,037,60	9 0. 00000	0.000000	23, 971	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 279, 90	0. 00000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	17, 358, 31	7 0. 00000	0.000000	134, 914	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	673, 07	B 0. 00000	0.000000	0	90.00
90. 01 09001 SENI OR CARE	0	457, 57	5 0. 00000	0. 000000	0	90.01
91.00 09100 EMERGENCY	0	8, 529, 02	9 0. 00000	0.000000	69, 557	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 242, 30	6 0. 00000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	72, 365, 34	9		519, 782	200. 00

Health Financial Systems P	ARKVIEW WABASH H	IOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS		CCN: 151310	Period: From 01/01/2015 To 12/31/2015	7/14/2016 3:4	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpatient			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 O5000 OPERATI NG ROOM	0	C		0		50.00
51.00 05100 RECOVERY ROOM	0	C		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.00
53.00 05300 ANESTHESI OLOGY	0	C		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
56. 00 05600 RADI 0I SOTOPE	0	C		0		56.00
60. 00 06000 LABORATORY	0	C		0		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0		63.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		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
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0		90.00
90. 01 09001 SENI OR CARE	0	0		0		90.01
91. 00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92.00
200.00   Total (lines 50-199)	0	0		0		200.00

Health Financial Systems P	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151310	Peri od: From 01/01/2015 To 12/31/2015		
		Ti +	le XIX	Hospi tal	7/14/2016 3:4 PPS	3 pili
		111	Charges	nospi tai	Costs	
Cost Center Description	Cost to Charge	DDS Doimburcod		Cost	PPS Services	
cost center beschiption		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(366 1131.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5,00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 446662	0	670, 12	20 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0.009832	0	82, 9 <sup>.</sup>	10 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 190833	0	2, 059, 80	58 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56.00
60. 00 06000 LABORATORY	0. 221730	0	1, 035, 30	04 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
66. 00 06600 PHYSI CAL THERAPY	0. 568187	0	191, 20	59 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 933999	0	94	46 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000081	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 479642	0	167, 99	99 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 483054	0	299, 70	64 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 475211	0	214, 70	02 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 272973	0	1, 157, 0	70 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 328983	0	23, 20	0 0	0	90.00
90. 01 09001 SENI OR CARE	1. 140412	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 291216	0	1, 804, 52	25 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 605758	0	81, 90	55 0	0	92.00
200.00 Subtotal (see instructions)		0	7, 789, 64	18 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	7, 789, 64	48 0	0	202.00

Health Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST		CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pro 7/14/2016 3:4	
	-	Ti t	le XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS	000.017					
50. 00 05000 OPERATING ROOM	299, 317	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	815	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	393, 091	0				54.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
60. 00 06000 LABORATORY	229, 558	0				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
66. 00 06600 PHYSI CAL THERAPY	108, 677					66.00
67.00 06700 OCCUPATI ONAL THERAPY	884	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	80, 579					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	144, 802					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	102, 029					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	315, 849	0				73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	7,634	0				90.00
90. 01 09001 SENI OR CARE	0	0				90.01
91.00 09100 EMERGENCY	525, 507	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	49, 651	0				92.00
200.00 Subtotal (see instructions)	2, 258, 393	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	2, 258, 393	0				202.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Pre 7/14/2016 3:4	pare
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		2, 342	1.
00	Inpatient days (including private room days, excluding swing-bed days,			2, 342	
00	Private room days (excluding swing-bed and observation bed days		ivate room days,	2, 1, 1	3.
	do not complete this line.		<b>J</b>		
00	Semi-private room days (excluding swing-bed and observation bed			1, 736	
00	Total swing-bed SNF type inpatient days (including private room reporting period	n days) through Decembe	r 31 of the cost	82	5
00	Total swing-bed SNF type inpatient days (including private room	davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	86	7.
~ ~	reporting period				
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8.
00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	910	9
00	newborn days)		Sinnig bed and	,10	ĺ
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	82	10
	through December 31 of the cost reporting period (see instructi			_	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11
2. 00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
. 00	through December 31 of the cost reporting period	only (meruaring privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar year				
	Medically necessary private room days applicable to the Program	n (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
0.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	1 10
. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost		17
	reporting period	5			
3. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18
00	reporting period	through December 21 of	the east	0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through becember 31 01	the cost	0.00	19
). 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions)			3, 876, 081	
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 3	a of the cost reportin	a period (line 6	0	23
. 00	x line 18)	in on the cost reporting	g period (inic o	0	25
I. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)			_	
5.00	Swing-bed cost applicable to NF type services after December 37	of the cost reporting	period (line 8	0	25
5.00	x line 20) Total swing-bed cost (see instructions)			140, 886	26
	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		3, 735, 195	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	$\label{eq:General} \textit{General inpatient routine service charges (excluding swing-bed}$	and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	lino 20)		0	30
	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 (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minu	ıs line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x line	9 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost an	nd private room cost di	fferential (line	3, 735, 195	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PART IT - HUSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see i			1, 718. 12	38
	Program general inpatient routine service cost (line 9 x line 3	-		1, 563, 489	
	Medically necessary private room cost applicable to the Program	. ,		0	40
	Total Program general inpatient routine service cost (line 39 -	line 40)		1, 563, 489	1 / 1

		PARKVIEW WABASH				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Prep	pared:
						7/14/2016 3:4	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription		Inpatient Days			(col. 3 x col.	
				col. 2)		4)	
42.00	NUDCEDV (+; +Lo V & VLV only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	0 0	0	42.00
43.00	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNI T						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						46.00 47.00
47.00	Cost Center Description						47.00
	· .					1.00	
	Program inpatient ancillary service cost (W					953, 534	48.00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructio	ons)		2, 517, 023	49.00
50.00	Pass through costs applicable to Program in	patient routine	services (from	n Wkst. D. sum	of Parts I and	0	50.00
	Pass through costs applicable to Program in and IV)		y services (fr	rom Wkst. D, s	um of Parts II	0	51.00
	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		lated non nh	voi ai an anaath	atiot and	0	52.00
53.00	medical education costs (line 49 minus line	5 1	erated, non-phy	si ci an anestri	etist, and	0	53.00
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient opera	ting cost and ta	irget amount (I	ine 56 minus	line 53)	0	57.00
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost ro	eporting period	ending 1006 i	undated and co	mounded by the	0 0.00	58.00 59.00
57.00	market basket	eporting period	ending 1990, c		ipounded by the	0.00	37.00
	Lesser of lines 53/54 or 55 from prior year					0.00	
61.00	If line 53/54 is less than the lower of line the lower of line the second secon					0	61.00
	which operating costs (line 53) are less the amount (line 56), otherwise enter zero (see		IS (TITIES 54 X	00), 01 1% 01	the target		
	Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive pay	ment (see instru	ictions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of the	e cost reporti	ng period (See	140, 886	64.00
	instructions)(title XVIII only)	Ū.					
65.00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the c	cost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line 6	55)(title XVII	l only). For	140, 886	66.00
	CAH (see instructions)				-		
67.00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31 d	of the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	a 68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER 1						
	Skilled nursing facility/other nursing faci	2		• •			70.00
	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00
	Medically necessary private room cost appli	,	line 14 x li	ne 35)			72.00 73.00
74.00	Total Program general inpatient routine ser						74.00
75.00	Capital-related cost allocated to inpatient	routine service	e costs (from V	Vorksheet B, P	art II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76.00
	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 min	us line 77)					78.00
79.00	Aggregate charges to beneficiaries for exce			· · · · · · · · · · · · · · · · · · ·			79.00
80. 00 81. 00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	UST IIMITATION	i (line /8 min	us line /9)		80.00 81.00
	Inpatient routine service cost per drem rum		)				82.00
	Reasonable inpatient routine service costs		· .				83.00
84.00	Program inpatient ancillary services (see i		>				84.00
	Utilization review - physician compensation Total Program inpatient operating costs (su	•					85.00 86.00
50.00	PART IV - COMPUTATION OF OBSERVATION BED PAS		n ough (00)				00.00
	Total observation bed days (see instruction	s)					87.00
	Adjusted general inpatient routine cost per					1, 718. 12	
07.00	Observation bed cost (line 87 x line 88) (s	ee instructions)				752, 537	07.00

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	
				To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	279, 221	3, 876, 081	0. 07203	7 752, 537	54, 211	90.00
91.00 Nursing School cost	0	3, 876, 081	0.00000	752, 537	0	91.00
92.00 Allied health cost	0	3, 876, 081	0.00000	752, 537	0	92.00
93.00 All other Medical Education	0	3, 876, 081	0.00000			93.00

MPUTA	ATION OF INPATIENT OPERATING COST	Provider CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Pre	pare
		Title XIX	Hospi tal	7/14/2016 3: 4 PPS	<u>3 pm</u>
	Cost Center Description			1.00	
I	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS	avaluding nawharn)		2 242	1 1
	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			2, 342 2, 174	
00	Private room days (excluding swing-bed and observation bed days		ivate room days,	0	3
	do not complete this line. Semi-private room days (excluding swing-bed and observation be	t dave)		1, 736	4
	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	82	
	reporting period			0	
	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) arter December	31 of the cost	0	6
	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	86	7
00	reporting period Total swing-bed NF type inpatient days (including private room	dave) after December 2	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	uays) arter becember 3	T OF THE COST	0	
	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	88	9
	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on	v (including private r	oom davs)	0	10
	through December 31 of the cost reporting period (see instruction	ons)	5 /	-	
	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11
	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period			0	1.1
	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	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		I	0	
	Medicare rate for swing-bed SNF services applicable to services	s through December 31 c	f the cost		17
	reporting period Medicare rate for swing-bed SNF services applicable to service:	s after December 31 of	the cost		18
	reporting period				
	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period Total general inpatient routine service cost (see instructions)			2 074 001	21
	Swing-bed cost applicable to SNF type services through December		ing period (line	3, 876, 081 0	
	5 x line 17)		0 1 1	_	
	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	g period (line 6	0	23
	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19) Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	pariod (line 9	0	25
	x line 20)	i of the cost reporting	perrou (rine o	0	20
1	Total swing-bed cost (see instructions)			140, 886	
	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		3, 735, 195	27
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	30
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)	us line 22) (see instruc	tions)	0.00	
	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line			0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36
	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	nd private room cost di	fferential (line	3, 735, 195	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			1 740 40	1
	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3	-		1, 718. 12 151, 195	
. 00	Medically necessary private room cost applicable to the Program	n (line 14 x line 35)		0	40
00	Total Program general inpatient routine service cost (line 39 -	+ line 40)		151, 195	41

JMPUT	ATI ON OF INPATIENT OPERATING COST		Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Pre	
						7/14/2016 3:4	
	Cost Center Description	Total Inpatient Cost 1.00	Total	I e XIX Average Per Diem (col. 1 col. 2) 3.00		PPS Program Cost (col. 3 x col. 4) 5.00	
. 00	NURSERY (title V & XIX only)	0					) 42.
	Intensive Care Type Inpatient Hospital Units	-				-	
. 00	INTENSIVE CARE UNIT						43.
. 00	CORONARY CARE UNI T						44.
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						40
	Cost Center Description			•			
00						1.00	10
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			nc)		157, 708	
00	PASS THROUGH COST ADJUSTMENTS	FI Enrough 48)(	see instructio	) 		308, 903	5 49
00	Pass through costs applicable to Program inpa	tient routine	services (from	n Wkst. D, su	m of Parts I and	10, 892	2 50
	111)						
. 00	Pass through costs applicable to Program inpa	itient ancillar	ry services (fr	om Wkst. D, s	sum of Parts II	14, 511	51
00	and IV) Total Program excludable cost (sum of lines 5	i0 and 51)				25, 403	3 52
. 00	Total Program inpatient operating cost exclude		lated, non-phy	sician anestl	netist, and	283, 500	
	medical education costs (line 49 minus line 5						
~~	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operati	ng cost and ta	irget amount (I	ine 56 minus	line 53)	C	
00	Bonus payment (see instructions)					C	
00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng 1996, ι	updated and c	ompounded by the	0.00	) 59
00	market basket Lesser of lines 53/54 or 55 from prior year o	ost report un	dated by the m	arket basket		0.00	60
	If line 53/54 is less than the lower of lines				the amount by	C	
	which operating costs (line 53) are less thar						
~~	amount (line 56), otherwise enter zero (see i	nstructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	nt (see instru	uctions)				
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cost	s through Dece	ember 31 of the	e cost report	ng period (See	C	64
~~	instructions)(title XVIII only)						
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s arter Decemb	er 31 of the c	cost reporting	g period (See	C	) 65
. 00	Total Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line 6	5)(title XVI	ll only). For	c	66
	CAH (see instructions)				•		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost r	eporting period	C	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	, costs after D	ecomber 31 of	the cost ren	orting period		68
. 00	(line 13 x line 20)		ecember 51 01	the cost rep	bitting period		
. 00	Total title V or XIX swing-bed NF inpatient r	routine costs (	line 67 + line	e 68)		C	) 69
~~	PART III - SKILLED NURSING FACILITY, OTHER NU				<u>,</u>		1 70
. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	5			)		70
	Program routine service cost (line 9 x line 7		The 70 ÷ Trhe	2)			72
	Medically necessary private room cost applica		n (line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi						74
. 00	Capital-related cost allocated to inpatient r	outine service	e costs (from V	lorksheet B, I	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lir	ne 2)					76
	Program capital -related costs (line 9 x line	,					77
00	Inpatient routine service cost (line 74 minus	,					78
	Aggregate charges to beneficiaries for excess						79
00 00	Total Program routine service costs for compa		ost limitation	ı (IINE 78 mi)	nus line 79)		80
00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		)				82
00	Reasonable inpatient routine service costs (s		· .				83
00	Program inpatient ancillary services (see ins		-				84
	Utilization review - physician compensation (						85
00	Total Program inpatient operating costs (sum		rough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					438	3 87
	5		1100 2)			1, 718. 12	
. 00	Adjusted general inpatient routine cost per c	niem (nine z/÷	· i i ne z)			1,710.12	

Health Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	
				To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	279, 221	3, 876, 081	0. 07203	7 752, 537	54, 211	90.00
91.00 Nursing School cost	0	3, 876, 081	0.00000	752, 537	0	91.00
92.00 Allied health cost	0	3, 876, 081	0.00000	752, 537	0	92.00
93.00 All other Medical Education	0	3, 876, 081	0.00000			93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151310	Period:	Wavelie has to D	
			From 01/01/2015	Worksheet D-3	
			To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 738, 775		30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		0.4444	(0 440 5 (7	F0 70/	50.00
50. 00 05000 OPERATING ROOM		0. 4466		50, 726	
51.00 05100 RECOVERY ROOM		0.0000		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
53. 00 05300 ANESTHESI OLOGY		0.0098		142	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE		0. 1908		66, 867	1
60. 00 06000 LABORATORY		0. 0000 0. 2217		0 132, 591	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2217			1
66. 00 06600 PHYSI CAL THERAPY		0. 5681		0 40, 159	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 9339		25, 109	
68. 00 06800 SPEECH PATHOLOGY		0.0000		25, 109	1
69. 00 06900 ELECTROCARDI OLOGY		0. 4796		199, 688	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.4830		105, 123	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4050		25, 859	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2729		305, 973	
OUTPATIENT SERVICE COST CENTERS		0.2727	1, 120, 070	000, 770	/ 0. 00
90. 00 09000 CLINIC		0. 3289	83 0	0	90.00
90. 01 09001 SENI OR CARE		1. 1404		0	1
91. 00 09100 EMERGENCY		0. 2912		-	91.00
92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART		0.6057		0	1
200.00 Total (sum of lines 50-94 and 96-98)			2, 993, 470	953, 534	
201.00 Less PBP Clinic Laboratory Services-Progr	ram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			2, 993, 470		202.00

Health Financial Systems	PARKVIEW WABASH HOSPITAL, INC.		In Lie	u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	;
	Componen	t CCN: 15Z310	From 01/01/2015 To 12/31/2015	Date/Time Pre	narod
	Component	L CON. 152510	10 12/31/2013	7/14/2016 3: 4	
	Titl	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			885		30.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS		0.4444	2	0	50.00
50.00 O5000 OPERATING ROOM		0. 44666		0	
51.00 05100 RECOVERY ROOM		0.00000		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
53.00 05300 ANESTHESI OLOGY		0.00983		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE		0. 19083		106	
60. 00 06000 LABORATORY		0.00000		-	•
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 22173		3, 340	
66. 00 06600 PHYSI CAL THERAPY		0. 56818			
67. 00 06700 OCCUPATIONAL THERAPY		0. 93399			
68. 00 06800 SPEECH PATHOLOGY		0. 00008			
69. 00 06900 ELECTROCARDI OLOGY		0. 47964			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 48305			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 47521			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 27297		-	
OUTPATIENT SERVICE COST CENTERS		012/2//	20,007	,,202	/ 01 00
90. 00 09000 CLINIC		0. 32898	33 0	0	90.00
90. 01 09001 SENI OR CARE		1, 14041		0	
91. 00 09100 EMERGENCY		0. 29121		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.60575		0	
200.00 Total (sum of lines 50-94 and 96-98			87, 895	37, 635	200.00
201.00 Less PBP Clinic Laboratory Services			0		201.00
202.00 Net Charges (line 200 minus line 20			87, 895		202.00

Health Financial Systems PARKVIEW WABAS	H HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet D-3 Date/Time Pre	
				7/14/2016 3:4	
	Tit	le XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			144, 494		30.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		0.4444		05 404	50.00
50. 00 05000 OPERATI NG ROOM		0.44660			
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0.0000		0 108	
53. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1908			
56. 00 05600 RADI 0L0G1-DI AGNOSTI C		0. 1908.			
60, 00 06000 LABORATORY		0. 22173		16, 300	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2217.		10, 300	
66. 00 06600 PHYSI CAL THERAPY		0. 56818		995	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 93399			
68. 00 106800 SPEECH PATHOLOGY		0. 00008		400	1
69. 00 06900 ELECTROCARDI OLOGY		0. 47964		-	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4830			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 4752		0	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2729			
OUTPATIENT SERVICE COST CENTERS		012727		00,020	10100
90. 00 09000 CLINIC		0. 32898	33 0	0	90.00
90. 01 09001 SENI OR CARE		1. 1404		0	
91. 00 09100 EMERGENCY		0. 2912		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.60575		0	
200.00 Total (sum of lines 50-94 and 96-98)			519, 782	157, 708	
201.00 Less PBP Clinic Laboratory Services-Program only cha	arges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)	<b>č</b>		519, 782		202.00
		1	1 017,702	I	1202.00

	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 151310 Period: From 01/01. To 12/31.	/2015 /2015	Worksheet E Part B Date/Time Prep 7/14/2016 3:43	
	Title XVIII Hospita	1	Cost	
			1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES		6 297 029	1 00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)		6, 387, 038 0	1.00 2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5		0. 000 0	5.00 6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6, 387, 038	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
12.00	Reasonable charges Ancillary service charges		0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge bas	sis	0	15.00
	Amounts that would have been realized from patients liable for payment for services on a chargeba		0	16.00
47 00	had such payment been made in accordance with 42 CFR §413.13(e)		0,000000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)		0. 000000 0	17.00 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see		0	19.00
20.00	instructions)			20.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		6, 450, 908	
	Interns and residents (see instructions)		0	22.00
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 8 and 9)		0	23.00 24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		16, 478 3, 597, 939	25.00 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	ee	2, 836, 491	
	instructions)			
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)		0	28.00 29.00
			2, 836, 491	30.00
	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		2, 836, 491	32.00
33.00	Composi te rate ESRD (from Wkst. I-5, line 11)		0	33.00
	Allowable bad debts (see instructions)		474, 751	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions)		308, 588 375, 004	
	Subtotal (see instructions)		3, 145, 079	37.00
	MSP-LCC reconciliation amount from PS&R		0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		0	39.00 39.50
	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
	Subtotal (see instructions) Sequestration adjustment (see instructions)		3, 145, 079 62, 902	40. 00 40. 01
	Interim payments		3, 160, 561	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		-78, 384 0	43.00 44.00
	§115. 2		0	44.00
44.00				
44.00	TO BE COMPLETED BY CONTRACTOR		-	00 00
44. 00 90. 00	Original outlier amount (see instructions)		0	90.00 91.00
44.00 90.00 91.00			0	90.00 91.00 92.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151310	Period: From 01/01/2015 To 12/31/2015		pared
		Ti tl	e XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	t 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 List separately each retroactive lump sum adjustment		2, 184, 2	22 0	2, 884, 661 0	1. 2. 3.
00	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					
01	ADJUSTMENTS TO PROVIDER			0 05/08/2015	69, 700	3.
02				0 07/10/2015	206, 200	3.
03 04				0	0	3
04 05				0	0	3
	Provider to Program	1				
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52 53				0	0	3
53 54				0	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	275, 900	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, 184, 2	22	3, 160, 561	4
	TO BE COMPLÉTED 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)					5
	Program to Provider	1		1		
01	TENTATI VE TO PROVIDER			0	0	5
02 03				0	0	5
13	Provider to Program	I	<u> </u>	U	0	0
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52	Subtatal (sum of lines E 01 E 40 minut sum of lin			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)					6
01	SETTLEMENT TO PROVIDER		72, 6	69	0	6
02	SETTLEMENT TO PROGRAM		_	0	78, 384	6
00	Total Medicare program liability (see instructions)		2, 256, 8		3, 082, 177	7
			)	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
00	Name of Contractor		)	1.00	2.00	8

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CCN: 151310 CCN: 15Z310	Period: From 01/01/2015 To 12/31/2015		epare
		Titl	e XVIII	Swing Beds - SNI		-
		I npati er	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider	1.00	154, 67		0	1.
00	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			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)					3.
	Program to Provider					
D1	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03				0	0	-
04 05				0	0	-
55	Provider to Program	1			0	1 3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	
53				0	0	
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		-
77	3, 50-3, 98)			0		'  <sup>3</sup>
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)		154, 67	78	0	4
	TO BE COMPLETED BY CONTRACTOR	1	1		1	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					1
)1	TENTATI VE TO PROVIDER		1	0	0	1 5
)2				0	0	
)3				0	0	5
	Provider to Program	-			•	
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
99 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	-
	5. 50-5. 98)					
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		19, 08	39	0	6
)2	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		173, 76		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	1	2	1.00	2.00	8

Heal th	Financial Systems PARKVIEW WABASH HOS	SPITAL, INC.	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151310	Period: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	615	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	-12		910	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			363	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	-12		1, 736	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			77, 514, 426	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li			813, 233	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of colline 168 $$	ertified HIT technology	Wkst. S-2, Pt. I	286, 474	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			269, 601	8.00
9.00	Sequestration adjustment amount (see instructions)			5, 392	9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		264, 209	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ne 31) (see instruction	s)	264, 209	32.00

Heal th	Financial Systems PARKVIEW WABASH HOSF	PITAL, INC.	In Lie	u of Form CMS-:	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151310	Period: From 01/01/2015	Worksheet E-2	
		Component CCN: 15Z310	To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		142, 295	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		38, 011	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst				
4.00	Per diem cost for interns and residents not in approved teaching	ng program (see		0.00	4.00
	instructions)			_	
5.00	Program days		82	0	5.00
6.00	Interns and residents not in approved teaching program (see ins			0	6.00
7.00	Utilization review - physician compensation - SNF optional meth	nod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		180, 306	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		180, 306	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applica professional services)	able to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		180, 306	0	12.00
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	(excl ude coi nsurance	2, 993	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14	1)	177, 313	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	0	0	18.00
19.00			177, 313	0	19.00
19.01	Sequestration adjustment (see instructions)		3, 546	0	19.01
20.00	Interim payments		154, 678	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, ar	nd 21)	19, 089	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	ce with CMS Pub. 15-2,	0	0	23.00
	Level of Crosse		I I		I

	Financial Systems PARKVIEW WABASH H			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151310	Period: From 01/01/2015	Worksheet E-3 Part V	
			To 12/31/2015	Date/Time Pre	
			11	7/14/2016 3:4	3 pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	E PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			2, 517, 023	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruct	i ons)		0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			2, 517, 023	
5.00	Primary payer payments			0	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 542, 193	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
7 00	Reasonable charges			0	7 7 00
7.00 8.00	Routine service charges			0	
8.00 9.00	Ancillary service charges			0	
9.00 10.00	Organ acquisition charges, net of revenue Total reasonable charges			0	
10.00	Customary charges			0	10.00
11.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable f			0	
12.00	had such payment been made in accordance with 42 CFR 413.13(	1 5	in a charge basi s	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0,000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete c	only if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)	-			
16.00	Excess of reasonable cost over customary charges (complete o	only if line 6 exceeds lin	e 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17.00
10.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	- 4 - Line - 40)		0	1 1 0 00
18.00	Direct graduate medical education payments (from Worksheet E	-4, 11ne 49)		0 2, 542, 193	
19.00 20.00	Cost of covered services (sum of lines 6, 17 and 18) Deductibles (exclude professional component)			2, 542, 193 250, 652	
20.00	Excess reasonable cost (from Line 16)			250, 852	
22.00	Subtotal (line 19 minus line 20 and 21)			2, 291, 541	
23.00	Coi nsurance			2, 271, 341	
24.00	Subtotal (line 22 minus line 23)			2, 291, 541	
25.00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		17, 552	
26.00	Adjusted reimbursable bad debts (see instructions)	, ( 100, 000, 010)		11, 409	
27.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		17, 552	
28.00	Subtotal (sum of lines 24 and 25, or line 26)	<i>`</i>		2, 302, 950	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29.50
29. 99	Recovery of Accel erated Depreciation			0	29.99
30.00	Subtotal (see instructions)			2, 302, 950	
30. 01	Sequestration adjustment (see instructions)			46, 059	
31.00				2, 184, 222	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 31,			72, 669	
34.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	34.00

ANCE	Financial Systems PARKVIEW WABASH SHEET (If you are nonproprietary and do not maintain	Provi der		Period:	u of Form CMS-2 Worksheet G	
nd-ty	pe accounting records, complete the General Fund column onl	у)		From 01/01/2015 To 12/31/2015	Date/Time Pre	pare
		General Fund	Specific Purpose Fund	Endowment Fund	7/14/2016 3:4 Plant Fund	<u>3 pr</u>
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS	4/5 445				
	Cash on hand in banks	465, 415			0	
	Temporary investments Notes receivable	0			0	
	Accounts receivable	7, 140, 577			0	
	Other receivable	-459, 231		0 0	0	
0	Allowances for uncollectible notes and accounts receivable	0		0 0	0	6
	Inventory	379, 758		0 0	0	
	Prepaid expenses	87, 893		0 0	0	
	Other current assets	170, 124		0	0	
	Due from other funds	-20, 110, 885			0	
	Total current assets (sum of lines 1-10)	-12, 326, 349		0	0	11
	Land	985, 290		0 0	0	1 12
	Land improvements	0		0 0	0	
	Accumulated depreciation	0		0 0	0	14
	Bui I di ngs	20, 662, 930		0 0	0	
	Accumulated depreciation	-4, 132, 794		0 0	0	
	Leasehold improvements	-3, 130		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Fixed equipment	117, 827			0	1
	Accumulated depreciation Automobiles and trucks	-20, 155 23, 432			0	
	Accumulated depreciation	-11, 098			0	
	Major movable equipment	2, 646, 597			0	
	Accumul ated depreciation	-877, 236		0 0	0	
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	26
00	HIT designated Assets	0		0 0	0	27
00	Accumul ated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	19, 391, 663		0 0	0	30
	DTHER ASSETS	270.047		0 0	0	3.
	Deposits on Leases	-270, 967			0	
	Due from owners/officers	0			0	
	Other assets	0		0 0	0	
	Total other assets (sum of lines 31-34)	-270, 967		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	6, 794, 347		0 0	0	
C	CURRENT LI ABI LI TI ES					
	Accounts payable	377, 933		0 0	0	
	Salaries, wages, and fees payable	361, 614		0 0	0	
	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	0		0	0	
	Deferred income Accelerated payments	0		0 0	U U	41
	Due to other funds			0 0	0	42
	Other current liabilities	-747, 682			0	
	Total current liabilities (sum of lines 37 thru 44)	-8, 135		0 0	0	
	LONG TERM LIABILITIES					
	Mortgage payable	0		0 0	0	46
	Notes payable	0	(	0 0	0	
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	123, 329		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	123, 329		0 0	0	
	Total liabilities (sum of lines 45 and 50)	115, 194	(	0 0	0	51
	CAPITAL ACCOUNTS General fund balance	6, 679, 153				52
	Specific purpose fund	0,077,100		0		53
	Donor created - endowment fund balance - restricted					54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	6, 679, 153		0 0	0	
00	Total liabilities and fund balances (sum of lines 51 and	6, 794, 347		0 0	0	60

Heal th	Financial Systems P/	ARKVIEW WABASH F	IOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES			CCN: 151310	Period: From 01/01/2015 To 12/31/2015	Worksheet G-1 Date/Time Pre 7/14/2016 3:4	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00		0.00	1.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ADDITIONS (CREDIT ADJUSTMENTS) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	1.00 -51,113,356 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 21,600,000 36,192,509 57,792,509 -51,113,356 6,679,153		4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 6, 679, 153		0		18.00 19.00
		Endowment Fund	PI ant	Fund			
1 00	Fund halonana at havinging of gooded	6.00	7.00	8.00	0		1.00
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) ADDITIONS (CREDIT ADJUSTMENTS)	0	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)	00	0 0 0 0 0 0 0		000		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

STATE	Financial Systems PARKVIEW WABASH HOSE IENT OF PATIENT REVENUES AND OPERATING EXPENSES		CCN: 151310	Peri od:	Worksheet G-2	2552-1
OTATE				From 01/01/2015 To 12/31/2015	Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services			( a)	0.4/0.0/0	1
1.00	Hospi tal		3, 162, 2	62	3, 162, 262	
2.00	SUBPROVIDER - IPF					2.0
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER					3.0
4.00 5.00	Swing bed - SNF		99, 0	40	99, 040	
6.00	Swing bed - SNF		99,0	40	99,040	
7.00	SKILLED NURSING FACILITY			0	0	7.0
8.00	NURSI NG FACILITY					8.0
9.00	OTHER LONG TERM CARE					9.0
10.00	Total general inpatient care services (sum of lines 1-9)		3, 261, 3	02	3, 261, 302	
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT					11.0
12.00	CORONARY CARE UNI T					12.0
13.00	BURN INTENSIVE CARE UNIT					13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.0
15.00	OTHER SPECIAL CARE (SPECIFY)					15.0
16.00	Total intensive care type inpatient hospital services (sum of I	i nes		0	0	16.0
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		3, 261, 3		3, 261, 302	
18.00	Ancillary services		6, 557, 4		6, 557, 466	
19.00	Outpati ent servi ces			0 69, 529, 947	69, 529, 947	
20.00	RURAL HEALTH CLINIC			0 0		
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			1, 039, 936	-	
22.00	AMBULANCE SERVICES			1, 037, 730	1, 039, 930	23.0
24.00	CMHC					24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.0
26.00	HOSPI CE			0 769, 881	769, 881	
27.00	OTHER (SPECIFY)			0 0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	o Wkst.	9, 818, 7	68 71, 339, 764	81, 158, 532	
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			35, 472, 322		29.0
30.00	ADD (SPECIFY)			0		30.0
31.00				0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)			0		36.0
37.00	DEDUCT (SPECI FY)			0		37.0
38.00				0		38.0
39.00				0		39.0
40.00 41.00				0		40.0
41.00	Total deductions (sum of lines 37-41)			0		41.0
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		35, 472, 322		42.0
+5.00	to Wkst. G-3, line 4)			55, 472, 522		+3.0

Heal th	Financial Systems PARKVIEW WABASH HOS	PITAL, INC.	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 151310	Peri od:	Worksheet G-3	
			From 01/01/2015 To 12/31/2015	Date/Time Pre	arad
			10 12/31/2015	7/14/2016 3:4	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		81, 158, 532	1.00
2.00	Less contractual allowances and discounts on patients' account	S		47, 718, 370	2.00
3.00	Net patient revenues (line 1 minus line 2)			33, 440, 162	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	3)		35, 472, 322	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-2, 032, 160	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			37, 444, 348	
7.00	Income from investments			-2, 053	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			245	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			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	5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	15.00
	Revenue from sale of medical and surgical supplies to other th	nan patients		0	16.00
	Revenue from sale of drugs to other than patients			126, 146	
	Revenue from sale of medical records and abstracts			0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			32	21.00
22.00				42, 848	
23.00				0	23.00
24.00				-2, 532	
	MISCELLANEOUS			615, 635	
	Total other income (sum of lines 6-24)			38, 224, 669	
	Total (line 5 plus line 25)			36, 192, 509	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			36, 192, 509	29.00

ALYS	Financial Systems GIS OF PROVIDER-BASED HOME HEALT		RKVIEW WABASH		CCN: 151310	Peri od:	u of Form CMS-2 Worksheet H	2002-
				HHA CCN:	157061	From 01/01/2015 To 12/31/2015		
						Home Health Agency I	PPS	
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	<u>5)</u> 6. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	0.00	
00	Capital Related - Bldg. &			0		0	0	1.0
00	Fixtures Capital Related - Movable			0		0	0	2.0
00	Equipment			0		0	0	2.0
00	Plant Operation & Maintenance	0	0	0		0 0	0	
00 00	Transportation	127 007	0	0		0 0	0	
00	Administrative and General HHA REIMBURSABLE SERVICES	137,007	0	63, 188	1	0 43, 914	244, 109	5.0
00	Skilled Nursing Care	326, 226	0	0	)	0 3	326, 229	6.0
00	Physical Therapy	178, 260		-		0 0	178, 260	
00	Occupational Therapy	27, 939				0 0	27, 939	
00	Speech Pathology Medical Social Services	0 168	0	0		0 0	0 168	
. 00	Home Heal th Aide	22, 966		0		0 0	22, 966	
. 00	Supplies (see instructions)	0	0	0		0 42, 451	42, 451	12. (
. 00	Drugs	0	0	0		0 6, 885	6, 885	
. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.0
. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15.0
. 00	Respiratory Therapy	0	0	0	)	0 0	0	
. 00	Private Duty Nursing	0	0	0		0 0	0	
. 00	Clinic	0	0	0		0 0	0	
. 00 . 00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	19. ( 20. (
. 00	Home Delivered Meals Program	0	0	0		0 0	0	
. 00	Homemaker Service	0	0	0		0 0	0	
. 00	All Others (specify)	0	0	0		0 0 93.253	0	1
. 00	Total (sum of lines 1-23)	692, 566 Recl assi fi cati	Recl assi fi ed	63,188 Adjustments	Net Expenses		849,007	24.0
		on	Trial Balance		for Allocatio			
			(col. 6 +		(col. 8 + col			
		7.00	<u>col.7)</u> 8.00	9.00	9) 10.00			1
	GENERAL SERVICE COST CENTERS				1	-		
00	Capital Related - Bldg. &	0	0	0		0		1.0
00	Fixtures Capital Related - Movable	0	0	0		0		2. (
00	Equipment	0	0	0		0		2.0
00	Plant Operation & Maintenance	0	0	0		0		3. (
	Transportation	0	0	0	244.10	0		4.0
	Administrative and General	0	244, 109	0	244, 10	J9		5.0
	IHHA RELMBURSABLE SERVICES							6.0
00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	326, 229	0	326, 22	29		
00 00 00	Skilled Nursing Care Physical Therapy	0	178, 260	0	178, 26	50		
00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy	0 0	178, 260 27, 939	0	178, 26 27, 93	50 39		8.
00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0	178, 260 27, 939 0	0 0 0	178, 26 27, 93	50 39 0		8. 9.
00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0	178, 260 27, 939 0 168	0 0 0 0	178, 26 27, 93	50 39 0 58		8. 9. 10.
00 00 00 00 00 . 00 . 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 0	178, 260 27, 939 0	0 0 0 0 0	178, 26 27, 93 16 22, 96	50 39 0 58 56		8. 9. 10. 11.
00 00 00 00 00 00 . 00 . 00 . 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	0 0 0 0 0 0 0 0	178, 260 27, 939 0 168 22, 966 42, 451 6, 885	0 0 0 0 0 0 0 0 0 0 0	178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35		8. 9. 10. 11. 12. 13.
00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0 0 0	178, 260 27, 939 0 168 22, 966 42, 451	0 0 0 0 0 0 0 0 0 0	178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51		8. 9. 10. 11. 12. 13.
00 00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0 0 0 0 0 0 0 0	178, 260 27, 939 0 168 22, 966 42, 451 6, 885 0		178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35 0		8. 9. 10. 11. 12. 13. 14.
00 00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	0 0 0 0 0 0 0 0	178, 260 27, 939 0 168 22, 966 42, 451 6, 885 0		178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35		8. 9. 10. 11. 12. 13. 14.
00 00 00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services		178, 260 27, 939 0 168 22, 966 42, 451 6, 885 0		178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35 0 0		8. 9. 10. 11. 12. 13. 14. 15. 16.
00 00 00 00 00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic		178, 260 27, 939 0 168 22, 966 42, 451 6, 885 0 0 0 0 0 0 0 0 0 0 0 0 0		178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35 0 0 0 0 0 0 0		8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18.
00 00 00 00 00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		178, 260 27, 939 0 168 22, 966 42, 451 6, 885 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35 0 0 0 0 0 0 0 0 0 0 0 0 0		8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
00 00 00 00 00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program		178, 260 27, 939 0 168 22, 966 42, 451 6, 885 0 0 0 0 0 0 0 0 0 0 0 0 0		178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35 0 0 0 0 0 0 0 0 0 0 0 0 0		8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.
00 00 00 00 00 00 00 00 00 00 00 00 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program		178, 260 27, 939 0 168 22, 966 42, 451 6, 885 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35 0 0 0 0 0 0 0 0 0 0 0 0 0		8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21.
	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program		178, 260 27, 939 0 168 22, 966 42, 451 6, 855 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		178, 26 27, 93 16 22, 96 42, 45 6, 88	50 39 0 58 56 51 35 0 0 0 0 0 0 0 0 0 0 0 0 0		7. ( 8. ( 9. ( 10. ( 11. ( 13. ( 13. ( 14. ( 15. ( 16. ( 17. ( 18. ( 18. ( 20. ( 21. ( 22. ( 23. (

Heal th	Financial Systems	PA	RKVIEW WABASH H	IOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
	NLLOCATION - HHA GENERAL SERVICE	COST		Provi der HHA CCN:	CCN: 151310 157061	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part I Date/Time Pre	pared:
						Home Health	7/14/2016 3:4 PPS	<u>3 pm</u>
			Capital Rel	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	
		0	1.00	2.00	3.00	4.00	4A. 00	
1.00 2.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment	0	0	0			c c	2.00
3.00 4.00 5.00	Pl ant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	0 0 244, 109	0 0 0	0 0 0		0 0 0 0 0	0 244, 109	4.00
6.00 7.00 8.00 9.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	326, 229 178, 260 27, 939 0	0 0 0 0	0 0 0		0 0 0 0 0 0 0 0 0 0	178, 260 27, 939 0	7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00	Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	168 22, 966 42, 451 6, 885 0	0 0 0 0	0 0 0 0 0			168 22, 966 42, 451 6, 885 0	11.00 12.00 13.00
	HHA NONREIMBURSABLE SERVICES	-			1			1
15.00 16.00 17.00 18.00 19.00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities		0 0 0 0	0 0 0 0 0				16. 00 17. 00 18. 00
20. 00 21. 00 22. 00	Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	0 0 0	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0		20.00 21.00 22.00
24.00	Total (sum of lines 1-23)	849,007 Administrative & General 5.00	0 Total (cols. 4A + 5) 6.00	0		0 0	849, 007	24.00
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable Equipment							2.00
3.00 4.00 5.00	Pl ant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	244, 109						3.00 4.00 5.00
6.00 7.00 8.00 9.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	131, 651 71, 938 11, 275 0	457, 880 250, 198 39, 214 0					6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00		68 9, 268 17, 131 2, 778 0	236 32, 234 59, 582 9, 663 0					10.00 11.00 12.00 13.00 14.00
22.00	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0 0 0 0 0 0 0						15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00
	All Others (specify) Total (sum of lines 1–23)	0	0 849, 007					23.00 24.00

	Financial Systems		ARKVIEW WABASH			In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider HHA CCN:	CCN: 151310 157061	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Pre 7/14/2016 3:43	pared: 3 pm
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
			Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A. 00	5.00	
1 00	GENERAL SERVICE COST CENTERS				1			1 4 65
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General	0	0	0		0 -244, 109	604, 898	5.00
	HHA REIMBURSABLE SERVICES	-	_	-	1			
6.00	Skilled Nursing Care	0	-	0		0 0	326, 229	6.00
7.00	Physical Therapy	0	0	0		0 0	178, 260 27, 939	
8.00 9.00	Occupational Therapy Speech Pathology	0	0	0		0 0	27,939	8.00 9.00
9.00	Medical Social Services		0	0		0 0	168	
11.00	Home Heal th Aide		0	0		0 0	22, 966	
12.00	Supplies (see instructions)	0	0	0		0 0	42,451	
13.00	Drugs	0	0	0		0	6, 885	
14.00	DME	0	0	0		0 0	0	
	HHA NONREI MBURSABLE SERVI CES							
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	19.00
	Day Care Program Home Delivered Meals Program			0			0	20.00 21.00
21.00	Homemaker Service		0	0			0	
	All Others (specify)	0	0	0		0 0	0	
24.00	Total (sum of lines 1-23)	0	0	0		0 -244, 109	604, 898	
25.00	Cost To Be Allocated (per	0	0	0		0	244, 109	
	Worksheet H-1, Part I)							
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.0000	00	0. 403554	26.00

	Financial Systems ATION OF GENERAL SERVICE COSTS T		RKVIEW WABASH TERS		CCN: 151310	Peri od:	Worksheet H-2	2552
				HHA CCN:	157061	From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 7/14/2016 3:4	pare 3 pm
						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS		, igeney i		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
. 00	Administrative and General	0	8, 881	0				
00 00	Skilled Nursing Care Physical Therapy	457, 880 250, 198	0	0		0 457, 880 0 250, 198		
00	Occupational Therapy	39, 214	0	0		0 230, 198		
00	Speech Pathol ogy	0	0	0		0 0		
00	Medical Social Services	236	0	0		0 236		
00	Home Health Aide	32, 234	0	0		0 32, 234		
00 00	Supplies (see instructions) Drugs	59, 582 9, 663	0	0		0 59, 582 0 9, 663		
. 00	DME	0	0	0		0 0		
. 00	Home Dialysis Aide Services	0	0	0		0 0	0	11
. 00	Respiratory Therapy	0	0	0		0 0	0	
. 00 . 00	Private Duty Nursing Clinic	0	0	0			0	
. 00	Health Promotion Activities	0	0	0				
. 00	Day Care Program	0	0	0		0 0	0	
. 00	Home Delivered Meals Program	0	0	0		0 0	0	
. 00		0	0	0		0 0	0	
0.00	All Others (specify) Total (sum of lines 1-19) (2)	0 849,007	0 8, 881	0	185, 28	0 0 84 1, 043, 172	0 404, 560	
. 00	Unit Cost Multiplier: column	649,007	0, 001	0	100,20	0. 000000		20
	26, line 1 divided by the sum					0.000000		<u>-</u> ·
	of column 26, line 20 minus							
	column 26, line 1, rounded to 6 decimal places.							
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		PLANT	LINEN SERVICE		10.00		ADMI NI STRATI ON	
00	Administrative and General	7.00 51,394	8.00	9.00	10.00	0 0	13.00	0 1
00	Skilled Nursing Care	0	0	22, 704		0 0		
00	Physical Therapy	0	0	0		0 0	0	3
00	Occupational Therapy	0	0	0		0 0	, v	
00 00	Speech Pathology Medical Social Services	0	0	0			0	
00	Home Heal th Aide	0	0	0			0	
00	Supplies (see instructions)	0	0	0		0 0	0	
00	Drugs	0	0	0		0 0	0	9
. 00	DME	0	0	0		0 0		
	Home Dialysis Aide Services	0	0	0			0	
. 00 . 00	Respiratory Therapy Private Duty Nursing	0	0	0				
. 00		0	0	0		0 0	0	
. 00	Health Promotion Activities	0	0	0		0 0	0	
. 00	3	0	0	0		0 0	0	
. 00		0	0	0			0	
	1	0	0	0			0	
<i>₹</i> , 00		51, 394	0	22, 904		0 0	0	20
			-		1	1		21
9.00 0.00 1.00	Unit Cost Multiplier: column							2'
0. 00	26, line 1 divided by the sum							
. 00								

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	Financial Systems ATION OF GENERAL SERVICE COSTS 1		<u>RKVIEW WABASH H</u> FERS		CCN: 151310	Peri od:	u of Form CMS-2 Worksheet H-2	
				HHA CCN:	157061	From 01/01/2015	Part I	pared:
						Home Health Agency I	PPS	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
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 20.00 21.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.				635, 4 347, 2 54, 4 3 44, 7 82, 6 13, 4	54       0         29       0         22       0         0       0         35       0         89       0         10       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       0         0       0	635, 454 347, 229 54, 422 0 328 44, 735	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 18.00 19.00
	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs		1			
1 00		27.00	28.00					1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00		185, 395 101, 305 15, 878 0 96 13, 052 24, 125 3, 912 0	820, 849 448, 534 70, 300 0 424 57, 787 106, 814 17, 322 0					2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0 0 0 0 0 0 343, 763 0. 291753	0 0 0 0 0 0 0 0 1,522,030					11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	n Financial Systems		ARKVIEW WABASH			In Lie	u of Form CMS-	
ALLOC BASI S	ATION OF GENERAL SERVICE COSTS 1	FO HHA COST CEN	TERS STATISTICA	AL Provider HHA CCN:	CCN: 151310 157061	Period: From 01/01/2015 To 12/31/2015	Worksheet H-2 Part II Date/Time Pre 7/14/2016 3:4	pared:
						Home Health	PPS	
		CAPI TAL REI	ATED COSTS			Agency I		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati	onADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	-
		1.00	2.00	4.00	5A	5.00	7.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 13.00\\ 14.00\\ 15.00\\ 14.00\\ 15.00\\ 14.00\\ 15.00\\ 14.00\\ 22.00\\ \end{array}$	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19)	1, 910 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 0 0 0	692, 567 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	CAFETERI A	0 194, 165 0 457, 880 0 250, 198 0 39, 214 0 0 0 236 0 32, 234 0 59, 582 0 9, 663 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, 910 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
1 00		8.00	9.00	10.00	11.00	13.00	14.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19)		1, 910 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         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         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		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$

Heal th	Financial Systems	PA	RKVIEW WABASH HOS	SPITAL, INC.		In Lie	u of Form CMS-	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICAL	Provi der	CCN: 151310	Period:	Worksheet H-2	
BASI S				HHA CCN:	157061	From 01/01/2015 To 12/31/2015		
						Home Health	7/14/2016 3:4 PPS	<u>3 pm</u>
						Agency I	FFJ	
	Cost Center Description	PHARMACY	MEDI CAL			Agency		
		(COSTED	RECORDS &					
		REQUIS.)	LI BRARY					
			(GROSS REV)					
		15.00	16.00					
1.00	Administrative and General	0	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic Health Promotion Activities	0	0					14.00 15.00
15. 00 16. 00		0	0					16.00
	Home Delivered Meals Program	0	0					17.00
17.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19)	0	0					20.00
20.00	Total cost to be allocated	0						20.00
	Unit cost multiplier	0. 000000	0. 000000					21.00
22.00		0.000000	0. 000000J					22.00

Heal th	Financial Systems	PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-2	2552-10
APPORT	FIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151310	Peri od:	Worksheet H-3	
				HHA CCN:	157061	From 01/01/2015 To 12/31/2015		
				Titl	e XVIII	Home Health	PPS	•
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (col s.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
		0	1.00	Part II)	2.00	4.00	4)	
	PART I - COMPUTATION OF LESSER			2.00 GGREGATE OF TH	3.00	4.00	5.00 R	
	BENEFICIARY COST LIMITATION	OF AGOREOATE 1		OUREONIE OF IT				
	Cost Per Visit Computation	1			1		1	
1.00	Skilled Nursing Care	2.00			820, 84			
2.00 3.00	Physical Therapy Occupational Therapy	3.00 4.00						2.00 3.00
3.00 4.00	Speech Pathol ogy	5.00			/0,30	0 148		
5.00	Medical Social Services	6.00			42			
6.00	Home Health Aide	7.00	57, 787		57, 78	37 3, 061	18.88	6.00
7.00	Total (sum of lines 1-6)		1, 397, 894	(				7.00
			1		Program Visit			
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	art B to Subject to		
	cost center bescription		CDSK NO. (1)		Deducti bl es Coi nsurance	& Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
-	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	(		56		8.00
8.01	Skilled Nursing Care		50031	(		96		8.01
9.00 9.01	Physical Therapy Physical Therapy		99915 50031			10 59		9.00 9.01
10.00	Occupational Therapy		99915		7	8		10.00
10.00	Occupational Therapy		50031	(	20			10.00
11.00	Speech Pathology		99915	(		0		11.00
11. 01	Speech Pathol ogy		50031	C	5	58		11.01
12.00	Medical Social Services		99915	0	0	0		12.00
12. 01 13. 00	Medical Social Services Home Health Aide		50031 99915			4		12. 01 13. 00
13.00	Home Heal th Aide		50031		·	17		13.00
	Total (sum of lines 8-13)		00001	(	1, 98			14.00
		From Wkst. H-2	Facility Costs		Total HHA	Total Charges	Ratio (col. 3	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computa							
15.00	1	8.00						
16.00	Cost of Drugs	9.00				22 0	0. 000000	16.00
			Program Visits		Cost of Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
			Deductibles &			Deductibles &		
		( 00	Coi nsurance	Coi nsurance	0.00	Coi nsurance	Coi nsurance	
	PART I - COMPUTATION OF LESSER	0F ACCRECATE	7.00	8.00			11.00	
	BENEFICIARY COST LIMITATION	OF AGONEDATE P	NOONNII COOT, A	SOMEONIE OF T			· <b>·</b>	
1.00	Cost Per Visit Computation Skilled Nursing Care	0	662			0 183, 890		1.00
2.00	Physical Therapy	0				0 216, 993		2.00
3.00	Occupational Therapy	0				0 35, 916		3.00
4.00	Speech Pathol ogy	0				0 0		4.00
5.00	Medical Social Services	0				0 212		5.00
6.00	Home Health Aide	0				0 887		6.00
7.00	Total (sum of lines 1-6)	0	1, 981	l	1	0 437, 898	1	7.00

PPOR	FIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151310	Period: From 01/01/2015	Worksheet H-3 Part I	}
				HHA CCN:	157061	To 12/31/2015		
				Titl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation	0.00	7.00	8.00	9.00	10.00	11.00	
. 00 . 01 . 00 . 01 0. 00 0. 01 1. 00 1. 01 2. 00 2. 01 3. 00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide							8. ( 8. ( 9. ( 9. ( 10. ( 11. ( 11. ( 12. ( 12. ( 13. (
3.01 4.00	Home Health Aide Total (sum of lines 8–13)							13.0
4.00		Prog	ram Covered Cha	arges	Cost of Services			14.0
	Cost Center Description	Part A	Not Subject to	t B Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
F 00	Supplies and Drugs Cost Computa	ations 0		0		0 0	(	1 1 5 /
5.00 6.00	Cost of Medical Supplies Cost of Drugs	0	0 1, 625	-		0 0	(	
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						_
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							-
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6)	183, 890 216, 993 35, 916 0 212 887 437, 898						1. ( 2. ( 3. ( 4. ( 5. ( 6. ( 7. (
. 00	Cost Center Description	437,070						7.0
		12.00						1
00	Limitation Cost Computation							
00 01 00 01 0.00 0.01 1.00 1.01 2.00 2.01 3.00	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Heal th Aide							8.0 9.0 9.0 10.0 11.0 11.0 12.0 12.0 13.0

Health Financial Systems	PA	ARKVIEW WABASH	HOSPITAL, INC		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provi der	CCN: 151310	Peri od:	Worksheet H-3	
					From 01/01/2015		
			HHA CCN:	157061	To 12/31/2015		
						7/14/2016 3:4	<u>3 pm</u>
			lit	le XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED HOSP	ITAL DEPARTMEN	ITS		
1.00 Physical Therapy	66.00	0. 568187		0	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 933999		0	Ocol. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 000081		o	0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 483054		o	0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 272973		o	Ocol. 2, line 1	6. 00	5.00

	Financial Systems PARKVIEW WABASH HOSPI ATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 151310	Peri od:	u of Form CMS-2 Worksheet H-4	
LUUL		HHA CCN:	157061	From 01/01/2015 To 12/31/2015	Part I-II	par
		Ti tl	e XVIII	Home Health Agency I	PPS	<u>5 p</u>
					rt B	
			Part A	Not Subject to	Subject to	
					Deductibles &	
				Coi nsurance	Coi nsurance	
	DADT 1. CONDUTATION OF THE LECCED OF DEACONADLE COST OD CUCTOMA		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA Reasonable Cost of Part A & Part B Services	KY CHARGE	.5			-
0	Reasonable cost of services (see instructions)		1	0 0	0	1 1
0	Total charges			0 1,625	-	
	Customary Charges				1 -	
0	Amount actually collected from patients liable for payment for s	servi ces		0 0	0	] 3
	on a charge basis (from your records)					
00	Amount that would have been realized from patients liable for pa			0 0	0	4
	for services on a charge basis had such payment been made in acc with 42 CEP 8412 12(b)	cordance				
0	with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 00000	0. 000000	
0	Total customary charges (see instructions)		0.0000	0 1, 625		
0	Excess of total customary charges over total reasonable cost (co	omplete		0 1, 625		
	only if line 6 exceeds line 1)					
0	Excess of reasonable cost over customary charges (complete only	ifline		0 0	0	8
0	1 exceeds line 6)			0		
<u> </u>	Primary payer amounts			0 0 Part A	0 Part B	
				Services	Services	
				1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1	
00	Total reasonable cost (see instructions)			0		1
00	Total PPS Reimbursement - Full Episodes without Outliers			0	374, 877	
00 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0	0 7, 975	
00	Total PPS Reimbursement - PEP Episodes			0	0	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	0	
00	Total PPS Outlier Reimbursement - PEP Episodes			0	0	
00	Total Other Payments			0	1, 592	1
00	DME Payments			0	0	
00	Oxygen Payments			0	0	
00 00	Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsura	nco)		0	0	
	Subtotal (sum of lines 10 thru 20 minus line 21)	ince)		0	384, 444	
00	Excess reasonable cost (from line 8)			0	0	
				0	384, 444	
00	Subtotal (line 22 minus line 23)				0	
00 00	Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)					2
00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)			0	384, 444	2
00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)			0	384, 444	2
00 00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst					2 2
00 00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2			0	384, 444	2 2 2
00 00 00 00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				384, 444 0	2 2 2 3
00 00 00 00 00 00 00 00 00 50	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)				384, 444 0 0	2 2 2 3 3
00 00 00 00 00 00 00 00 50 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)				384, 444 0 0 384, 444	2 2 2 3 3 3 3
00 00 00 00 00 00 00 00 50 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)				384, 444 0 0	2 <sup>-</sup> 21 31 31 31 31 31 31
00 00 00 00 00 00 00 00 50 00 01 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)				384, 444 0 0 384, 444 7, 657	27 28 29 30 30 31 31 31
<ul> <li>00</li> </ul>	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	27)			384, 444 0 384, 444 7, 657 376, 787	27 28 29 30 30 31 31 32 33

	IS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO M BENEFICIARIES	) Providei HHA CCN:	r CCN: 151310		: 1/01/2015 2/31/2015	Worksheet H-5 Date/Time Prep 7/14/2016 3:43	pared:
					Heal th ency I	PPS	
		Inpatie	ent Part A			t B	
		mm/dd/yyyy	Amount		dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
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			0		376, 787 0	1.00 2.00
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. 00
01	Program to Provider			0		0	3.0'
02				0		0	3.02
03				0		0	3.0
04				0		o	3.04
05				0		0	3.0
	Provider to Program						
50				0		0	3.5
51				0		0	3.5
52				0		0	3.5
53				0		0	3.5
54				0		0	3.5
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	3.9
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		376, 787	4.0
	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)						5.0
	Program to Provider						
D1				0		0	5. C
02				0		0	5.0
03				0		0	5. C
	Provider to Program						
50				0		0	5.5
51				0		0	5.5
52				0		0	5.5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	5.9
0	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)						6.0
)1	SETTLEMENT TO PROVIDER			0		0	6.0
2	SETTLEMENT TO PROGRAM			0		0	6.0
00	Total Medicare program liability (see instructions)			0		376, 787	
-					tractor lumber	NPR Date (Mo/Day/Yr)	
			0		1.00	2.00	
	Name of Contractor		v		1.00	2.00	8.

Heal th	Financial Systems P	ARKVIEW WABASH H	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 151310	Period: From 01/01/2015	Worksheet K	
			Hospi ce (	CCN: 151545	To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
				_	Hospi ce I		
		Salaries (from	Empl oyee	Transportatio		Other	
		Wkst. K-1)	Benefits (from	(see inst.)			
		1.00	<u>Wkst. K-2)</u>	0.00	Wkst. K-3)	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.			1	0	0	1.00
2.00	Capital Related Costs-Movable Equip.				0	0	2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	250, 515	C		-	-	
0.00	INPATI ENT CARE SERVI CE	230, 313	0	17, 5	0	03, 040	0.00
7.00	Inpatient - General Care	0	0	1	0 0	0	7.00
8.00	Inpatient - Respite Care	0	C		0 0		
0.00	VI SI TI NG SERVI CES	U	0		0 0	0	0.00
9.00	Physician Services	0	C	1	0 0	0	9.00
10.00	Nursi ng Care	0	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	0	0		0 0	0	12.00
12.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	
14.00	Medical Social Services	0	0		0 0	0	14.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
20.00	Other	0	0		0 0	0	
21.00	OTHER HOSPICE SERVICE COSTS	0	0		0 0	0	21.00
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	28, 021	22.00
23.00	Anal gesi cs	0	0		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	C		0 0	0	
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	C		0 0	0	26.00
27.00	Patient Transportation	0	0		0 0	0	
28.00	I magi ng Servi ces	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	138	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radi ati on Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	
34.00	0ther	0	0		0 0	0	
54.00	HOSPICE NONREIMBURSABLE SERVICE	U U	0	1	<u> </u>	0	57.00
35.00	Bereavement Program Costs	0	C		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	C		0 0	0	
38.00	Other Program Costs	0	C		0 0	0	38.00
	Total (sum of lines 1 thru 38)	250, 515	C		-		
	······································			1		,	

Heal th	Financial Systems P/	ARKVIEW WABASH	HOSPITAL, INC.		In	Li eu	of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 151310	Peri od:		Worksheet K	
			Hospi ce	CCN: 151545	From 01/01/2 To 12/31/2	2015 I	Date/Time Pre 7/14/2016 3:4	
					Hospi ce		77 147 2010 3.4	
		Total (cols.	Recl assi fi cat	Subtotal (co			otal (col. 8	
		1-5)	on	$6 \pm col. 7$			± col. 9)	
		6.00	7.00	8.00	9.00		10.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0		C	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0		D	0	0	0	2.00
3.00	Plant Operation and Maintenance	0		b	0	o	0	3.00
4.00	Transportation - Staff	0		D	0	0	0	4.00
5.00	Volunteer Service Coordination	0		b	0	o	0	5.00
6.00	Administrative and General	351, 715		351, 7	15	0	351, 715	6.00
	INPATIENT CARE SERVICE			· · · ·				
7.00	Inpatient - General Care	0		C	0	0	0	7.00
8.00	Inpatient – Respite Care	0		D	0	0	0	8.00
	VI SI TI NG SERVI CES							
9.00	Physi ci an Servi ces	0		C	0	0	0	9.00
10.00	Nursing Care	0		b	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0		b	0	o	0	11.00
12.00	Physical Therapy	0			0	0	0	12.00
13.00	Occupational Therapy	0		0	0	0	0	13.00
14.00	Speech/ Language Pathol ogy	0			0	0	0	14.00
15.00	Medical Social Services	0			0	0	0	15.00
16.00	Spiritual Counseling	0			0	ō	0	16.00
17.00	Dietary Counseling	0			0	0	0	17.00
18.00	Counseling - Other	0			0	0	0	18.00
19.00	Home Health Aide and Homemaker	0			0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0			0	Ō	0	20.00
21.00	Other	0			0	Ō	0	21.00
	OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	28, 021		28,0	)21	0	28, 021	22.00
23.00	Anal gesi cs	0			0	0	0	23.00
24.00	Sedatives / Hypnotics	0			0	0	0	24.00
25.00	Other - Specify	0			0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0			0	0	0	26.00
27.00	Patient Transportation	0			0	0	0	27.00
28.00	Imaging Services	0			0	0	0	28.00
29.00	Labs and Diagnostics	0			0	0	0	29.00
30,00	Medical Supplies	138		- 	38	ō	138	30,00
31.00	Outpatient Services (including E/R Dept.)	0			0	0	0	31.00
32.00	Radiation Therapy	0			0	0	0	32.00
33.00	Chemotherapy	0			0	o	0	33.00
34.00	Other	0			0	o	0	34.00
01.00	HOSPI CE NONREI MBURSABLE SERVI CE			5	0	<u> </u>		01.00
35.00	Bereavement Program Costs	0		b	0	0	0	35.00
36.00	Volunteer Program Costs	0			0	0	0	36.00
37.00	Fundrai si ng	0			õ	ő	0	37.00
38.00	Other Program Costs	0			0	0	0	38.00
	Total (sum of lines 1 thru 38)	379, 874		379,8	374	0	379, 874	
07.00		0,0/1		-1 0.7,0		~1	0,0/1	1 37.00

Heal th	Financial Systems	PARKVIEW WABASH F	IOSPI TAL, INC.			In Lie	u of Form CMS-	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 151310	Pe	eriod:	Worksheet K-1	
				CCN: 151545		rom 01/01/2015	Date/Time Pre	pared:
					-	llaant aa l	7/14/2016 3:4	<u>3 pm</u>
			Discontesta	Caral al	<u> </u>	Hospi ce I	Numera	
		Admi ni strator	Di rector	Soci al		Supervi sors	Nurses	
		1.00	2.00	Services 3.00	_	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00		4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00								2.00
	Capital Related Costs-Movable Equip.	0	0		~	0	0	
3.00	Plant Operation and Maintenance	0	0		0	0		
4.00	Transportation - Staff	0	0		0	0	0	
5.00	Volunteer Service Coordination	0	0		0	0	0	
6.00	Administrative and General	0	0		0	0	0	6.00
7 00	I NPATI ENT_CARE_SERVI CE							7 00
7.00	Inpatient - General Care	0	0		0	0	0	
8.00	Inpatient - Respite Care	0	0		0	0	0	8.00
	VI SI TI NG SERVI CES					a		
9.00	Physi ci an Servi ces	0	0		0	0	0	•
10.00	Nursing Care	0	0		0	0	0	
11.00	Nursing Care-Continuous Home Care	0	0		0	0	0	
12.00	Physical Therapy	0	0		0	0	0	
13.00	Occupational Therapy	0	0		0	0	0	
14.00	Speech/ Language Pathol ogy	0	0		0	0	0	
15.00	Medical Social Services	0	0		0	0	0	
	Spiritual Counseling	0	0		0	0	0	
17.00	Dietary Counseling	0	0		0	0	0	
18.00	Counseling - Other	0	0		0	0	0	
19.00	Home Health Aide and Homemaker	0	0		0	0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	
21.00	Other	0	0		0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy							22.00
23.00	Anal gesi cs							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen							26.00
27.00	Patient Transportation	0	0		0	0	0	
28.00	Imaging Services	0	0		0	0	0	
29.00	Labs and Diagnostics	0	0		0	0	0	29.00
30.00	Medical Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	0	32.00
33.00	Chemotherapy	0	0		0	0	0	33.00
34.00	Other	0	0		0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	36.00
37.00	Fundrai si ng	0	0		0	0	0	37.00
38.00	Other Program Costs	0	0		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0		0	0	0	39.00

Heal th	Financial Systems P	ARKVIEW WABASH HOS	SPITAL, INC.		In Lie	u of Form CMS-2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES			CCN: 151310	Peri od:	Worksheet K-1
					From 01/01/2015	
			Hospi ce C	CN: 151545	To 12/31/2015	Date/Time Prepared:
					lleeniee	7/14/2016 3:43 pm
		Total	Aides	All-Other	Hospi ce I	
		Therapists	Arues	AIT-Uther	Total (1)	
		6.00	7.00	8.00	9, 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	7.00	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4.00
5.00	Volunteer Service Coordination		0		0 0	5.00
6.00	Administrative and General		0	250, 5	0	6.00
0.00	I NPATI ENT_CARE_SERVI CE	II	0	200,0	200,010	0.00
7.00	Inpatient - General Care		0		0 0	7.00
8.00	Inpatient - Respite Care		0		0 0	8.00
0.00	VI SI TI NG SERVI CES	II	0			0.00
9.00	Physi ci an Servi ces		0		0 0	9,00
10.00	Nursi ng Care		0		0 0	10.00
11.00	Nursing Care-Continuous Home Care		0		0 0	11.00
12.00	Physical Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	14.00
15.00	Medi cal Social Services	U	0		0 0	15.00
16.00	Spiritual Counseling		0		0 0	16.00
17.00	Di etary Counsel i ng		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		0		0 0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00	Other		0		0 0	21.00
21.00	OTHER HOSPICE SERVICE COSTS		<u> </u>		0 0	21.00
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Anal gesi cs					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Pati ent Transportati on		0		0 0	27.00
28.00	Imaging Services		0		0 0	28.00
29.00	Labs and Diagnostics		0		0 0	29.00
30.00	Medi cal Supplies		0		0 0	30, 00
31.00	Outpatient Services (including E/R Dept.)		0		0 0	31.00
32.00	Radi ati on Therapy		0		0 0	32.00
32.00	Chemotherapy		0		0 0	33.00
33.00	Other		0		0 0	34.00
34.00	HOSPICE NONREIMBURSABLE SERVICE		0		0 0	
35.00	Bereavement Program Costs	[ [	0		0 0	35.00
36.00	Volunteer Program Costs		0		0 0	36.00
37.00	Fundrai si ng		0		0 0	30.00
37.00	Other Program Costs		0			37.00
	Total (sum of lines 1 thru 38)	0	0	250, 5	15 250, 515	38.00
07.00		, oj	9	200, 0	200,010	1 57:00

Heal th	Financial Systems P	ARKVIEW WABASH F	IOSPITAL, INC.			In Lie	u of Form CMS-2	2552-10
HOSPIC	E COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PA	AYROLL RELATED)	Provi der	CCN: 151310	Pe	eriod:	Worksheet K-2	
					Fr To	rom 01/01/2015 0 12/31/2015	Date/Time Pre 7/14/2016 3:4	pared:
						Hospi ce I	771472010 3.4	s pili
		Admi ni strator	Di rector	Soci al		Supervi sors	Nurses	
		1.00	2.00	Services 3.00		4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00		1.00	0.00	
1.00	Capital Related Costs-Bldg and Fixt.				Т			1.00
2.00	Capital Related Costs-Movable Equip.							2.00
3.00	Plant Operation and Maintenance	0	0		0	0	0	3.00
4.00	Transportation - Staff	0	0		0	0	0	1
5.00	Volunteer Service Coordination	0	0		0	0	0	
6.00	Administrative and General	0	0		0	0	0	
0.00	I NPATI ENT_CARE_SERVI CE	ч Ч	0	I				0.00
7.00	Inpatient - General Care	0	0		0	0	0	7.00
8.00	Inpatient - Respite Care	0	0		0	0	0	
0.00	VI SI TI NG SERVI CES				-			0.00
9.00	Physi ci an Servi ces	0	0		0	0	0	9.00
10.00	Nursing Care	0	0		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	0	11.00
12.00	Physical Therapy	0	0		0	0	0	12.00
13.00	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0	0	0	14.00
15.00	Medical Social Services	0	0		0	0	0	15.00
	Spiritual Counseling	0	0		0	0	0	16.00
17.00	Dietary Counseling	0	0		0	0	0	17.00
18.00	Counseling - Other	0	0		0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	20.00
21.00	Other	0	0		0	0	0	
21.00	OTHER HOSPICE SERVICE COSTS							200
22.00	Drugs, Biological and Infusion Therapy							22.00
23.00	Anal gesi cs							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen							26.00
27.00	Patient Transportation	0	0		0	0	0	27.00
28.00	Imaging Services	0	0		0	0	0	28.00
29.00	Labs and Diagnostics	0	0		0	0	0	29.00
30.00	Medical Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	0	32.00
33.00	Chemotherapy	0	0		0	0	0	33.00
34.00	Other	0	0		0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	· · · · · ·						1
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	36.00
37.00	Fundrai si ng	0	0		0	0	0	37.00
38.00	Other Program Costs	0	0		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0		0	0	0	39.00

Heal th	Financial Systems PA	ARKVIEW WABASH HOS	SPITAL, INC.		In Lie	u of Form CMS-2	2552-10
	E COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PA			CCN: 151310	Peri od:	Worksheet K-2	
					From 01/01/2015		
			Hospi ce C	CN: 151545	To 12/31/2015		
					11	7/14/2016 3:4	3 pm
		Tatal	Aidee	ALL Others	Hospi ce I		
		Total	Ai des	All-Other	Total (1)		
		Therapists 6.00	7.00	8,00	9,00		
	GENERAL SERVICE COST CENTERS	0.00	7.00	8.00	9.00		
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0		0 0		3.00
4.00	Transportation - Staff		0		0 0		4.00
4.00 5.00	Volunteer Service Coordination		0		0 0		5.00
6.00	Administrative and General		0		0 0		6.00
0.00	INPATIENT CARE SERVICE		0		0 0		0.00
7.00	Inpatient - General Care		0		0 0		7.00
7.00 8.00	Inpatient - General Care		0		0 0		8.00
0.00	VI SI TI NG SERVICES		0		0 0		0.00
9.00	Physician Services		0		0 0		9.00
9.00 10.00			0		0 0		9.00
	Nursing Care		0		0 0		
11.00	Nursing Care-Continuous Home Care				-		11.00
12.00	Physi cal Therapy	0	0		0 0		12.00
13.00	Occupational Therapy	0	0		0 0		13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0		14.00
15.00	Medical Social Services		0		0 0		15.00
16.00	Spiritual Counseling		0		0 0		16.00
17.00	Di etary Counsel i ng		0		0 0		17.00
18.00	Counseling - Other		0		0 0		18.00
19.00	Home Health Aide and Homemaker		0		0 0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0		20.00
21.00	Other		0		0 0		21.00
	OTHER HOSPICE SERVICE COSTS	1					
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0		0 0		27.00
28.00	Imaging Services		0		0 0		28.00
29.00	Labs and Diagnostics		0		0 0		29.00
30.00	Medical Supplies		0		0 0		30.00
31.00	Outpatient Services (including E/R Dept.)		0		0 0		31.00
32.00	Radiation Therapy		0		0 0		32.00
33.00	Chemotherapy		0		0 0		33.00
34.00	Other		0		0 0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0		0 0		35.00
36.00	Volunteer Program Costs		0		0 0		36.00
37.00	Fundrai si ng		0		0 0		37.00
38.00	Other Program Costs		0		0 0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0		0 0		39.00

Heal th	Financial Systems	PARKVI EW WABASH	HOSPITAL, INC.		In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - HOSPICE GENERAL SERVICE COST		Provi der	CCN: 151310	Peri od:	Worksheet K-4	
					From 01/01/2015		
			Hospi ce (	CCN: 151545	To 12/31/2015	Date/Time Pre 7/14/2016 3:4	
					Hospi ce I	771472010 3.4	s pili
				LATED COST	nospi ce i		
				LATED 0001			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATI ON	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAINT.		
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	C	)			1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2.00
3.00	Plant Operation and Maintenance	0	C		0 0		3.00
4.00	Transportation - Staff	0	C		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0		5.00
6.00	Administrative and General	351, 715	0		0 0		6.00
	I NPATI ENT CARE SERVI CE				-		
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0		
	VI SI TI NG SERVI CES			1	-		
9.00	Physician Services	0	C		0 0	0	9.00
10.00	Nursi ng Care	0	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0		11.00
12.00	Physi cal Therapy	0	0		0 0	-	
13.00	Occupational Therapy	0	0			0	
14.00	Speech/ Language Pathology	0	0			0	
14.00	Medi cal Soci al Servi ces	0	0			0	15.00
16.00	Spiritual Counseling	0	0			0	
17.00	Dietary Counseling	0	0		0	0	
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0			0	
20.00	Other	0				-	
21.00	OTHER HOSPICE SERVICE COSTS	0	U	/	0 0	0	21.00
22.00	Drugs, Biological and Infusion Therapy	28, 021	0	1	0 0	0	22.00
22.00	Anal gesi cs	20, 021				-	
23.00	Sedatives / Hypnotics	0				0	23.00
24.00 25.00	Other - Specify	0	0		0 0	0	
		0	0			0	
26.00 27.00	Durable Medical Equipment/Oxygen Patient Transportation	0	0				26.00
		0	0			0	
28.00	Imaging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	U		0 0	0	29.00
30.00	Medical Supplies	138	0	)	0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	)	0 0	0	31.00
32.00	Radiation Therapy	0	0	)	0 0	0	
33.00	Chemotherapy	0	0		0	0	
34.00		0	C	1	0 0	0	34.00
05 05	HOSPI CE NONREI MBURSABLE SERVI CE	-	-	1	-	-	05 00
35.00	Bereavement Program Costs	0	0		0 0		
36.00	Volunteer Program Costs	0	0		0 0		36.00
37.00	Fundrai si ng	0	0		0 0	-	
38.00	Other Program Costs	0	C		0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	379, 874	0	9	0 0	0	39.00

Heal th	Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - HOSPICE GENERAL SERVICE COST		Provi der	CCN: 151310	Peri od:	Worksheet K-4	
					From 01/01/2015		
			Hospi ce	CCN: 151545	To 12/31/2015		pared:
					lleent ee l	7/14/2016 3:4	3 pm
		VOLUNTEER	SUBTOTAL		Hospice I VETOTAL (col. 5A		
		SERVICES	(cols. 0 - 5)		$\pm$ col. 6)		
		COORDINATOR	(COIS. 0 - 5)		± COL. 0)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS	0.00	0/1	0.00	7.00	L	
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	351, 71	5 351, 7	15		6.00
	I NPATI ENT CARE SERVI CE	-				<u> </u>	1
7.00	Inpatient - General Care	0	(	C	0 0		7.00
8.00	Inpatient - Respite Care	0	(	b	0 0		8.00
	VI SI TI NG SERVICES						
9.00	Physi ci an Servi ces	0	(	C	0 0		9.00
10.00	Nursing Care	0	(	C	0 0		10.00
11.00	Nursing Care-Continuous Home Care	0	(	C	0 0		11.00
12.00	Physical Therapy	0	(	C	0 0		12.00
13.00	Occupational Therapy	0	(	C	0 0		13.00
14.00	Speech/ Language Pathology	0	(	C	0 0		14.00
15.00	Medical Social Services	0	(	C	0 0		15.00
16.00	Spiritual Counseling	0	(	C	0 0		16.00
17.00	Di etary Counsel i ng	0	(	C	0 0		17.00
18.00	Counseling - Other	0	(	C	0 0		18.00
19.00	Home Health Aide and Homemaker	0	(	C	0 0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0		C	0 0		20.00
21.00	Other	0	(	0	0 0		21.00
	OTHER HOSPICE SERVICE COSTS	1					
22.00	Drugs, Biological and Infusion Therapy	0	/				22.00
23.00	Anal gesi cs	0	(	C	0 0		23.00
24.00	Sedatives / Hypnotics	0	(	C	0 0		24.00
25.00	Other - Specify	0	(	C	0 0		25.00
26.00	Durable Medical Equipment/Oxygen	0	(	C	0 0		26.00
27.00	Patient Transportation	0	(		0 0		27.00
28.00	I maging Services	0			0 0		28.00
29.00	Labs and Diagnostics	0			0 0		29.00
30.00	Medical Supplies	0	13				30.00
31.00	Outpatient Services (including E/R Dept.)	0			0 0		31.00
32.00	Radi ati on Therapy	0		C	0 0		32.00
33.00	Chemotherapy	0		D	0 0		33.00
34.00		0	(	D	0 0		34.00
25 00	HOSPICE NONREI MBURSABLE SERVICE	0			0 0		25 00
35.00 36.00	Bereavement Program Costs Volunteer Program Costs	0			0 0		35.00 36.00
36.00	Fundrai si ng	0			0 0		36.00
37.00	Other Program Costs						37.00
	Total (sum of lines 1 thru 38)	0	379, 87	4	379, 874		39.00
37.00		0	3/7,0/4	1	317,014		37.00

near th	Financial Systems PA	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 151310	Peri od:	Worksheet K-4	
			Hospi ce (	CCN: 151545	From 01/01/2015 To 12/31/2015	Part II Date/Time Pre	nared
			nospi ce c	JON. 131343	10 12/31/2013	7/14/2016 3:4	
		i			Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
		1.00	2.00	FT.)	4.00	(HOURS)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.	0					1 1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0		0		3.00
4.00	Transportation - Staff	0	0		0 0		4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	0	0		0 0	0	6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0		0 0	0	
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
	VI SI TI NG SERVI CES			1			
9.00	Physician Services	0	0		0 0 0 0	0	
10.00 11.00	Nursing Care Nursing Care-Continuous Home Care	0	0		0 0	0	1
12.00	Physical Therapy	0	0		0 0	0	
13.00	Occupational Therapy	0	0		0 0	0	
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	
15.00	Medical Social Services	0	0		0 0	0	
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	
21.00		0	0		0 0	0	21.00
22.00	OTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
22.00	Anal gesi cs	0	0		0 0	0	
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00	Other - Specify	0	0		0 0	0	
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	1
27.00	Patient Transportation	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	28.00
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	
32.00	Radiation Therapy	0	0		0 0	0	
33.00	Chemotherapy	0	0		0 0	0	
34.00	Other HOSPICE NONREIMBURSABLE SERVICE	0	0		0 0	0	34.00
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	
37.00	Fundrai si ng	0	0		0 0	0	
38.00	Other Program Costs	0	0		0 0	0	
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0		0 0	0	39.00
	Unit Cost Multiplier	0. 000000	0. 000000	0.0000	0. 000000	0.00000	1 40 00

COST A	LLOCATION - STATISTICAL BASIS					
			Provider CCN: Hospice CCN:	Period: From 01/01/2015 To 12/31/2015	Worksheet K- Part II Date/Time Pr	epared:
					7/14/2016 3:	43 pm
				Hospi ce I		
		RECONCI LI ATI ON ADI	& GENERAL			
			ACC. COST)			
		6A	6.00			
	GENERAL SERVICE COST CENTERS	1 1				
1.00	Capital Related Costs-Bldg and Fixt.	0				1.00
2.00	Capital Related Costs-Movable Equip.	0				2.00
3.00	Plant Operation and Maintenance	0				3.00
4.00	Transportation - Staff	0				4.00
5.00	Volunteer Service Coordination					5.00
6.00	Administrative and General	-351, 715	28, 159			6.00
	I NPATI ENT CARE SERVI CE					
7.00	Inpatient - General Care	0	0			7.00
8.00	Inpatient - Respite Care	0	0			8.00
	VI SI TI NG SERVI CES					
9.00	Physician Services	0	0			9.00
10.00	Nursing Care	0	0			10.00
11.00	Nursing Care-Continuous Home Care	0	0			11.00
12.00	Physical Therapy	0	0			12.00
13.00	Occupational Therapy	0	0			13.00
14.00	Speech/ Language Pathol ogy	0	0			14.00
15.00	Medical Social Services	0	0			15.00
16.00	Spiritual Counseling	0	0			16.00
17.00	Di etary Counsel i ng	0	0			17.00
18.00	Counseling - Other	0	0			18.00
19.00	Home Health Aide and Homemaker	0	0			19.00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0			20.00
21.00	Other	0	0			21.00
	OTHER HOSPICE SERVICE COSTS					_
22.00	Drugs, Biological and Infusion Therapy	0	28, 021			22.00
23.00	Anal gesi cs	0	0			23.00
24.00	Sedatives / Hypnotics	0	0			24.00
25.00	Other - Specify	0	0			25.00
26.00	Durable Medical Equipment/Oxygen	0	0			26.00
27.00	Patient Transportation	0	0			27.00
28.00	Imaging Services	0	0			28.00
29.00	Labs and Diagnostics	0	0			29.00
30.00	Medical Supplies	0	138			30.00
31.00	Outpatient Services (including E/R Dept.)	0	0			31.00
32.00	Radiation Therapy	0	0			32.00
33.00	Chemotherapy	0	0			33.00
34.00	Other HOSPICE NONREIMBURSABLE SERVICE	0	U			34.00
35.00	Bereavement Program Costs	0	0			35.00
36.00	Volunteer Program Costs	0	0			36.00
37.00	Fundrai si ng	0	0			37.00
38.00	Other Program Costs	0	0			38.00
50.00		5				
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		351, 715			39.00

	2	ARKVIEW WABASH			_	In Lie	u of Form CMS-2	
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 151310 CCN: 151545	F		Worksheet K-5 Part I Date/Time Pre 7/14/2016 3:4	pared:
						Hospi ce I		
			CAPI TAL REI	LATED COSTS				
	Cost Center Description	Hospice Trial Balance (1)	BLDG & FIXT	MVBLE EQUIF	C	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00		4.00	4A	
1.00	Administrative and General		0		0	6, 736	6, 736	1.00
2.00	Inpatient - General Care	0	0		0	0	0	2.00
3.00	Inpatient - Respite Care	0	0		0	0	0	3.00
4.00	Physi ci an Servi ces	0	0		0	0	0	4.00
5.00	Nursing Care	0	0		0	36, 077	36, 077	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	0	6.00
7.00	Physical Therapy	0	0		0	102	102	7.00
8.00	Occupational Therapy	0	0		0	0	0	8.00
9.00	Speech/ Language Pathology	0	0		0	0	0	9,00
10.00	Medical Social Services	0	0		0	8, 521	8, 521	10.00
11.00	Spiritual Counseling	0	0		0	0	0	11.00
12.00	Di etary Counsel i ng	0	0		0	0	0	12.00
13.00	Counseling - Other	0	0		0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0	924	924	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	14, 661	14, 661	15.00
16.00	Other	0	0		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	378, 012	0		0	0	378, 012	17.00
18.00	Anal gesi cs	0	0		0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	0	19.00
20.00	Other - Specify	0	0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	0	21.00
22.00	Patient Transportation	0	0		0	0	0	22.00
23.00	I magi ng Servi ces	0	0		0	0	0	23.00
24.00	Labs and Diagnostics	0	0		0	0	0	24.00
25.00	Medical Supplies	1, 862	0		0	0	1, 862	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	26.00
27.00	Radiation Therapy	0	0		0	0	0	27.00
28.00	Chemotherapy	0	0		0	0	0	28.00
29.00	Other	0	0		0	0	0	29.00
30.00	Bereavement Program Costs	0	0		0	0	0	30.00
31.00	Volunteer Program Costs	0	0		0	0	0	31.00
32.00	Fundrai si ng	0	0		0	0	0	32.00
33.00	Other Program Costs	0	0		0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	379, 874	0		0	67, 021	446, 895	34.00
35 00	Unit Cost Multiplier (see instructions)			1			0	35.00

Heal th	Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Li	eu of Form CMS-	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 151310	Peri od:	Worksheet K-5	
					From 01/01/2015		
			Hospi ce C	CN: 151545	To 12/31/2015	5 Date/Time Pre 7/14/2016 3:4	
					Hospi ce I	// 1// 2010 0.1	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	·	& GENERAL	PLANT	LINEN SERVIC			
	T	5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	2, 612	0		0 (	°	
2.00	Inpatient - General Care	0	0		0 (	0 0	
3.00	Inpatient - Respite Care	0	0		0 (	0	
4.00	Physician Services	0	0		0 0	0	
5.00	Nursing Care	13, 991	0		0 0	0	
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	
7.00	Physical Therapy	40	0		0 0		
8.00 9.00	Occupational Therapy	0	0				0.00
9.00 10.00	Speech/ Language Pathology Medical Social Services	3, 305	0		0 0		
	Spiritual Counseling	3, 305	0		0 0		
11. 00 12. 00	Dietary Counseling	0	0				
12.00	Counseling - Other	0	0		0 0		12.00
14.00	Home Health Aide and Homemaker	358	0		0 0		1
15.00	HH Aide & Homemaker - Cont. Home Care	5, 686	0				
16.00	Other	0,000	0		0 (		1
17.00	Drugs, Biological and Infusion Therapy	146, 599	Ŭ		0 0		
18.00	Anal gesi cs	0	0		0 0	ol o	
19.00	Sedatives / Hypnotics	0	0		0 0	0 0	19.00
20.00	Other - Specify	0	0		0 0	o o	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	o o	21.00
22.00	Patient Transportation	0	0		0 0	o o	22.00
23.00	Imaging Services	0	0		0 0	0 0	23.00
24.00	Labs and Diagnostics	0	0		0 (	0 0	24.00
25.00	Medical Supplies	722	0		0 0	0 0	
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0 0	
27.00	Radiation Therapy	0	0		0 0	0 0	
28.00	Chemotherapy	0	0		0 (	0 0	
29.00	Other	0	0		0 (	0 0	
30.00	Bereavement Program Costs	0	0		0 (	0	
31.00	Volunteer Program Costs	0	0		0 0	0	
32.00	Fundrai si ng	0	0		0 0	0	
33.00	Other Program Costs Total (sum of lines 1 thru 33) (2)	172 212	0		0 0		
34.00 35.00	Unit Cost Multiplier (see instructions)	173, 313	0		U U	ן י	34.00
33.00		I I			I	I	1 33.00

Heal th	Financial Systems PA	ARKVIEW WABASH	HOSPI TAL, INC.		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 151310 CCN: 151545	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I Date/Time Pre 7/14/2016 3:4	pared:
					Hospi ce I	// 11/2010 0.1	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0		0 0	0	1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physi ci an Servi ces	0	0		0 0	0	4.00
5.00	Nursing Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physi cal Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8,00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9,00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0 0	0	34.00
	Unit Cost Multiplier (see instructions)						35.00
		ļ.		1	ļ		

Health Financial Systems P.	ARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-	2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST	- CENTERS		CCN: 151310 CCN: 151545	Period: From 01/01/2015 To 12/31/2015		pared:
	_	_		Hospi ce I		
Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
	(col s. 4A-23)	Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
		& Post	25)	(See Part II)	26 ± 27)	
		Stepdown				
		Adjustments				
	24.00	25.00	26.00	27.00	28.00	
1.00 Administrative and General	9, 348					1.00
2.00 Inpatient - General Care	0	0		0 0	-	2.00
3.00 Inpatient - Respite Care	0	0		0 0		3.00
4.00 Physician Services	0	0		0 0	0	4.00
5.00 Nursing Care	50, 068	0	50, 00	58 766	50, 834	5.00
6.00 Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00 Physical Therapy	142	0	1.	42 2	144	7.00
8.00 Occupational Therapy	0	0		0 0	0	8.00
9.00 Speech/ Language Pathology	0	0		0 0	0	9.00
10.00 Medical Social Services	11, 826	0	11, 8:	26 181	12, 007	10.00
11.00 Spiritual Counseling	0	0		0 0	0	11.00
12.00 Dietary Counseling	0	0		0 0	0	12.00
13.00 Counseling - Other	0	0		0 0	0	13.00
14.00 Home Health Aide and Homemaker	1, 282	0	1, 2	32 20	1, 302	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	20, 347	0	20, 3	47 311	20, 658	15.00
16.00 Other	0	0		0 0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	524, 611	l o	524, 6	11 8, 028	532, 639	17.00
18.00 Anal gesi cs	0	0		0 0		18.00
19.00 Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00 Other - Specify	0	0		0 0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00 Patient Transportation	0	0		0 0	0	22.00
23.00 Imaging Services	0	0		0 0	0	23.00
24.00 Labs and Diagnostics	0	0		0 0		24.00
25.00 Medical Supplies	2, 584	0	2, 5	34 40	2, 624	
26.00 Outpatient Services (including E/R Dept.)	0	0	_, _,	0 0		1
27.00 Radi ati on Therapy	0	0		0 0	0	
28.00 Chemotherapy	0	0		0 0	0	28.00
29. 00   0ther	0	0		0 0	0	
30.00 Bereavement Program Costs	0	n		0 0	0	
31.00 Volunteer Program Costs	0	0		0 0	0	31.00
32. 00 Fundrai si ng	0	n		0 0	0	32.00
33.00 Other Program Costs	0	0		0 0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	620, 208	, o	620, 20		620, 208	
	020,200		520, 20			35.00
35.00 Unit Cost Multiplier (see instructions)				0. 015303	I	3

19.00       Sedatives / Hypnotics       0       0       0         20.00       Other - Specify       0       0       0         21.00       Durable Medical Equipment/Oxygen       0       0       0         22.00       Patient Transportation       0       0       0         23.00       Imaging Services       0       0       0         24.00       Labs and Diagnostics       0       0       0         25.00       Medical Supplies       0       0       0       1,86	2552-10
Cost Center Description         CAPITAL RELATED COSTS         EMPLOYEE         Reconciliation         ADMINISTRATIV & GENERAL (COULAR VALUE)           1.00         Administrative and General         0         0         2.00         4.00         5A         5.00           1.00         Inpatient - General Care         0         0         2.7,233         0         6,73           2.00         Inpatient - Respite Care         0         0         0         0         0           3.00         Inpatient - Respite Care         0         0         0         0         0           5.00         0         0         0         0         0         0         0           0.00         Nursing Care-Continuous Home Care         0         0         0         0         0           0.00         Speech/ Language Pathology         0         0         0         0         0           0.00         0         0         0         0         0         0         0           0.00         Department         0         0         0         0         0         0           0.00         0         0         0         0         0         0         0 <tr< td=""><td></td></tr<>	
Cost Center Description         CAPITAL RELATED COSTS         Reconciliation         ADMINISTRATIV           BLOG & FIXT (SOUARE FEET)         MVBLE EQUIP (DOLLAR VALUE)         EMPLOYEE BENEFITS DEPARTMENT         Reconciliation         ADMINISTRATIV & GENERAL (ACCUM. COST)           1.00         Administrative and General         0         0         2.00         4.00         5A         5.00           1.00         Longatient - General Care         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         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         0         0         0 <td< td=""><td></td></td<>	
Lost Center Description         BLDG & FLXT (SOUARE FEET)         MVBLE EQUIP (DOLLAR VALUE)         Reconciliation         ADMINISTRATIV & GENERAL (ACCUM. COST)           1.00         Administrative and General         0         0         2.00         4.00         5A         5.00           2.00         Inpatient - General Care         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         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         0         0         0         0         0         0         0         0         0         0         0         0	<u>o p</u>
Image: second	
Image: second	
Loc         DEPARTMENT (GROSS SALARIES)         (ACCUM. COST) (GROSS           1.00         2.00         4.00         5A         5.00           1.00         2.00         Inpatient - General Care         0         0         0         0           2.00         Inpatient - General Care         0         0         0         0         0         0           3.00         Inpatient - Respite Care         0         0         0         0         0         0         0           4.00         Physicial Therapy         0         0         145,864         0.60,07         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         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	
Image: 100         CROSS SALARIES         SALARIES           1.00         2.00         4.00         5A         5.00           1.00         Impatient - General Care         0         0         2.7,233         0         6.73           2.00         Inpatient - General Care         0         0         0         0         0           3.00         Inpatient - Respite Care         0         0         0         0         0           4.00         Physician Services         0         0         0         0         0         0           5.00         Nursing Care-Continuous Home Care         0         0         0         0         0         0         0         0           7.00         Physical Therapy         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         0         0         0         0         0         0         <	
Image: 1.00         SALARLES         SALARLES           1.00         Administrative and General         0         2.00         4.00         5A         5.00           1.00         Inpatient - General Care         0         0         0         0         0         0         0           2.00         Inpatient - General Care         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         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         0         0         0         0         0         0         0         0         0	
1.00       Administrative and General       0       0       27,233       0       6,73         2.00       Inpatient - General Care       0       0       0       0       0         3.00       Inpatient - Respite Care       0       0       0       0       0         4.00       Physician Services       0       0       0       0       0       0         5.00       Nursing Care       0       0       0       0       0       0       0       0         6.00       Nursing Care-Continuous Home Care       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       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	
2.00       Inpatient - General Care       0       0       0         3.00       Inpatient - Respite Care       0       0       0         4.00       Physician Services       0       0       0         5.00       Nursing Care       0       0       0       0         6.00       Nursing Care-Continuous Home Care       0       0       0       0         7.00       Physical Therapy       0       0       0       0       0         9.00       Speech/ Language Pathology       0       0       0       0       0         9.00       Spect/ Language Pathology       0       0       0       0       0       0         11.00       Spiritual Counseling       0       0       0       0       0       0         12.00       Dietary Counseling       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       0       0	
3.00       Inpatient - Respite Care       0       0       0         4.00       Physician Services       0       0       0       0         5.00       Nursing Care       0       0       145,864       0       36,07         6.00       Nursing Care-Continuous Home Care       0       0       0       0       0         7.00       Physical Therapy       0       0       0       0       0       0         8.00       Occupational Therapy       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       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       0       0	1
4.00       Physician Services       0       0       0       0         5.00       Nursing Care       0       0       145,864       0       36,07         6.00       Nursing Care-Continuous Home Care       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       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       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	
5.00       Nursing Care       0       0       145,864       0       36,07         6.00       Nursing Care-Continuous Home Care       0       0       0       0       0         7.00       Physical Therapy       0       0       412       0       10         8.00       Occupational Therapy       0       0       0       0       0         9.00       Speech/ Language Pathology       0       0       0       0       0         10.00       Medical Social Services       0       0       0       0       0       0         11.00       Spiritual Counseling       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       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>	
6.00       Nursing Care-Continuous Home Care       0       0       0       0         7.00       Physical Therapy       0       0       412       0       10         8.00       Occupational Therapy       0       0       0       0       0       0         9.00       Speech/Language Pathology       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       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       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	
7.00       Physical Therapy       0       0       412       0       10         8.00       Occupational Therapy       0       0       0       0       0         9.00       Speech/ Language Pathology       0       0       0       0       0         10.00       Medical Social Services       0       0       34,453       0       8,52         11.00       Spiritual Counseling       0       0       0       0       0         12.00       Dietary Counseling       0       0       0       0       0         13.00       Counseling - Other       0       0       0       0       0         14.00       Home Heal th Aide and Homemaker       0       0       3,736       0       92         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         18.00       Analgesics       0       0       0       0       0       0       0         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       0	
9.00       Speech / Language Pathol ogy       0       0       0       0         10.00       Medical Social Services       0       0       34,453       0       8,52         11.00       Spiritual Counseling       0       0       0       0       0         12.00       Dietary Counseling       0       0       0       0       0         13.00       Counseling - Other       0       0       0       0       0         14.00       Home Heal th Aide and Homemaker       0       0       3,736       0       92         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         18.00       Anal gesics       0       0       0       0       0       0         19.00       Sedatives / Hypnotics       0       0       0       0       0       0         20.00       Other - Specify       0       0       0       0       0       0         21.00       Durable Medical Equipment/0xygen       0       0       0       0       0       0 <td></td>	
10.00       Medical Social Services       0       0       34,453       0       8,52         11.00       Spiritual Counseling       0       0       0       0         12.00       Dietary Counseling       0       0       0       0         13.00       Counseling - Other       0       0       0       0         14.00       Home Heal th Aide and Homemaker       0       0       3,736       0       92         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0         16.00       Other       0       0       0       0       0       0       0         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       0         18.00       Anal gesi cs       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       0       0       0	8.00
11.00       Spiritual Counseling       0       0       0         12.00       Dietary Counseling       0       0       0         13.00       Counseling - Other       0       0       0         14.00       Home Heal th Aide and Homemaker       0       0       3,736       0       92         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       59,276       0       14,66         16.00       Other       0       0       0       0       0       0         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         18.00       Anal gesics       0       0       0       0       0       0         19.00       Sedatives / Hypnotics       0       0       0       0       0       0         20.00       Other - specify       0       0       0       0       0       0       0         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<	9.00
12.00       Dietary Counseling       0       0       0         13.00       Counseling - Other       0       0       0       0         14.00       Home Heal th Aide and Homemaker       0       0       3,736       0       92         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       59,276       0       14,66         16.00       Other       0       0       0       0       0       0         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0         18.00       Anal gesics       0       0       0       0       0       0         19.00       Sedatives / Hypnotics       0       0       0       0       0       0         20.00       Other - Specify       0       0       0       0       0       0         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       0         23.00       Imaging Services       0       0       0       0       0       0         24.00       Labs and Diagnostics       0       0       0       0       0       1,86     <	1
13.00       Counseling - Other       0       0       0       0         14.00       Home Health Aide and Homemaker       0       0       3,736       0       92         15.00       HH Aide & Homemaker - Cont. Home Care       0       0       59,276       0       14,66         16.00       Other       0       0       0       0       0       0         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0         18.00       Anal gesics       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       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 <t< td=""><td>1</td></t<>	1
14.00       Home Heal th Ai de and Homemaker       0       0       3,736       0       92         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       59,276       0       14,66         16.00       Other       0       0       0       0       0       14,66         16.00       Other       0       0       0       0       0       0       14,66         16.00       Other       0       0       0       0       0       0       0       0       14,66         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       378,01         18.00       Anal gesics       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       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td></t<>	
15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       59,276       0       14,66         16.00       Other       0       0       0       0       0         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       378,01         18.00       Anal gesics       0       0       0       0       0       378,01         18.00       Sedatives / Hypnotics       0       0       0       0       0       0         19.00       Sedatives / Hypnotics       0       0       0       0       0       0         20.00       Other - Specify       0       0       0       0       0       0       0         21.00       Durable Medical Equipment/Oxygen       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       0       0       0       0       0       0       0       0	
16.00       Other       0       0       0       0         17.00       Drugs, Biological and Infusion Therapy       0       0       0       378,01         18.00       Anal gesics       0       0       0       0       0         18.00       Anal gesics       0       0       0       0       0         19.00       Sedatives / Hypnotics       0       0       0       0       0         20.00       Other - Specify       0       0       0       0       0       0         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       0         22.00       Pati ent Transportation       0       0       0       0       0       0         23.00       Imaging Services       0       0       0       0       0       0         24.00       Labs and Diagnostics       0       0       0       0       1,86	
17.00       Drugs, Biological and Infusion Therapy       0       0       0       378,01         18.00       Analgesics       0       0       0       0         19.00       Sedatives / Hypnotics       0       0       0       0         19.00       Sedatives / Hypnotics       0       0       0       0         20.00       Other - Specify       0       0       0       0         21.00       Durable Medical Equipment/Oxygen       0       0       0       0         22.00       Patient Transportation       0       0       0       0         23.00       Imaging Services       0       0       0       0         24.00       Labs and Diagnostics       0       0       0       0         25.00       Medical Supplies       0       0       0       1,86	1
18.00       Anal gesi cs       0       0       0       0         19.00       Sedati ves / Hypnoti cs       0       0       0       0         20.00       Other - Speci fy       0       0       0       0         21.00       Durable Medical Equipment/Oxygen       0       0       0       0         22.00       Pati ent Transportation       0       0       0       0         23.00       Imagi ng Services       0       0       0       0         24.00       Labs and Di agnostics       0       0       0       0         25.00       Medi cal Supplies       0       0       0       1,86	
20.00       0ther - Specify       0       0       0         21.00       Durable Medical Equipment/Oxygen       0       0       0         22.00       Patient Transportation       0       0       0         23.00       Imaging Services       0       0       0         24.00       Labs and Diagnostics       0       0       0         25.00       Medical Supplies       0       0       0       1,86	18.00
21.00         Durable Medical Equipment/Oxygen         0         0         0         0           22.00         Patient Transportation         0         0         0         0         0           23.00         Imaging Services         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         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86<	19.00
22.00         Pati ent Transportation         0         0         0           23.00         Imaging Services         0         0         0           24.00         Labs and Diagnostics         0         0         0           25.00         Medical Supplies         0         0         0         1,86	
23.00       Imaging Services       0       0       0         24.00       Labs and Diagnostics       0       0       0         25.00       Medical Supplies       0       0       0       1,86	1
24.00         Labs and Diagnostics         0         0         0         0         0         0         0         0         0         0         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86         1,86	
25.00 Medical Supplies 0 0 0 1,86	
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0	1
27.00 Radiation Therapy 0 0 0 0	27.00
28.00 Chemotherapy 0 0 0 0	28.00
29.00 Other 0 0 0	
30.00         Bereavement Program Costs         0         0         0         0         0	
31.00   Volunteer Program Costs   0   0   0	
32.00 Fundraising 0 0 0 0	
33.00         Other Program Costs         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         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         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         0         0	
35. 00 Total cost to be allocated 0 0 67,021 173, 31	1
36. 00 Unit Cost Multiplier (see instructions) 0. 000000 0. 000000 0. 247334 0. 38781	

Health Financial Systems	PARKVI EW WABASH	HOSPITAL. INC.		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE CO			CCN: 151310	Peri od:	Worksheet K-5	
STATI STI CAL BASI S				From 01/01/2015	Part II	
		Hospi ce (	CCN: 151545	To 12/31/2015		pared:
				lleest ee l	7/14/2016 3:4	<u>3 pm</u>
Cost Conton Decemination				Hospice I G DIETARY	CAFETERIA	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI N			
	(SQUARE FEET)	(POUNDS OF	(SQUARE FEET	) (MEALS SERVED)	(HOURS)	
	(SQUARE ILLI)	LAUNDR)				
	7.00	8.00	9,00	10.00	11.00	
1.00 Administrative and General	0			0 0		1.00
2.00 Inpatient - General Care	0	0		0 0		
3.00 Inpatient - Respite Care	0	0		0 0	0	
4.00 Physician Services	0	0		0 0	0	
5.00 Nursing Care	0	0		0 0	0	•
6.00 Nursing Care-Continuous Home Care	0	0		0 0	0	
7.00 Physical Therapy	0	0		0 0	0	
8.00 Occupational Therapy	0	0		0 0		
9.00 Speech/ Language Pathol ogy	0	0		0 0	0	
10.00 Medical Social Services	0	0		0 0		10.00
11.00 Spiritual Counseling	0	0		0 0	0	
12.00 Di etary Counsel i ng	0	0		0 0	0	
13.00 Counseling - Other	0	0		0 0	0	
14.00 Home Health Aide and Homemaker	0	0		0 0	0	
15.00   HH Aide & Homemaker - Cont. Home Care	0	0		0 0		
16.00 Other	0	C		0 0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	C		0 0	0	17.00
18.00 Anal gesi cs	0	C		0 0	0	18.00
19.00 Sedatives / Hypnotics	0	C		0 0	0	19.00
20.00 Other - Specify	0	C		0 0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	C		0 0	0	21.00
22.00 Patient Transportation	0	C		0 0	0	22.00
23.00 Imaging Services	0	C		0 0	0	23.00
24.00 Labs and Diagnostics	0	C		0 0	0	24.00
25.00 Medical Supplies	0	0		0 0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00 Radiation Therapy	0	0		0 0	0	27.00
28.00 Chemotherapy	0	0		0 0	0	28.00
29.00 Other	0	0		0 0	0	29.00
30.00 Bereavement Program Costs	0	0		0 0	0	30.00
31.00 Volunteer Program Costs	0	C		0 0	0	31.00
32.00 Fundrai si ng	0	0		0 0	0	32.00
33.00 Other Program Costs	0	0		0 0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0		0 0	0	34.00
35.00 Total cost to be allocated	0	C		0 0	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.0000	00 0. 000000	0. 000000	36.00

Heal th Financial Systems PARKVIEW WABASH HOSPI				CON 151010			u of Form CMS-	
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS STATISTICAL BASIS				Provi der CCN: 151310 Hospi ce CCN: 151545		eriod: com 01/01/2015 0 12/31/2015		
						Hospi ce I	77 147 2010 3.4	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		MEDI CAL		
	•	ADMI NI STRATI ON	SERVICES &	(COSTED		RECORDS &		
			SUPPLY	REQUIS.)		LI BRARY		
		(DI RECT NRSI NG	(COSTED			(GROSS REV)		
		HR)	REQUIS.)	45.00		14.00		
1 00	Advisi at a tractioner and Compared	13.00	14.00	15.00		16.00		1.00
1.00 2.00	Administrative and General	0	0		0 0	0		1.00
	Inpatient - General Care	0	0		0	0		
3.00 4.00	Inpatient - Respite Care Physician Services	0	0		0	0		3.00
4.00 5.00	Nursi ng Care	0	0		0	0		5.00
5.00 6.00	Nursing Care-Continuous Home Care	0	0		0	0		6.00
7.00	Physi cal Therapy	0	0		0	0		7.00
8.00	Occupational Therapy	0	0		0	0		8.00
9.00	Speech/ Language Pathol ogy	0	0		0	0		9.00
10.00	Medi cal Soci al Servi ces	0	0		0	0		10.00
10.00	Spiritual Counseling	0	0		0	0		11.00
12.00	Dietary Counseling	0	0		0	0		12.00
13.00	Counseling - Other	0	0		0	0		13.00
14.00	Home Health Aide and Homemaker	0	0		0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0		15.00
16.00	Other	0	0		0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0		17.00
18.00	Anal gesi cs	0	0		0	0		18.00
19.00	Sedatives / Hypnotics	0	0		0	0		19.00
20.00	Other - Specify	0	0		0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0		21.00
22.00	Patient Transportation	0	0		0	0		22.00
23.00	Imaging Services	0	0		0	0		23.00
24.00	Labs and Diagnostics	0	0		0	0		24.00
25.00	Medical Supplies	0	138		0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0		26.00
27.00	Radiation Therapy	0	0		0	0		27.00
28.00	Chemotherapy	0	0		0	0		28.00
29.00	Other	0	0		0	0		29.00
30.00	Bereavement Program Costs	0	0		0	0		30.00
31.00	Volunteer Program Costs	0	0		0	0		31.00
32.00	Fundrai si ng	0	0		0	0		32.00
33.00	Other Program Costs	0	0		0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	138		0	0		34.00
35.00	Total cost to be allocated	0	0	0.0000	Ŭ	0		35.00
30.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.0000	000	0. 000000		36.00

Heal th	Financial Systems	PARKVIEW WABASH H	HOSPI T	AL, INC.			In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF TOTAL HOSPICE SHARED COSTS		P	rovi der	CCN:		Period: From 01/01/2015	Worksheet K-5 Part III		
			Н	ospi ce (	CCN:		To 12/31/2015		
							Hospi ce I		
	Cost Center Description		Wkst.	C, Part	Cost	to Charg	e Total Hospice	Hospi ce Shared	
			I, CO	ol. 11	1	Ratio	Charges	Ancillary	
			Li	ne			(Provi der	Costs (cols. 1	
							Records)	x 2)	
				0		1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS				_				
1.00	PHYSI CAL THERAPY			66.00	)	0.56818	7 0	0	1.00
2.00	OCCUPATIONAL THERAPY			67.00		0.93399	9 0	0	2.00
3.00	SPEECH PATHOLOGY			68.00		0.00008	1 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS			73.00		0.27297	3 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED			96.00					5.00
6.00	LABORATORY			60.00		0. 22173	0 0	0	6.00
6.01	BLOOD LABORATORY			60.01	1				6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT			71.00		0.48305	4 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER			93.00					8.00
9.00	RADI OLOGY-THERAPEUTI C			55.00					9.00
10.00	OTHER ANCI LLARY SERVICE COST CENTERS			76.00					10.00
11.00	Totals (sum of lines 1-10)							0	11.00

Health Financial Systems PARKVIEW WABASH	HOSPITAL, INC.		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST		CCN: 151310	Period:	Worksheet K-6	
		CCN: 151545	From 01/01/2015 To 12/31/2015		
	_		Hospi ce I		
	Title XVIII	Title XIX	Other	Total	
	1.00	2.00	3.00	4.00	
1.00 Total cost (see instructions)				620, 208	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4, 551	2.00
3.00 Average cost per diem (line 1 divided by line 2)				136.28	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	4, 551				4.00
5.00 Aggregate Medicare cost (line 3 time line 4)	620, 210				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			0		6.00
7.00 Aggregate Medicaid cost (line 3 time line 60)			0		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00 Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00 Aggregate NF cost (line 3 times line 10)			0		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00 Aggregate cost for other days (line 3 times line 12)			0		13.00